Behavioral Health Home Learning Collaborative

Embracing Excellence in Health

The Quality Improvement Journey

Maine Behavioral Healthcare, Community Health and Counseling Services, UCP of Maine

Colby College - June 25, 2015

This work is made possible with funding from the Maine State Innovation Model Initiative
Agenda for Today’s Breakout Session

• Introductions
• QI Refresh
• Three BHHOs share their QI Journey
• Group Talk
BHH 10 Core Expectations

1. Demonstrated Leadership
2. Team-Based Approach to Care
3. Population Risk Stratification and Management
4. Enhanced Access
5. Comprehensive Consumer/Family Directed Care Planning
6. Behavioral-Physical Health Integration
7. Inclusion of Members & Families
8. Connection to Community Resources & Social Support Services
10. Integration of Health Information Technology
Core Expectation 9: QI Work

The BHHO has processes in place to reduce wasteful spending of healthcare resources and improving the cost-effective use of healthcare services, as evidenced by at least one initiative that targets waste reduction, such as:

• Reducing avoidable hospitalizations
• Reducing avoidable ED visits
• Working with specialists to develop new models of specialty consultation to improve member experience and quality
• Directing referrals to specialists who consistently demonstrate high quality and cost effective use of resources
### BHH Quality Improvement Definition

<table>
<thead>
<tr>
<th>QI Definition</th>
<th>QI for BHH Definition</th>
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<tbody>
<tr>
<td>Quality Improvement is the practice of taking current processes and identifying and testing changes to enhance outcomes of the process.</td>
<td>Quality Improvement for BHH Teams means testing changes in providing better care for members and families to improve outcomes for these individuals and families.</td>
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Focus of QI Projects

DHHS/OMS: BHHOs should develop QI projects around:

• **High Utilization of Health Care Services;**

• **Unnecessary Emergency Department Visits;**

• **Unnecessary Hospital Admissions**
QI Refresher

AIM Statements, Plan-Do-Study-Act, Data
The specific aim is a statement of what you intend to accomplish with numeric goals, dates/times, and with specific measures to be used.
Example: Reduce ED Utilization

We Aim to: Reduce the percentage of unnecessary visits our patients make to the local emergency room

From: 45%

To: 42%

By: August 31, 2015
What are we trying to accomplish?

How will we know that a change is an improvement?

What changes can we make that will result in improvement?

Plan

Act

Do

Study

Circle diagram with arrows indicating the cycle of Plan, Act, Do, and Study.
PDSA

- **Plan:** Plan the test or observation, including data collection plan
- **Do:** Try Out the test on a small scale
- **Study:** Set aside time to analyze the data and study the results
- **Act:** Refine the change, based on what was learned from the test
Data Sources available to BHHOs

• Health Home Enrollment System Portal
  – Aka “The Muskie Portal”
• Health Info Net Data
• Self-collected clinical data
  – BHHO Electronic Health Record
Data Types

Quantitative Data

• Number of clients
• Client wait time
• Percent of clients who have private insurance
• Client satisfaction with services received

Qualitative Data

• Reason for client’s visit
• Suggestions for agency improvement
• Name of insurance company
• Description of satisfaction with services
BHHL QI Projects

- ED Visits: 10
- Chronic Disease: 4
- Hospitalizations: 2
BHH Quality Improvement Specialist

Who I am:

- Mary T Beyer, M.A.
- MBeyer@mainequalitycounts.org
- 207-620-8526x1030

What I do:

- Provide technical assistance with Core Expectations and QI Projects
- Assist with methods of collecting, synthesizing and applying data to improve outcomes
- Facilitate integration and collaboration of BHH Team
Thank you to our BHH Presenters

• Maine Behavioral Healthcare:
  – Sara Schmalz
    • A1 screenings for people with diabetes

• Community Health and Counseling Services
  – Brian Moynihan
    • Hypertension screening for members with high blood pressure

• United Cerebral Palsy of Maine
  – Jonathan Smith
    • Decreasing avoidable ED use
Maine Behavioral Healthcare

• 260 clients, peer support, nurse care management, 15 case managers (some with mixed caseloads of CI/BHH)

• Adults-Greater Portland

• 165 Lancaster St in Portland and 12 Westbrook Common in Westbrook
Deciding on a QI initiative

