

# Effective Benchmarking in Integrated Care

Dr. Jeff Capobianco  
Integrated Health Senior Consultant  
SAMHSA-HRSA Center for Integrated Health Solutions  
National Council for Behavioral Health

# Why Benchmarking

- Answers how well you are doing.
- Assesses how your performance compares to others: both externally & internally.
- Helps you know what areas need Continuous Quality Improvement (CQI) focus.
- Supports a culture of improvement for the patient, practice & population you serve.
- Enables hard but transformational conversations.
  - “We are at the bottom 25<sup>th</sup> percentile with satisfied patients.”



# Internal Benchmarking

- Compares performance of a team/clinician on measures to either the same team over a period of time or another team or clinician within the *same organization*.
- Examples:
  - Productivity differences among staff
  - Unit cost differences among programs
  - Staff satisfaction differences across teams

## Dr. Smith: May Benchmark Report

- 92% patients screened for depression
  - +7% over Organization Average
- 78% patients screened for colorectal cancer
  - +3% over Organization Average
- 92% Likelihood to recommend patient rating
  - +5% over Organization Average

## Dr. Adams: May Benchmark Report

- 80% patients screened for depression
  - -5% below Organization Average
- 67% patients screened for colorectal cancer
  - -8% below Organization Average
- 88% Likelihood to recommend patient rating
  - At Organization Average

# External Benchmarking

- Compares an organization's process or outcome measures to a set external standard.
- Many contracts require key external benchmarks to be reached in order to draw down payments.
  - Quality benchmarks are usually HEDIS measures
- External benchmarking standards are published by:
  - National Committee for Quality Assurance (NCQA)
  - Centers for Medicaid & Medicare Services
  - State Medicaid & Behavioral Health agencies
  - Managed Care Organizations
  - The Advisory Board & other consulting organizations.

## Sample Medicare Advantage Benchmark Report

1-5 star rating system. 1 = Poor Quality. 5 = High quality.

Measure	Wgt	Elig	Pass	Gap	Pass %	Star Lvl
Adult BMI Assessment	1	<a href="#">1,645</a>	1,539	<a href="#">106</a>	93.6%	3
Breast Cancer Screening	1	<a href="#">788</a>	574	<a href="#">214</a>	72.8%	3
Care for Older Adults - Functional Status Assessment	1	<a href="#">33</a>	26	<a href="#">7</a>	78.8%	4
Care for Older Adults - Medication Review	1	<a href="#">33</a>	15	<a href="#">18</a>	45.5%	1
Care for Older Adults - Pain Screening	1	<a href="#">33</a>	27	<a href="#">6</a>	81.8%	4
Colorectal Cancer Screening	1	<a href="#">1,750</a>	1,280	<a href="#">470</a>	73.1%	4

# Aiming for Excellence

- Choose which benchmarked level you want to achieve
  - 3 star, 4 star or 5 star?
- Target areas with the biggest opportunities for improvement.
- Link your goals w/ your organizational strategic plan.
- Determine the ROI & Risk associated w/ different benchmarked levels.
  - Risk of 1 star = Lost contract.
  - 4 star = higher PMPM payment.

Create goals related to external benchmarks for all key performance areas of your integrated care organization:

