TRANSLATE

Framework for Evaluating Practice Transformation

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History

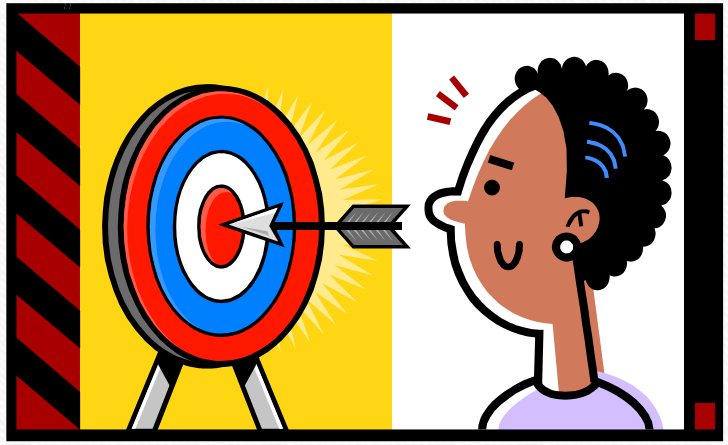
- Late 1990's Kevin Peterson wanted to improve DM care in PCP offices
- Did literature search on modalities that would be effective
- He found nine that were put into the acronym TRANSLATE
- Did successful randomized control trial in over 8,000 diabetic patients
- It was modified and adapted for a 40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

TRANSLATE

- **T**arget
- **R**eminder
- **A**dministrative Buy-In
- **N**etwork Information System
- **S**ite Coordinator
- **L**ocal Clinician Champion
- **A**udit and Feedback
- **T**eam Approach
- **E**ducation

