TRANSLATE

Framework for Evaluating Practice Transformation
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History

• Late 1990’s Kevin Peterson wanted to improve DM care in PCP offices
• Did literature search on modalities that would be effective
• He found nine that were put into the acronym TRANSLATE
• Did successful randomized control trial in over 8,000 diabetic patients
• It was modified and adapted for a 40 practice NIH R-01 pragmatic clinical trial comparing Computer Decision support to facilitated support
• TRANSLATE Rubric was developed for evaluation
TRANSLATE

- Target
- Reminder
- Administrative Buy-In
- Network Information System
- Site Coordinator

- Local Clinician Champion
- Audit and Feedback
- Team Approach
- Education
Target

• Goal setting
• Needs to be
  • Clear Measurable and feasible
• Common office problems
  • No targets
  • Trying to do too many things at once
Reminder

- Actionable information at the point of care
Administrative Buy-in

- Commitment of Resources
  - Money
  - Personnel
Networked Information Systems

- Population Health
- Registries
- Preferably easily created
Local Clinician Champion

- For Clinician buy-in
  - Explanation of Evidence Base
- Does not have to be MD (but usually is)
  - NPs and PAs have done a good job with this
    - Large regional variation
    - Some only accept MD
Audit and Feedback

- Longitudinal Reports
  - How the practice is progressing over time
- Benchmarking Reports
  - How the practice is doing compared to others
Team Approach

• Based on other successful work such as:
  • Toyota Quality Circles
  • Patient safety in the Airline industry.
• Huddles (brief micro-team meetings) have also shown success
Education

- Training in all its forms:
  - Academic Detailing*
  - Collaborative Learning Groups)*
  - In-service
  - CME etc

* Most commonly used in practice transformation
<table>
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<th>TRANSLATE Scoring Rubric</th>
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<tr>
<td><strong>Translate element</strong></td>
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Preliminary Results

Total Score

Translate Rubric Total Score

Baseline  Quarter 1  Quarter 2

Practice 1
Practice 2
Practice 3
Practice 4
Practice 5
Practice 6
Practice 7
Practice 8
Practice 9
Practice 10
Individual elements for individual practice
MEASURING PRACTICE TRANSFORMATION

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PPRNet Member Practices

R03HS018830  and R18HS022701
Agency for Healthcare Research and Quality (AHRQ)
OBJECTIVES

- Disseminate a conceptual model for improving primary care using health information technology (IPC-HIT)
- Discuss model concepts and practice activities
- Explain how these concepts were used to develop a survey measuring “meaningful use”
- Consider implications of measuring these activities for their correlation with clinical quality measures (CQM)
SYNTHEIZING LESSONS LEARNED

- Secondary analysis of seven PPRNet studies qualitative data (2001-2012)
  - Cardiovascular/stroke prevention, alcohol screening and brief intervention, broad primary care measures, colorectal cancer screening, medication safety, standing orders
- 134 practices nationwide participated in this collaborative learning community

Findings
- Practices use HIT/staff in new ways
- Complex interventions rely on four main concepts
IMPROVING PRIMARY CARE USING HEALTH INFORMATION TECHNOLOGY (HIT)
PPRNet - TRIP - QI

INVESTMENTS NEEDED
> IN HIT RESOURCES
> EDUCATE/ PRACTICE DEVELOPMENT
> ESTABLISH LEADERSHIP

ACTIVATE PATIENTS
Transform practice culture & quality
Adapt & use HIT tools
Practice team care

REWARDS
> FINANCIAL ALIGNMENT WITH QUALITY MEASURES
> RETENTION OF STAFF & PROVIDERS

IMPROVED OUTCOMES
QUALITY MEASURES: PPRNet, NCQA, CMS
## Concepts and Strategies: Complex Interventions

### Specific Approaches by Study

- **Practice Team Care**
  - Liaisons coordinate projects/communication, use PLRs
  - Staff education; SO's increased, explicit policies, practice culture rewarded by P4P etc.

- **Adapt and Use HIT Tools**
  - Emphasis on quality, set goals, celebrated successes
  - Quality committees/ coordinators
  - Liaisons coordinate projects/communication, use PLRs
  - Staff education; SO's increased, explicit policies, practice culture rewarded by P4P etc.

- **Transform Practice Culture and Quality**
  - Emphasis on quality, set goals, celebrated successes
  - Quality committees/ coordinators
  - Liaisons coordinate projects/communication, use PLRs
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- **Activate Patients**
  - Emphasis on quality, set goals, celebrated successes
  - Quality committees/ coordinators
  - Liaisons coordinate projects/communication, use PLRs
  - Staff education; SO's increased, explicit policies, practice culture rewarded by P4P etc.

### Concepts

- **Practice Team Care**
  - Structured screening tools (MAs/nurses)
  - Complementary team roles better defined, providers closing loop
  - Specific templates used for decision support
  - Revised/edited, add macros, applied age, gender, Dx/ Rx templates
  - Lab interfaces, scanning, eRX, web-based patient portals added

- **Adapt and Use HIT Tools**
  - Performance reports for outreach, refill protocols, standing orders for labs, printed medication lists used
  - Structured screening tools (MAs/nurses)
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Meaningful Use Study provided opportunity

Proposed Meaningful Use Stage 3 CQM

- 21 measures selected relevant to primary care

Survey developed using five iterative rounds to examine practices substantial engagement or “meaningful use” of their EHR

Each item mapped to the CQM domain, IPC-HIT concept and CFIR domain
EXEMPLARS OF MEANINGFUL USE SURVEY

 IPC-HIT concepts
 - Practice Team Care
 - Adapt and Use HIT tools
 - Transform Practice Culture and Quality
 - Activate Patients

 CFIR domains
 - Intervention Characteristics
 - Outer Setting
 - Inner Setting
 - Characteristics of Individuals
 - Process of Implementation
Do you agree with the following CQM?