- Quality
- Safety
- Efficiency
- Cost-effectiveness

# Data Sharing

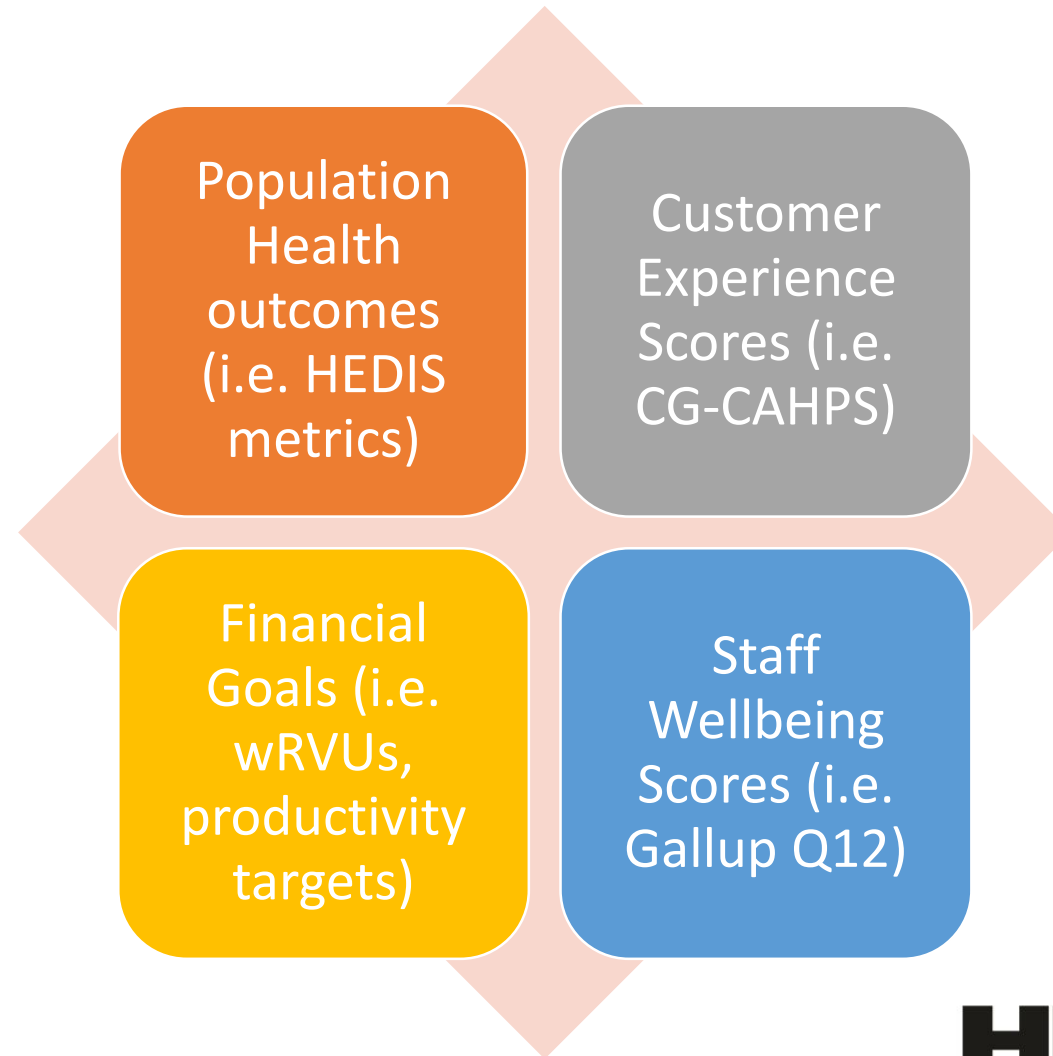
## Internal

- Create dashboards to transparently rank providers & teams.
- Identify high performers publicly.
- Engage in root cause analyses w/ lower performers.
- Use an internal incentive program to encourage clinicians to reach key benchmarks.
- Implement a balanced scorecard.

## External

- Set up data exchanges with managed care organizations.
- Use external portals to track benchmarked metrics.
- Explore how your Electronic Health record & Health Information Exchange system can help you share data.
- Ask if there are any regular reports you can receive:
  - All medicare advantage plans provide monthly PCOR reports.
  - Many Medicaid plans provide monthly quality reports as well.

# Balanced Scorecard



# Beyond Traditional Clinical Measures



Measuring the unique qualities of integrated behavioral health and primary care may mean setting targets that fall outside of the usual set of patient health indicators. Consider how you may measure items such as:

- Patient satisfaction scores
- Number of patients with a family member involved in treatment planning process
- Number of patients with a signed consent to allow family to talk to the provider
- Frequency of consumer advisory committee meetings, or tracking priorities identified by the committee
- % of children who've received EPSDT screening in last 12 months.



# The 4 D's of Benchmarking

1. **D**efine the Goal
2. **D**escribe the Steps
3. **D**evelop the Means
4. **D**iligence to Maintain the Benchmark



# Define the Goal

- What is the measure?
- Why is it key to your organization's vision, mission &/or patient well being?
- What is the baseline?
  - 35% of patients screened for tobacco use.
- What is the benchmarked goal?
  - Target Goal (realistic w/ effort)= 80% of patients screened for tobacco use in 1 year.
  - Stretch goal (best practice) = 95% of patients screened for tobacco use.

The benchmark measure should be:

- **Strategically significant.** Staff understand how achieving the benchmark is tied to establishing the organization's reputation or supporting the organization's vision and mission, as well as patient outcomes.
- **Applicable.** The measure is appropriate to the organization's size, setting and patient population.
- **Actionable.** Staff understand the measure's specifications and see that using CQI will improve the measure in their workflow.
- **Urgent.** The benchmark measure is set at a level and within a defined timeline that creates a sense of urgency among staff.