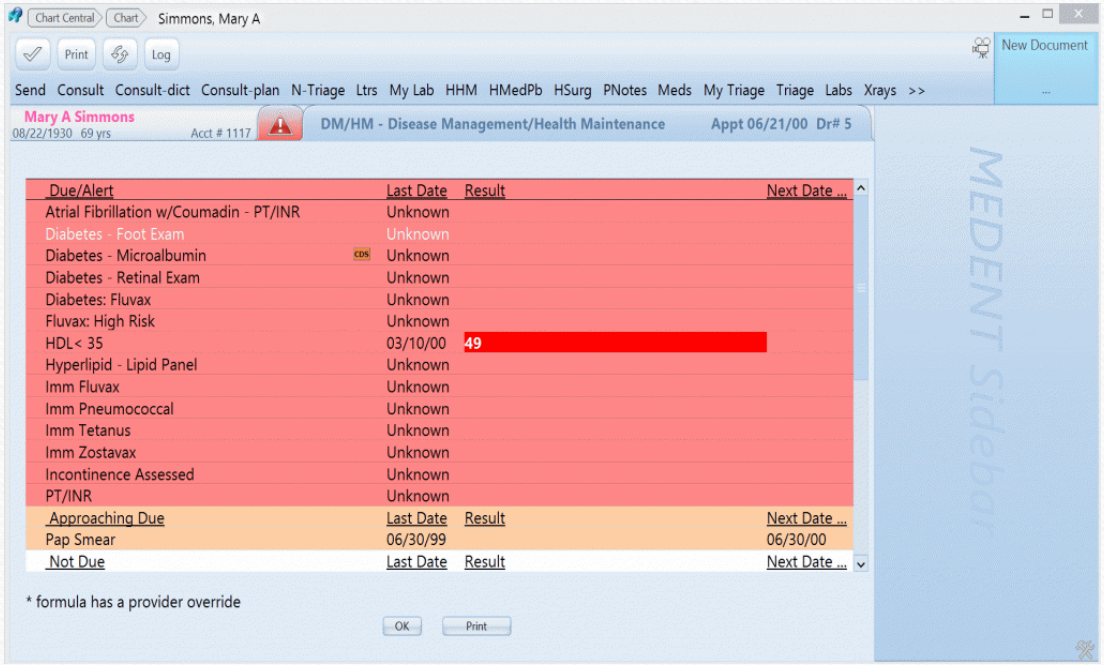
Target

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



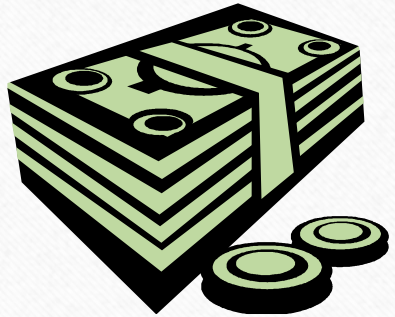
Reminder

- Actionable information at the point of care



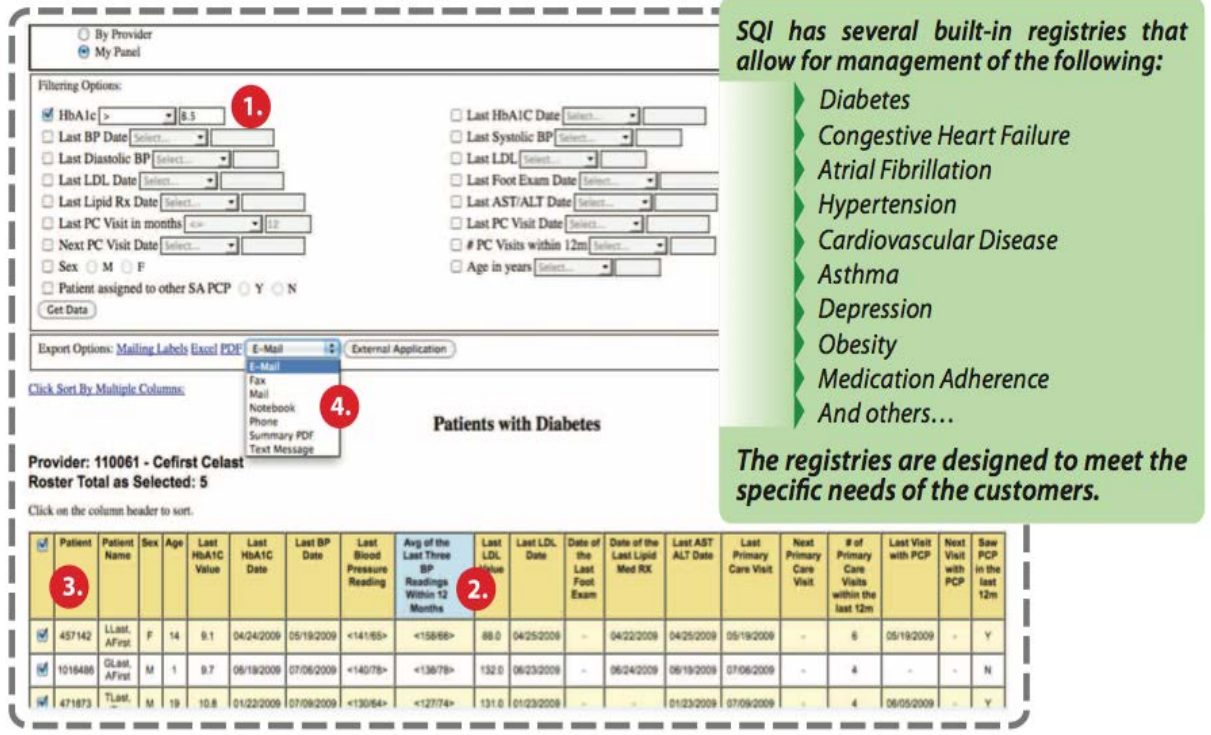