- What proportion of your practice's clinical staff members are educated on specific clinical quality goals for the following?
- Are practice clinical staff authorized by standing order protocols to order or perform the following?
- To what extent does your practice use EHR reminders (flags, health maintenance, or note templates with prompts, etc), as decision-support to help meet the following clinical quality goals?
- To what extent does your practice use EHR tools (embedded web links, templates, letters) for patient education that reinforce the selected population management/public health goals?
Detailed presentation by Steve Ornstein
- 1:30 *Learning from Primary Care Meaningful Use Exemplars*

When correlating with CQM performance the following measures showed interesting results:
- Educating staff
- Using EHR reminders
- Standing orders
Exemplars of Meaningful Use Survey needs further testing to be able to more widely measure transformation.

A quantitative measure can be used to further test associations of practice strategies with CQM performance.

There is an important need to understand how practices can make improvement—measurement of these core strategies may signal specific areas that can be used to address the goals.
QUESTIONS:
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The Solberg-Mold Practice Change/QI Model

Proposed effects of the QI Interventions on Change Elements

- **Priority**
  - Performance Feedback: Baseline and “mini” chart reviews over the project (PF can do)

- **Change Capacity**
  - Academic Detailing: Faculty introduces the project at kick-off meeting (also the PF)
  - Practice Facilitation: Practice assessment, tailoring interventions, empowering teams

- **Change Process Content**
  - Local Learning Collaboratives: Geographical or virtual learning practice communities for cross-pollination and prob. solv.
  - HIT Support: New technol. resources or enabling staff to use existing tools efficiently
Example: The CKD Project Funded by AHRQ (2010-2013)

- Multi-PBRN R18 to implement and disseminate CKD clinical guidelines in primary care practices (multi-comp.)
- Academic detailing on CKD management best practices
- Regular performance feedback on reaching practice goals
- Facilitation of CKD guideline implementation (workflow redesign, tailoring, sharing solutions, empowering staff)
- Technical support for new features in EHR (e.g., eGFR)
- First wave (32) of practices accelerates diffusion to other practices (64) using LLCs
Measuring Change Process Capability

- The Change Process Capability Questionnaire (CPCQ)
- Developed to measure an organization’s ability to maintain change
  - 30 factors and strategies ranked most important for successful implementation by experienced quality improvement leaders
- Relationship between survey scores and depression improvement among 41 medical groups
Measuring Change Process Capability

- Organizational factors
  - Previous history of change
  - Plans for organizational refinement
  - Ability to initiate and sustain change

- Strategies – used to implement improved [target] care
  - Yes (worked well, did not work well)/No

- Priority - visual analog scale
  - “Considering all the priorities your clinic has over the next year (e.g., EHR, financial goals, QI of various conditions, physician recruitment), what is the priority for your clinic to improve [target] care (on a scale of 0-10, where 0 = not a priority, 5 = medium priority, and 10 = highest priority of all)?”
Systematic Behavioral Primary Care Transformation: An End to the Tower of Babel

Rodger Kessler Ph.D. ABPP
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Assistant Professor of Family Medicine
University of Vermont College of Medicine
Director, Collaborative Care Research Network, National Research Network
Senior Scientist, American Academy of Family Physicians

Clinical Associate Professor,
Nicholas A. Cummings Doctoral Program in Behavioral Health
Arizona State University
The Critical issues in Behavioral Integration Are the Same As the Issues Driving Primary Care Transformation

• Measurement
  • Patient Based
  • Practice Based
• Panel Based Focus on Complexity
• Transparent Bi-directional EHR with minimal text and extractable data fields used to impact care
• Implementation Science Driven Evidence Based Care
Integration Efforts Cannot Continue to Ignore Measurement at the Practice and Individual Levels

- This is not about anxiety and depression
- The focus is measuring health risk and health status at patient level
- My Own Health Report 16 items 10 dimensions
- What elements and models of integration at the practice level best achieve Triple Aim outcomes?
- The Vermont Integration Profile
  - measures 6 clauses of Peek’s Lexicon
Panel Based Complexity Driven Behavioral Care

- Practice level Diabetes Intervention using PRO’s and EHR data to plan and deliver care
- Patient behavioral risk data become registry functions to assist in identification of cohorts
- Out of office data collection including patient assessment of willingness to work on an identified risk
- Team based care
EHR Clinical and Quality Improvement Compatibility

• Templated drop down populated clinical assessment and notes
• Bi directional access communication
• Same scheduling and rescheduling process
• Retrievable elements and easily accessed reports
• Clinical and claims data able to associate
Implementation Science Driven Evidence Supported Care

- Most behavioral care delivered is not evidence supported even when there is evidence based care available
- There is little relationship between emerging primary care integration developers and the Behavioral Medicine and Health Psychology research base
- Systematic PROCESS improvement focus to primary care behavioral integration is rare, despite evidence supported toolkits and resources
Conclusions

• Behavioral transformation rarely receives the attention that primary care transformation receives

• Until the core areas identified, population focus and measurement, informatics and systematic process improvement are a strong focus of transformation, primary care transformation suffers

• It is no longer a technological issue or research limitation, it is a primary care leadership and investigator issue