# Communicate the Goal

Take the time to clearly define the problem to be addressed, the measures that define current status and future goals and the timelines associated with achieving these goals.

- **Vision:** XYZ Community Health Center's vision is to improve the health of all patients served using evidence-based practices.
- **Goal:** XYZ Community Health Center will screen for substance use disorder and provide brief interventions for patients who screen positive.
- **Method:** XYZ Community Health Center has chosen to implement the evidence-based practice of SBIRT as part of all adult & adolescent intakes.

- **Target Rates:**
  - 95% percent of patients will be screened for substance use disorder.
  - 80% percent of those who screen positive for mild-to-moderate substance use will be provided a brief intervention.
  - 95% percent of those who meet criteria for a diagnosis of substance use disorder will be referred to substance use treatment by a credentialed provider. (See example at [www.sbirtoregon.org/incentive\\_measure.php](http://www.sbirtoregon.org/incentive_measure.php).)
  - 58% percent of the patient records of those referred to treatment will indicate if they attended an appointment with the referred provider.
- **Timeframe:** These target benchmarks will be achieved by the end of the fiscal year.

# Describe the Steps to Achieve Benchmark Targets

- Clarify the “why” and “what” of benchmarking behavioral health services.
- Determine the “how”, “who” and “when” of the benchmarking process.
- Incorporate in your strategic plan: measures that define base (current) rates and target (future) rates to be met within a certain period of time (timeline).

The work plan must include:

- A list of assigned staff with percentage of effort, including roles and amount of staff time dedicated to the work plan.
- Resources the work group can access.
- Objectives and associated tasks to achieve the goal.
- Staff responsible for each task.
- Timelines for each task.
- Measures indicating task completion.

# Sample Work Group Goals

A leadership team may charge a CQI work group to improve execution of the [collaborative care model](#) by achieving industry benchmark standards, for example:

- X% percent of patients who meet criteria will be screened for depression using the PHQ-2.
- X% percent of patients who screen positive for suicide will be provided a [Columbia Suicide Screening](#) by trained staff.
- X% percent of people who screen positive for depression using the PHQ-2 will be given the PHQ-9. (See [Guidelines](#).)
- X% percent of the patients that screen positive for the diagnosis of depression will receive medication and therapy as indicated by the chronic care management clinical protocol.

# Develop the Means to Achieve the Benchmarks

## What to do?

- Create a sense of urgency w/aggressive, but realistic, task completion timelines.
- Clearly map out which team members are involved in what task.
- Implement frequent action meetings (i.e., weekly) by work group staff.
- Regular clear communication by leadership to all staff about developing new workflows to achieve the benchmark(s).
- Regularly update the work plan to reflect progress made.
- Track & solve to completion any barriers encountered.
  - To address barriers, implement CQI techniques like the Plan-Do-Study-Act process.

## Plan-Do-Study-Act

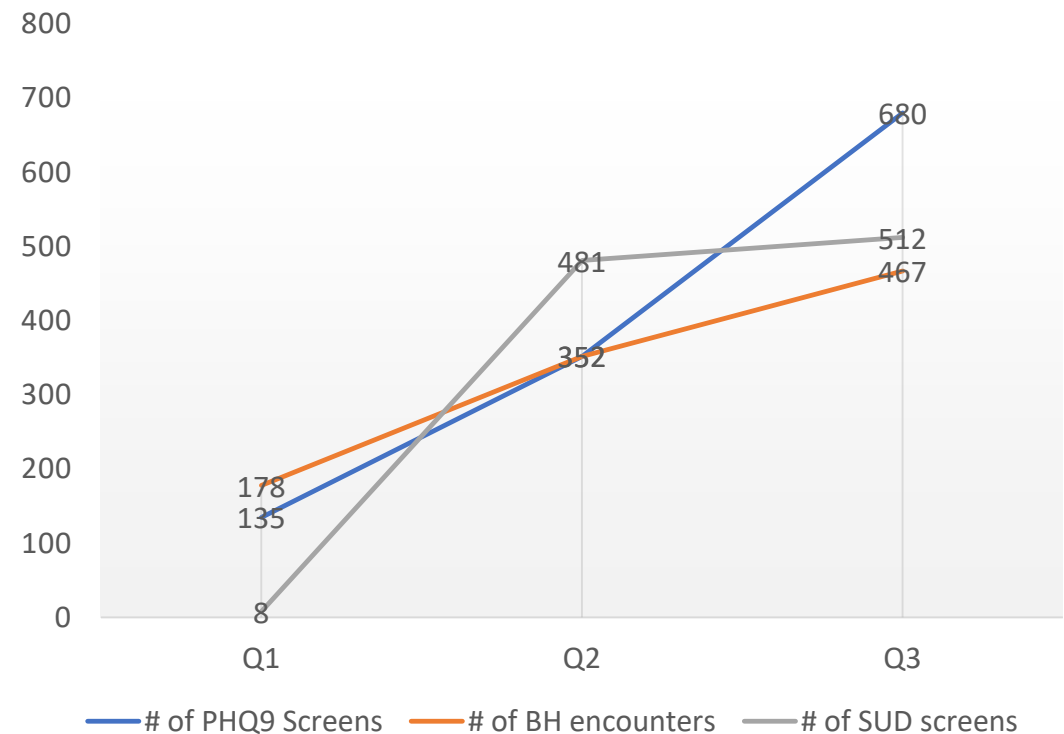
- **Plan.** To improve PHQ-9 use, create a workflow for the process to identify areas for improvement and developing a new approach.
- **Do.** Implement the new approach and collect data.
- **Study.** Analyze the data to see if the new process is moving the organization closer to the benchmark rate desired. Interview high & low performers to identify optimization opportunities.
- **Act.** The work group determines if a new plan is needed because the target was not met, or if the plan worked, then the new process becomes the new protocol for all staff.