Administrative Buy-in

- Commitment of Resources
  - Money
  - Personnel



Networked Information Systems

- Population Heatlh
  - Registries
  - Prefereably easily created

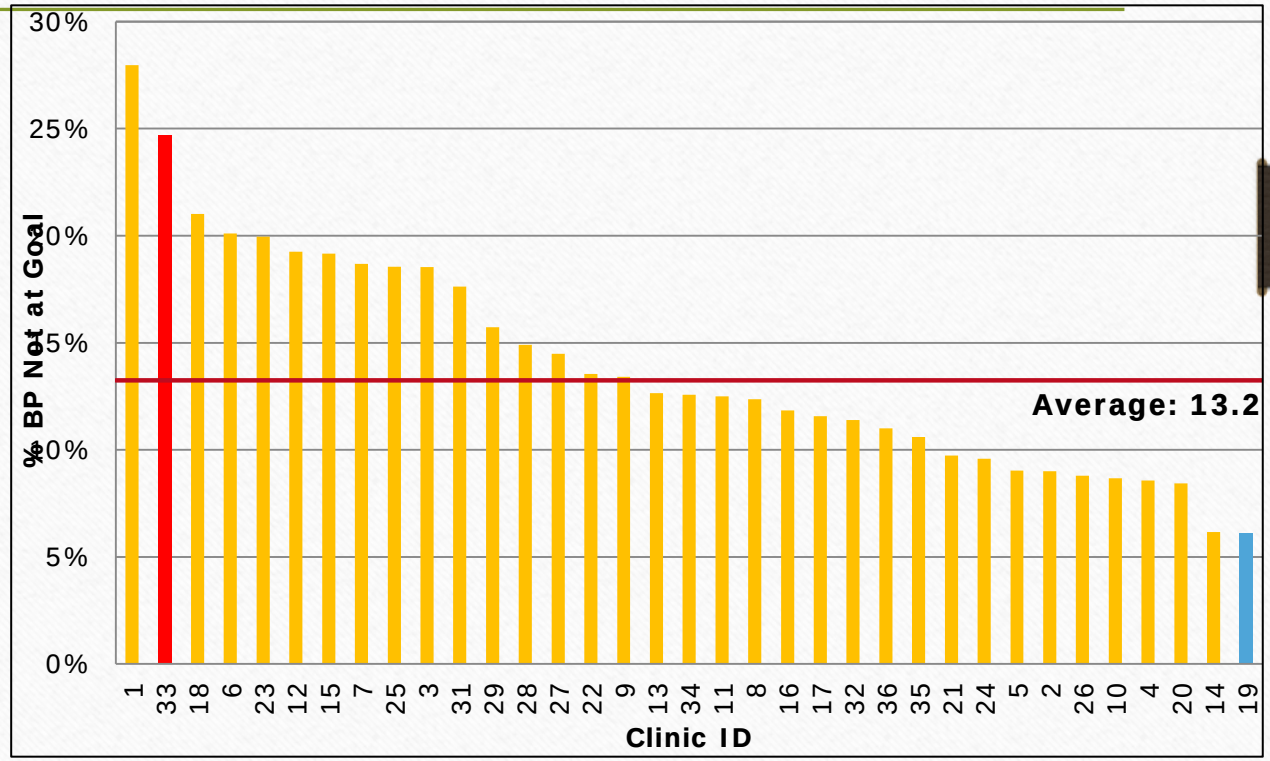


