Moderator:

Madhana Pandian, Associate, CIHS
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Before We Begin

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Learning Objectives

Participants will be:

1. Able to define quality benchmarking.
2. Able to explain what healthcare marketplace conditions are driving the need for quality benchmarking.
3. Able to understand how quality benchmarking can be used to prioritize quality improvement efforts specific to the integration of behavioral and primary care.
4. Able to explain how benchmarking can be used to define and describe value.
5. Able to identify available tools to help you benchmark.
Today’s Speakers

Jeff Capobianco, PhD, LLP
Director of Practice Improvement
The National Council for Behavioral Health

Virna Little, PsyD, LCSW-R, SAP, CCM
Senior Vice President of Pyschosocial Services and Community Affairs
The Institute for Family Health

Elizabeth Lever, LMSW
Director of Process Improvement and Analytics
The Institute for Family Health
What do we mean by “Quality Benchmarking”?

• The Agency for Healthcare Research and Quality (AHRQ) defines benchmarking as, “the process of comparing a practice’s performance with an external standard.”

• Benchmarking is an important quality improvement tool to help healthcare providers understand how their performance compares to others – both externally and internally.

What do we mean by “Quality Benchmarking”? Benchmarking metrics are always quantitative and can address the efficiency and/or effectiveness of processes such as:

- Productivity
- Quality
- Time
- Cost
What is Driving Renewed Focus on Benchmarking?

- Integration of Primary Care & Behavioral Healthcare (IH)
- Value-based Reimbursement (VBR)
Why Do We Need to Benchmark?

• To get staff input and ownership of practice

• To be sure we are reaching or identifying the full denominator of our practice…not just who comes through the door.
Internal benchmarking compares the base rate performance of a team or clinician on a specific metric(s) to another team or clinician within the same organization.

External benchmarking compares an organization’s process or outcome metrics to another provider or standard established by an accrediting body or funder.

Internal Benchmarking for Integrated Health Examples & Sources

Clinical Measures:
- Depression Rating Scale (e.g., PHQ-9)
- Substance Use (e.g., AUDIT-C)

Administrative Measures:
- Staff Capacity
- Use of Concurrent/Collaborative Documentation
- No-shows/Referral Completion/Admission/Discharge/Transfer (ADT)
- Efficient/Effective Billing

Sources:
- Provider Electronic Health Record Registry
- Spreadsheet or Databases
- Managed Care Portals and/or State Claims Data
External Benchmarking for Integrated Health Examples & Sources

Regional Sources:

- Be sure to start by engaging local providers to see if they will be willing to share/compare data
- State level collaborative or healthcare associations often have datasets that can be mined for benchmarking
- Managed care and State funders are also good sources of data for comparison (e.g., NY State Statistics & Reports Portal)
External Benchmarking for Integrated Health Examples & Sources

National Sources:

Health Resources Services Administration (HRSA)
- Nationwide Individual clinic level data
- Data comparison feature

AHRQ National Quality & Healthcare Disparities Reports
- Comprehensive Guide to Benchmarking; Access to Care; Disease; Priority Populations; Health Ins; Type & Setting of Care

The Center for Quality Assessment & Improvement in Mental Health (CQAIMH)
- For choosing BH process measures
- Over 300 source databases

(See Resources Section for Links to these sites)
External Benchmarking for Integrated Health Examples & Sources

National Sources:
Dartmouth Atlas of Healthcare
  • State & Region Medicare Data

Center for Medicaid/Medicare Services Hospital Compare
  • State & Regional Hospital Medicare Quality Data

NASMHPD Research Institute, Inc. (NRI)
  • Comprehensive Nationwide inpt. & outpt. data warehouse

(See Resources Section for Links to these sites)
Four Steps to Quality Benchmarking

1. **Define** why you need to benchmark and what will the benchmark be?
2. **Describe** the steps your organization will take to achieve the benchmark target.
3. **Develop** new organizational processes to achieve the benchmark(s) target.
4. **(with) Diligence** maintain the benchmark through dashboard monitoring and Continuous QI.

*Define ➔ Describe ➔ Develop ➔ with Diligence*
Defining & Describing:
Examples from Institute for Family Health Depression Care

• Defining the population (new, age)
• Defining the purpose (why?)
• Describing the flow (how?)
Defining the Benchmarks

- % of patients who were screened for depression over age 12
- % of patients who were positive at screen who received a PHQ9
- % of patients positive for PHQ9
- % of Patients with follow up
- % of patients with CSSRS, Safety Plans
- % of patients who got better !!
<table>
<thead>
<tr>
<th>Metric</th>
<th>Target</th>
<th>Acceptable</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Depression Collaborative Care Measures</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Three Contacts (Active Pts):</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denominator: Total quarterly enrollment in CC (see Quarterly Enrollment metric). Numerator: Number (#) of those patients that were “active” during the reporting period. “Active” defined by having had at least 3 clinical contacts during the quarter.</td>
<td>✔️ 95%</td>
<td>✔️ 75%</td>
</tr>
<tr>
<td><strong>Improvement Rate:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number (#) and proportion (%) of patients in treatment for 70 days (10 weeks) or greater who demonstrated clinically significant improvement either by: a 50% reduction from baseline PHQ-9 or a drop from baseline PHQ-9 of at least 5 points and to less than 10.</td>
<td>✔️ 50%</td>
<td>✔️ 35%</td>
</tr>
<tr>
<td><strong>Consultation Rate:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Among those in treatment for 70 days (10 weeks) or greater who did not improve, number (#) and proportion (%) who received a Psychiatric Consultation note. A psychiatric consultation is a patient case review between the Care Manager and the Psychiatric Consultant.</td>
<td>✔️ 75%</td>
<td>✔️ 60%</td>
</tr>
<tr>
<td><strong>Change in Treatment Rate:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Among those in treatment for 70 days (10 weeks) or greater who did not improve, number (#) and proportion (%) who had a change in treatment.</td>
<td>✔️ 75%</td>
<td>✔️ 60%</td>
</tr>
</tbody>
</table>
Develop the Process!