# Diligence to Maintain the Benchmark

## Key Steps for Sustaining Success

- Continually maintain and monitor dashboards & benchmark reporting systems.
- Ensure transparency & communication w/
  - Senior leadership
  - Middle management
  - Frontline staff.
- Be generous w/ benchmark report access. Do staff have access to meaningful data they need to act?
- Be prepared to change! Your targeted score will not stay the same.
  - Commercial NCQA benchmark targets change in July.
  - CMS benchmark targets change in October.

## Use graphics to tell a story



# Sample Dashboard





# Build for Benchmarking

- Build Buy-In.
  - Identify & engage key opinion leaders to help you train & pilot.
  - Involve the whole team in improvement.
  - Demonstrate the value of data.
  - Link to improved patient care.
- Build Infrastructure.
  - Determine which technology, team & processes will be used.
  - Make reporting methods & any related staff incentives crystal clear *before* project start.
- Build Data Trust
  - Data mistrust is always the 1<sup>st</sup> stage.
  - Validate the data before go lives w/ quality team.
  - After go-lives, spend 2 weeks asking staff to help further validate the data.
    - Reward staff for finding errors (chocolate!)
  - Answer all concerns & fix any issues possible as rapidly as possible.

# Sample Standard-Based Benchmarks

Standard	Element	Possible Benchmark Measure
Team Based Care	2B: Medical Home Responsibilities	100% of staff complete documentation concurrently/collaboratively as evidenced by documentation being completed during the appointment.
	2D*: The Practice Team	100% of care plans will be integrated as evidenced by inclusion of both behavioral and physical health goals
Population Health Management	3B: Clinical Data	100% of patients are screened for depression, anxiety and substance use disorders
		An up-to-date problem list w/ current and active diagnoses for 80% of patients
		Allergies, including medication allergies and adverse reactions* for 80% of patients
		Blood pressure for more than 80% of patients 3 years and older+
		System plots and displays growth charts (length/height, weight and head circumference) and BMI for at least 80% of patients 0-20 years+
		Status of tobacco use for patients 13 years and older for 80% of patients+
		Status of prescription medications for more than 80% of patients
		More than 20% of patients have family history recorded as structured data

# Resources

## Standards for Behavioral Health in Primary Care

- Advancing Behavioral Health Integration within National Committee on Quality Assurance (NCQA) recognized Patient-Centered Medical Homes:  
[http://www.integration.samhsa.gov/integrated-care-models/Behavioral\\_Health\\_Integration\\_and\\_the\\_Patient\\_Centered\\_Medical\\_Home\\_FINAL.pdf](http://www.integration.samhsa.gov/integrated-care-models/Behavioral_Health_Integration_and_the_Patient_Centered_Medical_Home_FINAL.pdf)
- CMS' Hospital Compare Tool:  
<https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/hospitalqualityinits/hospitalcompare.html>
- AHRQ Integrated Care Quality Measures:  
<http://integrationacademy.ahrq.gov/resources/ibhc-measures-atlas>