Local Clinician Champion

- 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

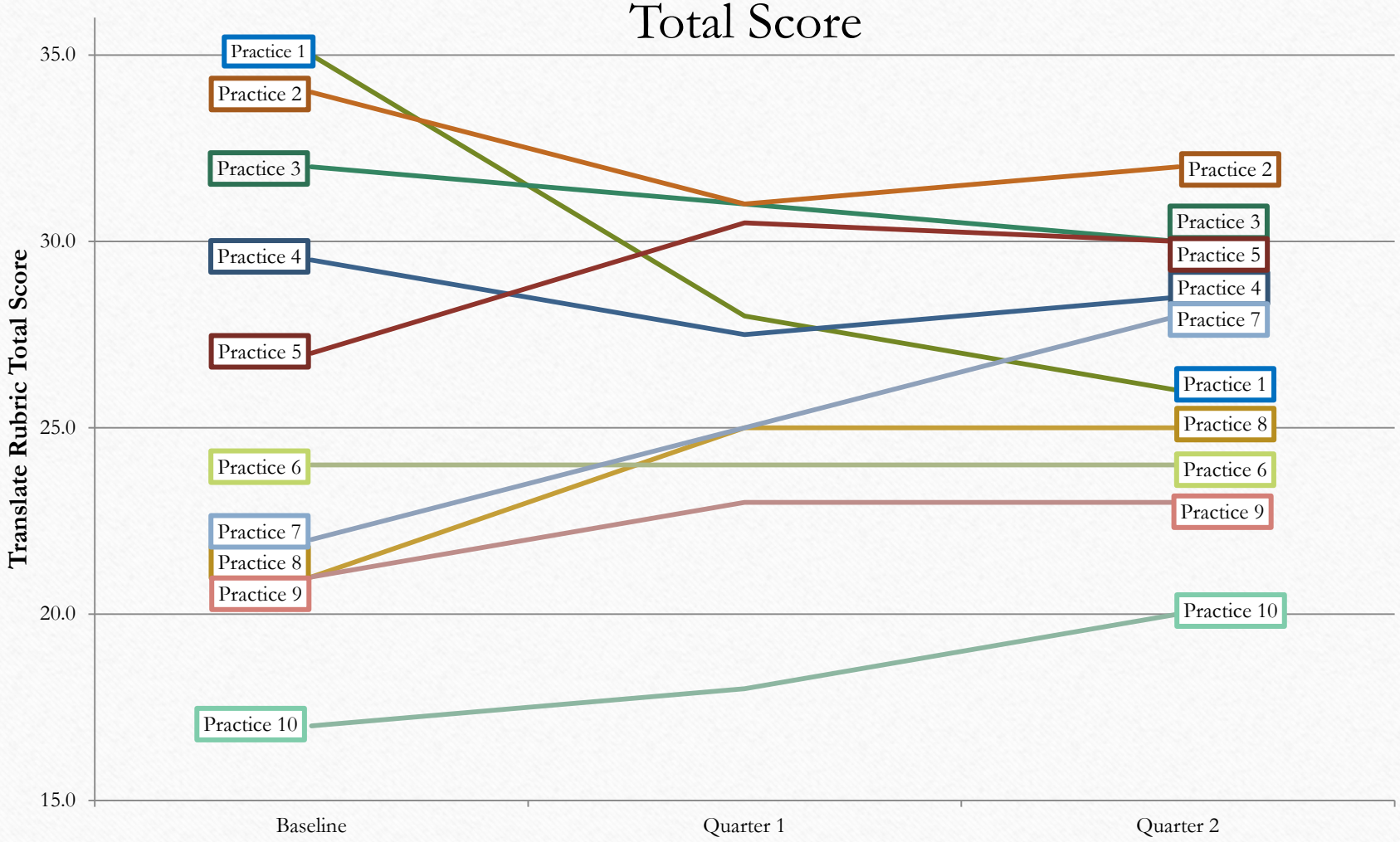
- Training in all its forms:
  - Academic Detailing*
  - Collaborative Learning Groups}*
  - In-service
  - CME etc