• Who was involved:
  – MBH BHH QI Committee
  – Clinical Team Lead
  – Case Manager
  – Nurse CM
  – Medical and psychiatric consultants and others
Deciding on a QI initiative

• Major Considerations:
  – **Data** Sources
  – **EHR** Status
  – Starting Small
  – **Numbers on the portal showed that A1c screenings were a significant issue for our BHH population**
  – Amount of time involved for project staff
AIM Statement

• For BHH clients, we will increase the number of clients with diabetes who receive quarterly A1c screenings by X % by April 1, 2016.
Measurement Considerations

- **Plan**: First we will address the number of clients getting screened, next we will work to improve the screening results.
- **HHES Portal** for A1c information *(39 clients should have been screened)*
- Reliability of diagnosis information, exploring options for data that do not involve self-report needed for accurate ongoing ratio and measurements
Observations to date

• Clinical team lead is **point person**
• **Continual process for QI committee** with several revisions to date of what is needed for reliability and data analysis even for initial project
• **Increasing QI capability**
• **Helpful in changing culture** toward **overall health outcomes and integrated goals**
Next Steps

• Identifying **EHR needs/priorities** for tracking QI data, explore new data sources
• **Review approach for effectiveness**, consider new approach
• Prepare for **collecting actual A1c results-protocols/consistency**
Quality Improvement Project

Brian Moynihan
Clinical Program Coordinator
Overview of the Community Health and Counseling Behavioral Health Home program

Choosing our Quality Improvement Project

Our Quality Improvement AIM Statement

Measurements and Data Gathering

Observations and Outcomes

Next Steps
The CHCS BHH program includes three BHH teams in different office locations, each integrated into our larger system of mental health services and integrated care/wellness programs.

The CHCS BHH presently serves adults ages 18 and up over a wide geographic area in central and down east Maine.

Our three BHH teams are located in Bangor, Ellsworth, and Machias/Calais.
Choosing our Quality Improvement Project

• Planning team members included the clinical and administrative lead, case management, RN care managers, and peer support specialist.

• Many factors influenced our choice:
  – Potential impact on population health
  – Feasibility/access to data
  – Training/education needed for implementation
Our Quality Improvement Aim Statement

• Our goal is to have a positive impact on the overall health of our population and reduce healthcare costs by targeting hypertension in our BHH population.

• We will increase identification and treatment of hypertension in our population in order to reduce overall levels of hypertension and reduce associated health risks.
Objectives:

1. Staff and client education around hypertension
2. Identify target date for completion of 100% of blood pressure data
3. Capture baseline blood pressure data for our BHH population

Using standard protocols for blood pressure, we identified individuals who have normal blood pressure, pre-hypertension, and hypertension.
Based on the baseline data, interventions were identified to address the specific level of risk.

Protocols:

• Normal blood pressure: Repeat within one year

• Pre-hypertension: Provide education, support for lifestyle changes, and increased monitoring

• Hypertension: Provide education, support for lifestyle changes, increased monitoring, and coordination with primary care.
Observations to Date

- Blood pressure readings were gathered by the RN care manager, case managers, and from primary care records.
- RN care manager is the point person for organizing the data and identifying needs.
- Initial efforts for gathering baseline blood pressure data resulted in readings for 97% of our BHH population.
# Baseline Blood Pressure Data

<table>
<thead>
<tr>
<th>Total Clients</th>
<th>Clients with BP Reading</th>
<th>Clients with normal BP</th>
<th>Clients with Pre-Hypertension</th>
<th>Clients with Hypertension</th>
</tr>
</thead>
<tbody>
<tr>
<td>119</td>
<td>116 (97%)</td>
<td>36 (31%)</td>
<td>51 (43%)</td>
<td>27 (25%)</td>
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## CHCS BHH Population, by Age

<table>
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<tr>
<th>Age 18-39</th>
<th>Age 40-59</th>
<th>Age 60 +</th>
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<tbody>
<tr>
<td>25%</td>
<td>50%</td>
<td>25%</td>
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Next Steps

• Implement our protocol for follow-up blood pressure measurements
• Client education and support
• Identify clients currently treated for hypertension
• Identify clients outside the normal range who are without treatment
• Coordination with primary care regarding monitoring and treatment
UCP’S BEHAVIORAL HEALTH HOME QUALITY IMPROVEMENT JOURNEY