Think about pathways!

Different from flows!
Managing Depression: Clinical Workflows in Primary & Behavioral Health Care
Managing Depression: Clinical Pathways in Primary & Behavioral Health Care
Monitoring Your Benchmarks with Diligence

Think about all of the data you might want such as:

- Patients
- Visits
- Services
- Scripts

Think about summary levels of interest:

- Individual providers – Everyone on the Care team?
- Types of Providers
- Locations
- System wide
## Monitoring: Point of Care Reports with Diligence

### Features

- Event as unit of analysis
- Focus on expected procedure; individual steps (the how) leading to intended outcome
- Evaluate action/behavior

### Benefits

- High degree of accountability
- Highly reactive – each new instance of an event is a clean slate
  - “Starting tomorrow…”

### Point of Care Depression Screening

1. Identified best practice – consider depression screening a vital sign
2. Single step process achievable in single visit
3. Engage members of the care team according to role
### Monitoring: Depression Care Population Outcomes

<table>
<thead>
<tr>
<th>Year</th>
<th>Quarter</th>
<th>Improvement Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>Q2</td>
<td>33%</td>
</tr>
<tr>
<td>2015</td>
<td>Q3</td>
<td>44%</td>
</tr>
<tr>
<td>2015</td>
<td>Q4</td>
<td>76%</td>
</tr>
<tr>
<td>2016</td>
<td>Q1</td>
<td>71%</td>
</tr>
</tbody>
</table>

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**Metric**

<table>
<thead>
<tr>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Improvement Rate:</strong> Number (#) and proportion (%) of patients in treatment for 70 days (10 weeks) or greater who demonstrated clinically significant improvement either by: a 50% reduction from baseline PHQ-9 or a drop from baseline PHQ-9 of at least 5 points and to less than 10.</td>
</tr>
</tbody>
</table>

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**Improvement Rate**

![Graph showing improvement rates over time](image_url)

- **NY State Target** = 50%

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Variables & Monitoring with Diligence

• Any organizational changes that might affect your flows or pathways?

• Any system changes (external) that might impact your processes, volume or flows?

• Staffing or program changes?

• Account for them beforehand or note when they occur in order to track impact on your data
Ulster County Uninsured Mental Health Patients  
1/1/2015 - 4/1/2016

<table>
<thead>
<tr>
<th>Uninsured Mental Health Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychosocial</td>
</tr>
<tr>
<td>Psychiatry</td>
</tr>
</tbody>
</table>

Mental Health Visits by Quarter

- **Psychiatry**: 121, 166, 145, 136, 204
- **Psychosocial**: 53, 55, 44, 58, 69

Mental Health Free Clinic opens
The Institute is committed to treating patients with Opioid use and dependence and has paid particular attention to this patient population in Ulster County, where opioid abuse is on the rise.

**Buprenorphine Prescriptions**

<table>
<thead>
<tr>
<th>Year</th>
<th>2015 Q1</th>
<th>2015 Q2</th>
<th>2015 Q3</th>
<th>2015 Q4</th>
<th>2016 Q1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>591</td>
<td>612</td>
<td>737</td>
<td>738</td>
<td>777</td>
</tr>
</tbody>
</table>

**Number of Patients**

<table>
<thead>
<tr>
<th>Year</th>
<th>Opioid Use Disorder/Opioid Dependence</th>
<th>Prescribed Buprenorphine</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>631</td>
<td>222</td>
</tr>
</tbody>
</table>

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Benchmarking-All Areas of Business

- Clinical services and outcomes
- Program services
- Staffing- productivity and capacity
- Revenue
Staffing - productivity & capacity
Wrap-up!

- As you can see, Benchmarking is a powerful tool for improving the efficiency and effectiveness of your organization.

- It is a tool that in many ways describes the shift from Fee-for-Service/Volume-based Care to Value-based Care where marketplace comparisons between providers on a variety of measures is becoming the norm.
Questions ?
Benchmarking Resources

**Dartmouth Atlas of Healthcare**
http://www.dartmouthatlas.org/tools/benchmarking.aspx

**CMS Hospital Compare**
https://www.medicare.gov/hospitalcompare/search.html

**AHRQ**

**HRSA**
http://bphc.hrsa.gov/datalreporting/
Benchmarking Resources

The Center for Quality Assessment and Improvement in Mental Health (CQAIMH)

http://cqaimh.org/benchmarks%20for%20quality%20measures%20samhsa.pdf
http://www.cqaimh.org/

NASMHPD Research Institute, Inc. (NRI)

http://www.nri-inc.org/#!data-sets/czyr
CIHS Tools and Resources

Visit [www.integration.samhsa.gov](http://www.integration.samhsa.gov) or e-mail [integration@thenationalcouncil.org](mailto:integration@thenationalcouncil.org)
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