* Most commonly used in practice transformation

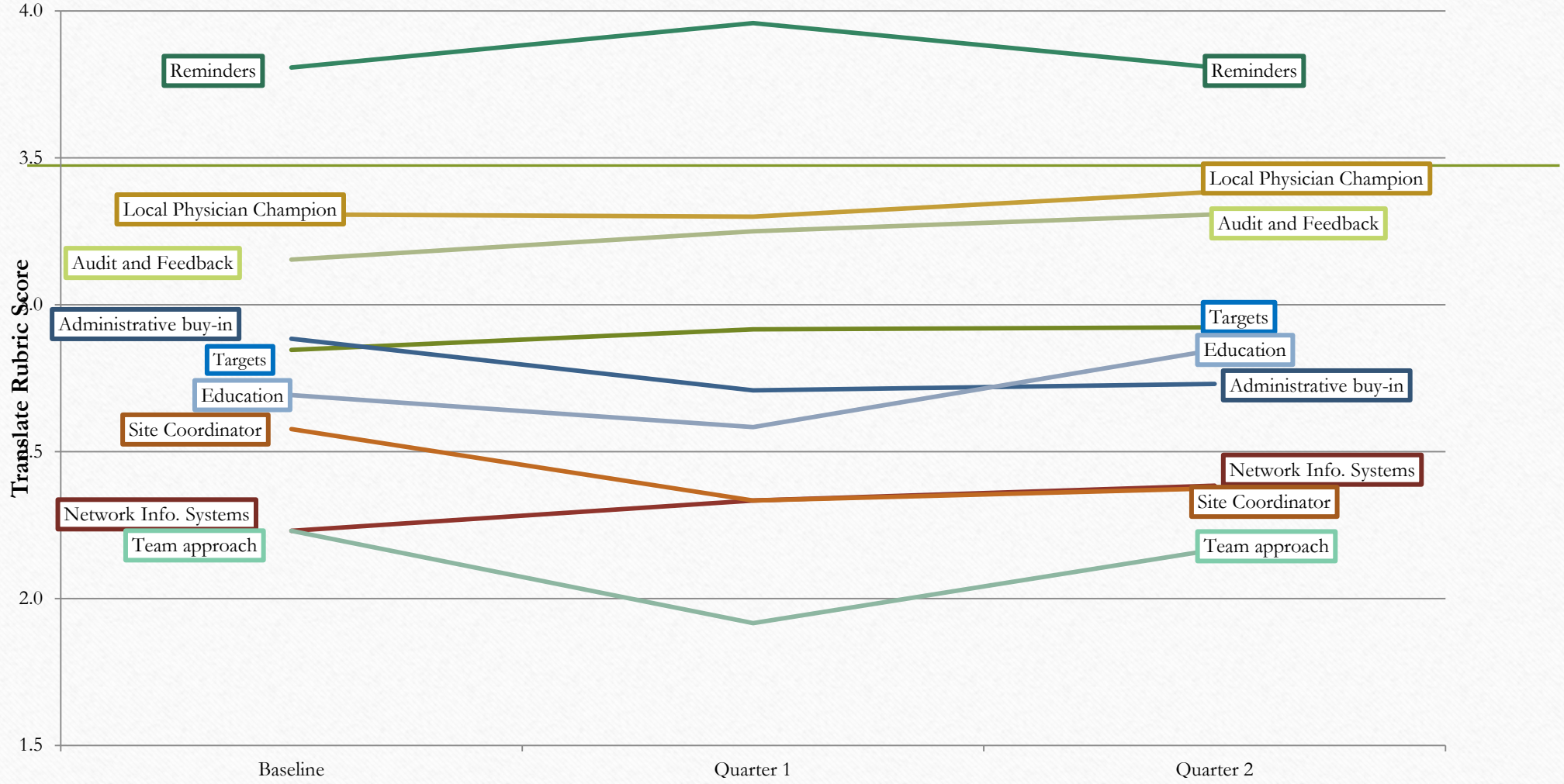
TRANSLATE Scoring Rubric

Translate element	1	2	3	4	Score
Targets	No targets set	Vague or non-measurable targets	Clear, measurable, but not feasible targets	Clear, measurable and feasible targets	
Reminders	No Reminders available	Reminders available but never used	Reminders available but used infrequently	Reminders routinely used	
Administrative buy-in (Resource allocation)	Leaders resistant	Leaders agreeable but unwilling to commit resources (cool)	Leaders agreeable and willing to commit limited resources (lukewarm)	Leader willing to commit all resources necessary (enthusiastic)	
Network Information Systems (Registries)	No information system or unable to create registries	Able to create registries but none created	Few registries created or used < 3 conditions	Registries created and used for at least 3 conditions	
Site Coordinator	No site coordinator identified	Site coordinator identified but has no time for QI activities	Site coordinator has limited time to do QI	Site coordinator with clear mission, resources, and personnel to complete QI work	
Local Physician Champion	Not identified	Identified but uninvolved (name only)	Lukewarm support	Enthusiastic support	
Audit and Feedback	Never done	Reports available but not disseminated	Reports disseminated occasionally and only at the practice level	Individual reports disseminated at least 2 times per year	
Team approach	No teams formed	Limited teams that function from a top down approach	Limited teams that get input from just a few individuals	Non-hierarchical broadly based teams	
Education - CME, collaborative learning groups, staff training	No opportunities for education	Rare educational opportunities	Occasional educational opportunities	Frequent educational opportunities	
				Total score for all elements at benchmark	0.0

