December Data Jam

Using Data to Stratify Risk

Featuring TCPI Faculty:
Anna Ratzliff, MD, PhD
Anna Ratzliff, MD, PhD
TCPI National Faculty
University of Washington, Associate Professor
Dept. Psychiatry and Behavioral Sciences
Director of Integrated Care Training Program
annar22@uw.edu

Elizabeth Arend, MPH
Quality Improvement Advisor
National Council for Behavioral Health
ElizabethA@TheNationalCouncil.org

Kate Davidson, LCSW
Clinical Advisor
National Council for Behavioral Health
KateD@TheNationalCouncil.org

Anna Ratzliff, MD, PhD
TCPI National Faculty
University of Washington, Associate Professor
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annar22@uw.edu

Elizabeth Arend, MPH
Quality Improvement Advisor
National Council for Behavioral Health
ElizabethA@TheNationalCouncil.org

Kate Davidson, LCSW
Clinical Advisor
National Council for Behavioral Health
KateD@TheNationalCouncil.org
Review: November Data Jam

• Central Nassau Guidance and Counseling Services modeled use of Care Transitions Network Data Dashboard
• Risk Stratification Tool debut!
  • Excel tool enables practices to stratify patients’ risk level by several variables
  • Helps administrators and supervisors easily pinpoint opportunities for improvement
# CMS Change Package: Primary and Secondary Drivers

## Patient and Family-Centered Care Design

1. **Patient & family engagement**
2. **Team-based relationships**
3. **Population management**
   - 1.3.3 **Stratify risk**
4. **Practice as a community partner**
5. **Coordinated care delivery**
6. **Organized, evidence-based care**
7. **Enhanced access**

## Continuous, Data-Driven Quality Improvement

1. **Engaged and committed leadership**
2. **QI strategy supporting a culture of quality and safety**
   - 2.2.4 **Actively participate in shared learning**
3. **Transparent measurement and monitoring**
   - 2.3.1: Use data to continuously and transparently monitor and improve performance, quality and service
4. **Optimal use of HIT**

## Sustainable Business Operations

1. **Strategic use of practice revenue**
2. **Staff vitality and joy in work**
3. **Capability to analyze and document value**
4. **Efficiency of operation**
Mental Health in Primary Care Settings

- Primary Care
- Brief Behavioral Interventions
- Collaborative Care
- Specialty Care
- Hospital

COORDINATION
Patient-Centered Collaborative Care Team

- Primary Care Provider
- Psychiatrist
- Therapist/Care Manager (MSW, RN, PhD)
- New Roles
- Patient

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What is performance?

• Process Outcomes
  • Close follow-up (Minimum 2 contacts/month)
  • Regular use of behavioral health measures (PHQ-9)
  • Psychiatric consultation if patient not improved

• Clinical Outcomes
  • PHQ-9 (depression measure for screening and tracking)
  • GAD-7 (anxiety measure for screening and tracking)
Using Data to Manage Performance

• **Registry tool allows practice to track patient data and response to treatment**
  • Visits
  • Indirect assessments
  • Graphs of measures
  • Stratify risk

• **Clinic level data**
  • Caseload number
  • Processes (ex. Completed clinical assessment)
  • Outcomes (ex. Current number of patient with clinical improvement)
Sort 1: Engagement
Look at last appointment > 1 month

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### Sort 2: Severity of Symptoms

Look at PHQ-9 scores

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Ms. B: Measurement-Based Treatment to Target

- Regular use of behavioral health measures to track response to treatment
- Use of psychiatrists to help intensify treatment
- Stepped care makes efficient use of behavioral health resources
## Culture of Quality Improvement

### Case Load Statistics L1

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<td><strong># of P.</strong></td>
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<td><strong>Mean GAD</strong></td>
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<td><strong>50% Improved after &gt; 10 WKS</strong></td>
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- **Therapist 1**
  - CO: 70
    - # of P.: 68 (97%), 15.1 (n=61), 12.8 (n=52)
    - Mean # of P.: 62 (91%), Mean # of PHQ: 6.7
    - Mean # of GAD: 5.5 (82%), Mean # of GAD: 1.2 (18%)
    - PHQ: 19 (49%) (n=39), GAD: 16 (41%) (n=39)

- **Therapist 2**
  - CO: 86
    - # of P.: 86 (100%), 15.9 (n=86), 14.2 (n=84)
    - Mean # of P.: 79 (92%), Mean # of PHQ: 12.4
    - Mean # of GAD: 6.4 (52%), Mean # of GAD: 6.0 (48%)
    - PHQ: 34 (66%) (n=50), GAD: 28 (56%) (n=50)

- **All**
  - CO: 156
    - # of P.: 154 (99%), 15.6 (n=147), 13.6 (n=136)
    - Mean # of P.: 141 (92%), Mean # of PHQ: 9.9
    - Mean # of GAD: 6.0 (61%), Mean # of GAD: 3.9 (39%)
    - PHQ: 53 (60%) (n=89), GAD: 44 (49%) (n=89)

*C/C = Continued Care Plan*
Data Lessons Learned

• Critical to communicate a clear vision
  • the ‘Why’ to everyone involved

• IT infrastructure important
  • tools to support the registry, tracking of patients and metrics

• Operationally, it helped to have strong pilot sites and specific measures to focus on
How to Get Started

• Introduce measures to behavioral health providers
  • Why are the measures important?
  • What resources are available to track them?

• Look at data regularly for patterns and be curious!
  • Regular time to review data together
  • What makes sense? What is surprising?
  • What do we want to sustain?
  • What are opportunities to improve?

• Celebrate successes!
  • Patient stories, progress toward goals, goal achievement
  • Newsletters, staff meetings, bulletin boards
Next Steps

• Attend our next Data Jam in January and invite your colleagues!

• Use the risk stratification tool to:
  • Stratify risk of different patient populations and determine which populations to focus on as a top priority
  • Pinpoint opportunities for improvement
  • Identify potential data quality issues
  • Share your observations and ideas with your team!
Thank you!

www.CareTransitionsNetwork.org
CareTransitions@TheNationalCouncil.org

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