United Cerebral Palsy of Maine (UCP) Behavioral Health Home’s Journey of Quality Improvement in Practice
Who We Are

• A private, non-profit organization established in 1954

• Governed by a volunteer Board of Directors

• Employer of nearly 250 qualified staff members who serve over 1,500 individuals and families across the state each year.
What We Do

- UCP of Maine is a comprehensive Disability Resource Network
  - Early Childhood Services
  - Behavioral Health Home and Case Management Services
  - Adult Residential Services (Shift-Staff Homes and Shared Living)
  - Behavioral Health Services
Steps in our Quality Improvement (QI) Journey

QI Selection

• Based on Core Expectation #9

  • MaineCare Objective: Reduction in avoidable emergency room use

• UCP’s ER data from the Health Home Enrollment System (HHES)
Steps in our QI Journey

QI Target Population

- UCP BHH clients who have visited the ER at least once in 2014 for a physical health issue indicated as low-to-moderate severity
Steps in our QI Journey

Decision process regarding our measures

• 30 out of 127 clients had visited the ER at least once for a low-to-moderate severity issue (23.6%) for a total of 39 visits.
Steps in our QI Journey

AIM Statement

• Utilized the Michigan QI Guidebook SMART Aim Statement Template Worksheet
## Developing a SMART Aim Statement Worksheet

<table>
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<tr>
<th>Aim Statement Criteria</th>
<th>Developmental Questions</th>
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</thead>
<tbody>
<tr>
<td><strong>Specific</strong></td>
<td>Who are the target population and persons doing the activity? What is the action or activity?</td>
</tr>
<tr>
<td><strong>Measurable</strong></td>
<td>How much change is expected? Will there be an increase or decrease? Can you measure it?</td>
</tr>
<tr>
<td><strong>Achievable</strong></td>
<td>Can it be done? Can you accomplish it in the prescribed timeframe? Do you have resources?</td>
</tr>
<tr>
<td><strong>Relevant</strong></td>
<td>Does the action relate to what you want to accomplish? Is it important &amp; meaningful? Does it relate to broader program or organizational goals?</td>
</tr>
<tr>
<td><strong>Time-Bound</strong></td>
<td>What is the timeline for change? When will this be accomplished? Month, day, time, or year?</td>
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**Aim Statement**

Write your SMART aim statement below:
Steps in our QI Journey

Aim Statement

• By January 2016, only 18% of UCP’s BHH Clients have visited the Emergency Department (ED) at least once for a low-to-moderate severity reason.
Steps in our QI Journey

Sub AIM Statement

• 60% of UCP BHH Clients who have visited the ED at least once for a low-to-moderate severity reason in 2014 will report being more aware of alternative care options by October 2015.

• Measurement: Baseline awareness survey and repeating the survey four months after education
Steps in our QI Journey

• Questions asked: How much change is expected? Will there be an increase or decrease? Can we measure it?
Steps in our QI Journey

Next Steps
• Compare results of awareness study to the baseline awareness survey data

• Encourage use of the Guide to Good Health, which will include individualized handouts
  ▫ Considering client’s location and situation

• Developed write-on health contact magnets to personalize different care options
Health Contacts

PCP: ____________________________

Walk-In: _________________________

Emergency Room: ________________

BHH: ____________________________

Crisis Number is 1-888-568-1112
If this is a life threatening emergency, call 911.
Steps in our QI Journey

Next Steps

• Plan of Care objective seeking increased awareness of alternative care options and appropriate use of health care resources

• “Act/Adjust” – modify approach after reviewing the second set of survey data
Steps in our QI Journey

Next Steps:

Help clients make
good healthcare decisions and
improve cost-effective use of
healthcare services.
Questions for BHHOs?
Reactions!

Your:
Learnings!
Surprises!
Satisfactions!
Dissatisfactions!
Turn to Your Neighbor

• Find the QI Project Discussion Question sheet!
• Share!
Discussion Questions

- *How did you choose your QI Project?*

- *Have your revised/revisited your AIM statement?*

- *Were you able to access the data you originally identified? Have you been able to report out on your key measures?*

- *Has your target population stayed the same?*

- *Have you developed an improvement theory (If we do X, then Y will result).*

- *What is your improvement theory?*

- *What is your next step?*