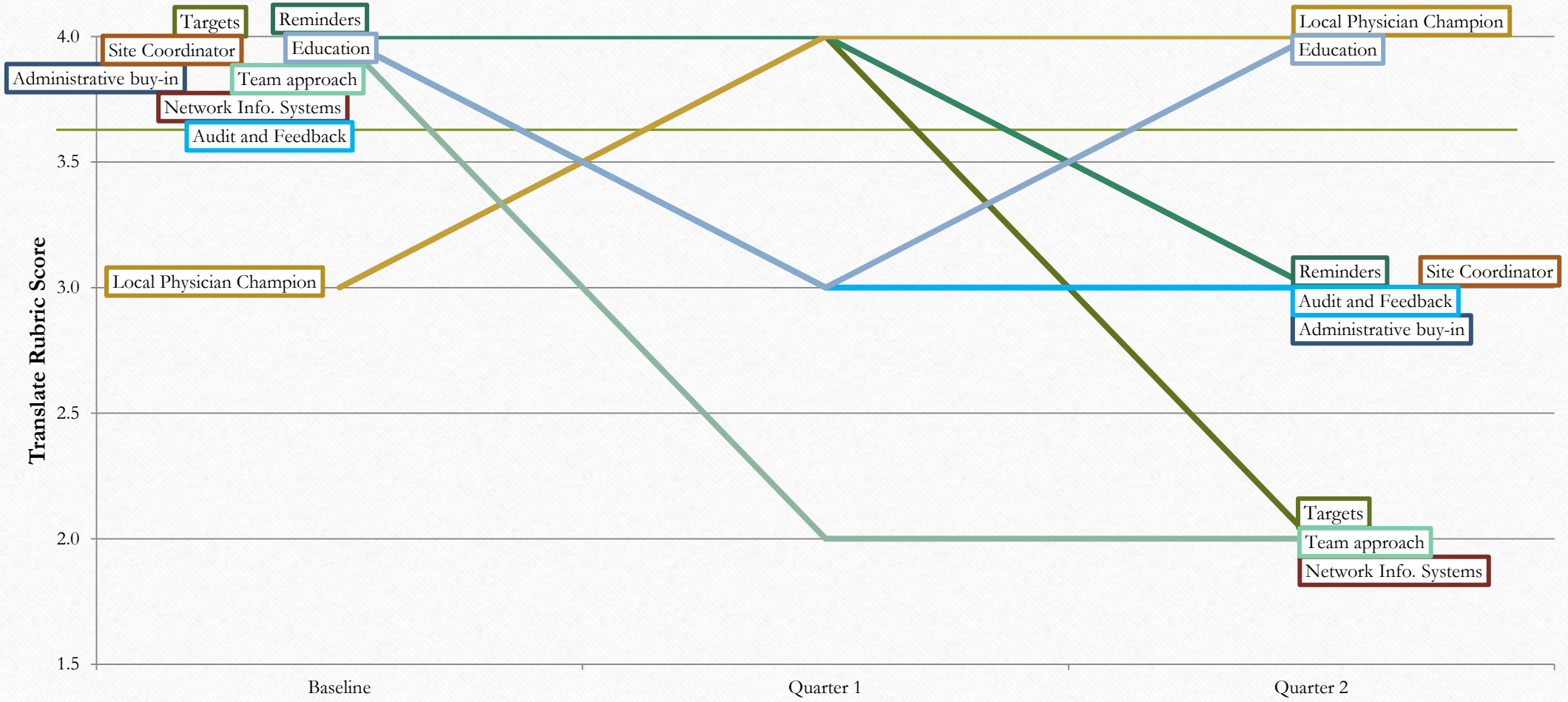
Preliminary Results
Total Score



Change by Individual element (all practices)



Individual elements for individual practice



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MEASURING PRACTICE TRANSFORMATION

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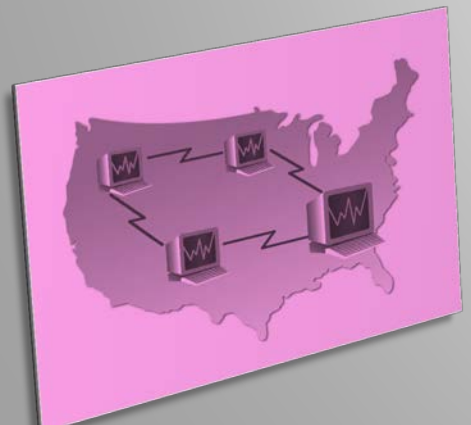

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- Paul J. Nietert, PhD
- PPRNet Member Practices

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)