## Assessment Tools and Terms

- AHRQ Care Coordination Atlas:  
<http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/atlas2014/index.html>
- *Behavioral Health Integration Capacity Assessment (BHICA)*:  
<https://www.resourcesforintegratedcare.com/tool/bhica>
- *Integrated Practice Assessment Tool (IPAT)*:  
[http://www.integration.samhsa.gov/operations-administration/IPAT\\_v\\_2.0\\_FINAL.pdf](http://www.integration.samhsa.gov/operations-administration/IPAT_v_2.0_FINAL.pdf)

# Resources

## Creating Dashboards and Other Data Visualizations

- Data Visualization and Reporting Websites and Tools, American Evaluation Association.  
<http://comm.eval.org/datavisualizationandreporting/tigresources/websitesccombined>
- IDEA Data Center Resource Library.  
<https://ideadata.org/resource-library/listing/?search=benchmark&sort=relevancy>
- DaSy Center Data Evaluation Toolkit. <http://dasycenter.org/data-visualization-toolkit/data-tables/>

## Benchmarking Examples and Collaboratives

- SAFTINET program (University of Denver):  
<http://www.ucdenver.edu/academics/colleges/medicalschool/programs/ACCORDS/coho/saftinet/Pages/default.aspx>
- New York State Collaborative Care Initiative:  
<http://uwaims.org/nyscci/pcmh/>
- Dartnet Institute (QI and practice improvement registry):  
<http://www.dartnet.info/default.htm>

# References

This presentation was adapted from the SAMHSA-HRSA Center for Integrated Health Solutions resource:

*Effective Benchmarking for the Integration of Behavioral Health & Primary Care*

i Knox, L. Brach, C. Practice Facilitation Handbook: Module 7. Measuring and Benchmarking Clinical Performance. June 2013. Agency for Healthcare Research and Quality, Rockville, MD.  
<http://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/index.html> 4/29/2016.

ii MHI Data and tools. PowerPoint Presentation. MHI Ops Meeting. Intermountain Healthcare.

iii MHI Data and tools. PowerPoint Presentation. MHI Ops Meeting. Intermountain Healthcare.

iv Douglas W Hubbard (2014). Hot measure anything: Finding the value of intangibles in business third edition New York New York: Wiley NY.

v Advancing Behavioral Health Integration with NCQA Recognized Patient-centered Medical Homes. September 2014. SAMHSA-HRSA Center for Integrated Health Solutions. Washington, DC.  
[http://www.integration.samhsa.gov/integrated-care-models/Behavioral\\_Health\\_Integration\\_and\\_the\\_Patient\\_Centered\\_Medical\\_Home\\_FINAL.pdf](http://www.integration.samhsa.gov/integrated-care-models/Behavioral_Health_Integration_and_the_Patient_Centered_Medical_Home_FINAL.pdf) 8/15/2016.

# CIHS News and Resources

Visit

[www.integration.samhsa.gov](http://www.integration.samhsa.gov)

or e-mail

[integration@thenationalcouncil.org](mailto:integration@thenationalcouncil.org)

Free consultation on any  
integration-related topic!

Making Integrated Care Work | 202.684.7457

**SAMHSA-HRSA Center for Integrated Health Solutions** eSolutions newsletter

About Us | Integrated Care Models | Workforce | Financing | Clinical Practice | Operations & Administration | Health & Wellness

Glossary | Facebook | Twitter | Listerve | Ask a Question | Email

### ABOUT CIHS

## SAMHSA-HRSA Center for Integrated Health Solutions

CIHS promotes the development of integrated primary and behavioral health services to better address the needs of individuals with mental health and substance use conditions, whether seen in behavioral health or primary care provider settings.

LEARN MORE

### TOP RESOURCES

View Our RSS Feed

FEBRUARY 24, 2014  
Integrating Physical and Behavioral Health Care: Promising Medicaid Models

FEBRUARY 21, 2014  
February Is American Heart Month!

### CALENDAR OF EVENTS

FEB 26 Substance Use and Mental Disorders: Early Detection, Prevention, and Treatment  
FEBRUARY 26-26, 2014

FEB 27 Integrating Peer Support in Primary Care  
FEBRUARY 27-27, 2014

# Thank You

SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

The mission of HRSA is to improve health and achieve health equity through access to quality services, a skilled health workforce, and innovative programs.

[www.hrsa.gov](http://www.hrsa.gov) | [www.samhsa.gov](http://www.samhsa.gov)  
[integration.samhsa.gov](http://integration.samhsa.gov)