SYNTHESIZING LESSONS LEARNED

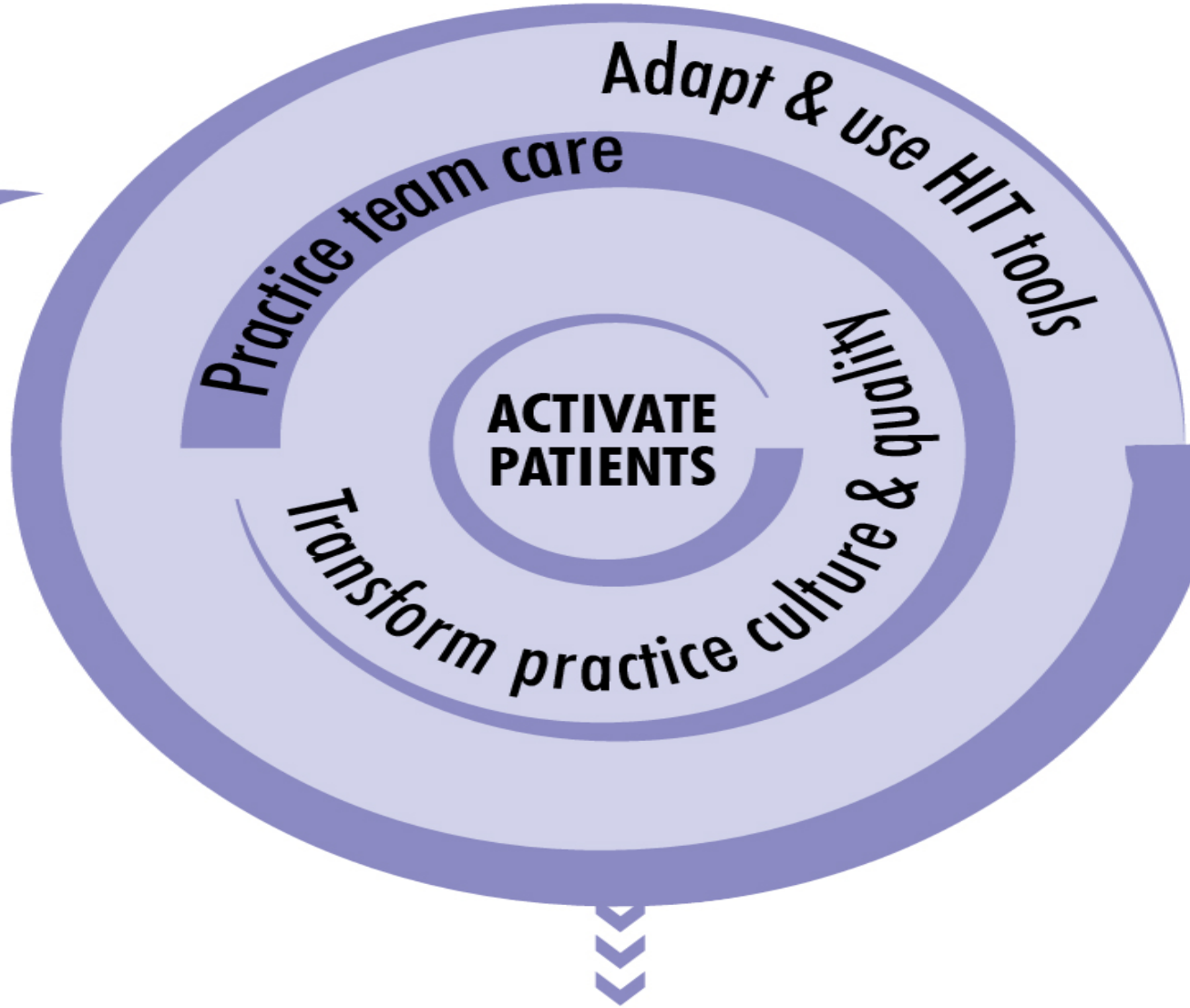
- Secondary analysis of seven PPRNet studies qualitative data (2001-2012)
  - Cardiovascular/stroke prevention, alcohol screening and brief intervention, broad primary care measures, colorectal cancer screening, medication safety, standing orders
- 134 practices nationwide participated in this collaborative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

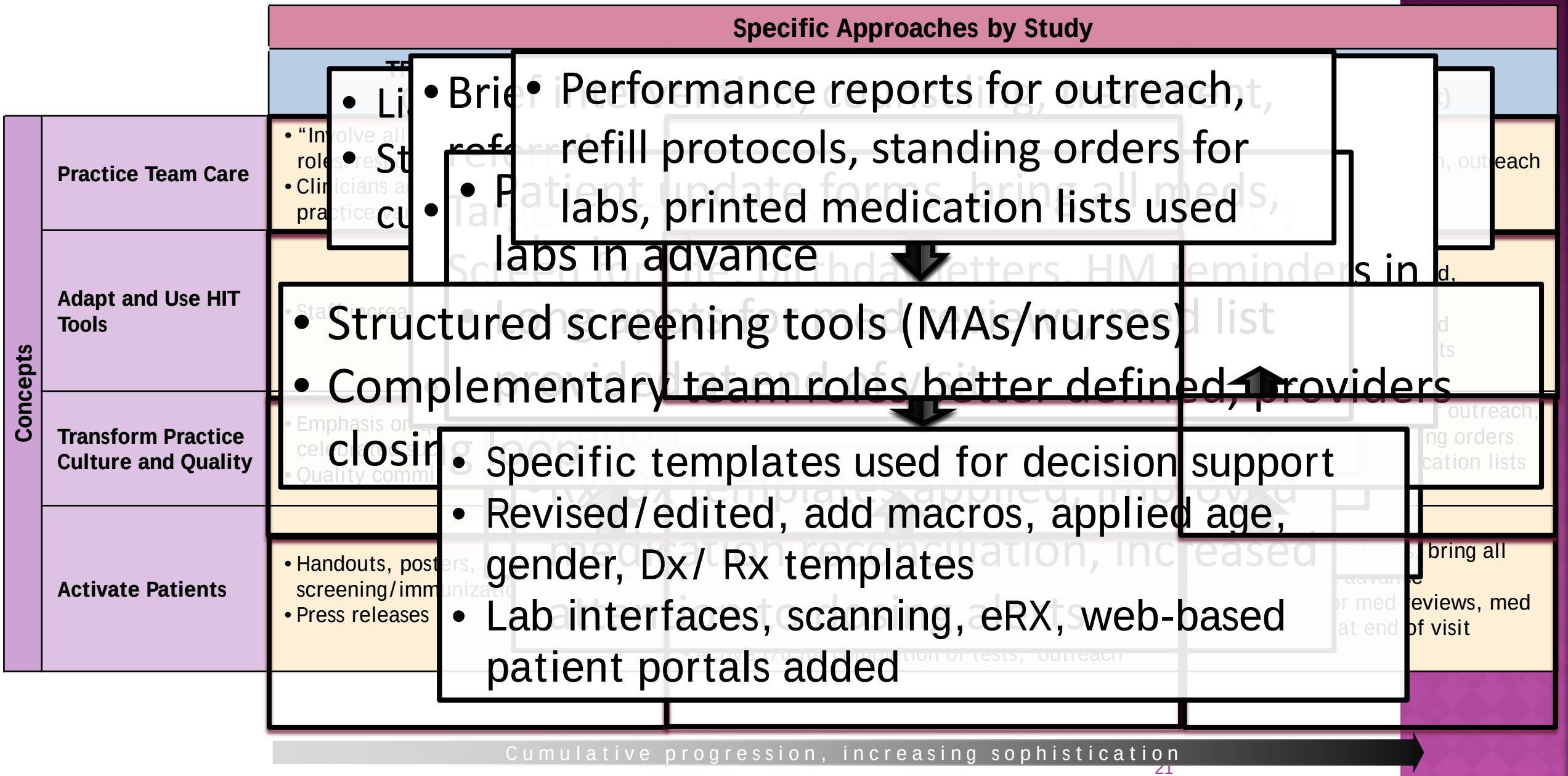
REWARDS

- FINANCIAL ALIGNMENT WITH QUALITY MEASURES
- RETENTION OF STAFF & PROVIDERS

IMPROVED OUTCOMES

QUALITY MEASURES: PPRNet, NCQA, CMS

Concepts and Strategies: Complex Interventions



NEED: MEASUREMENT TOOL

- Meaningful Use Study provided opportunity
- Proposed Meaningful Use Stage 3 CQM
  - 21 measures selected relevant to primary care
  - *Measures: Population/Public Health, Clinical Process/Effectiveness and Patient Safety and Efficient Use of Healthcare Resources*
- 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*

KEY QUESTIONS

- 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?

FINDINGS OF SURVEY

- 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

FUTURE RESEARCH IS NEEDED

- 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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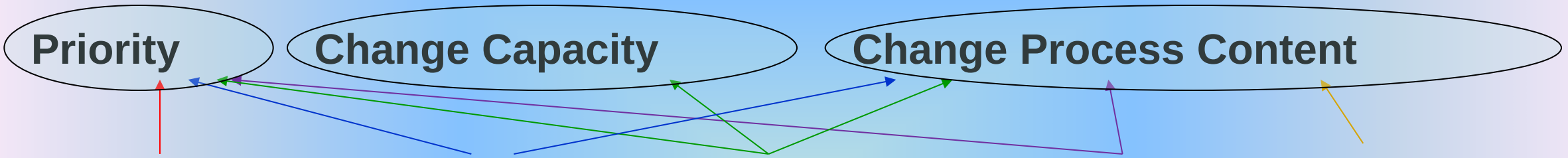
The Solberg-Mold Practice Change/QI Model

Proposed effects of the QI Interventions on Change Elements



Performance Feedback	Academic Detailing	Practice Facilitation	Local Learning Collaboratives	HIT Support
Baseline and "mini" chart reviews over the project (PF can do)	Faculty introduces the project at kick-off meeting (also the PF)	Practice assessment, tailoring interventions, empowering teams	Geographical or virtual learning practice communities for cross-pollination and prob. solv.	New technol. resources or enabling staff to use existing tools efficiently

The Solberg-Mold Practice Change/QI Model

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
- Solberg, Asche, Margolis, Whitebird - Am J Med Qual 2008

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

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CCRN Collaborative Care Research Network

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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