# Making Performance Measures Work for You!

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# About the Presenters:

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# Workshop Learning Objectives

▶ Understand the role of data and performance measurement in relation to value, accountability and high quality service provision.

▶ Provide an overview of PDSA quality improvement cycle

# Questions

- What data do you currently collect?
- What is your process?
- What tools do you use?
- What do you do with the information?
- How does it inform practice?

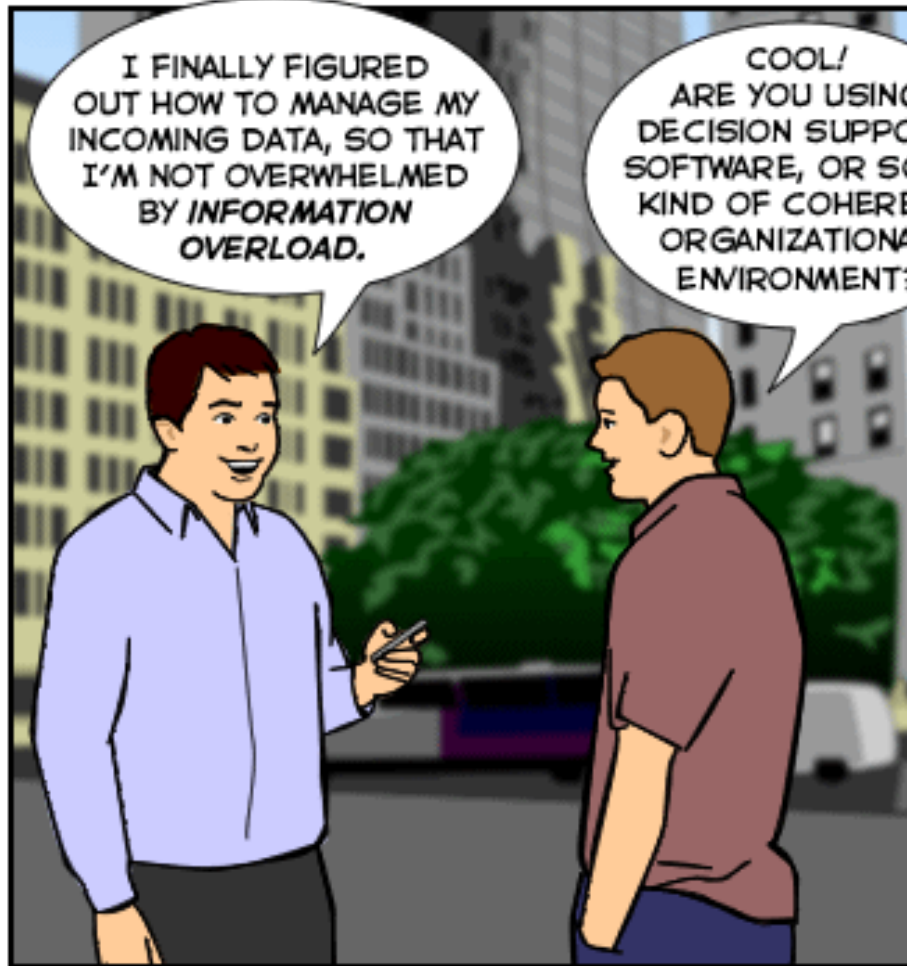# Why is data important and what is the impact of my services?

▶ Collect relevant information

▶ Use your data to ensure that you are meeting the needs of the people you provide services to

▶ Learn about the value of your services by examining data

  ▶ Use satisfaction survey information

But avoid data overload!

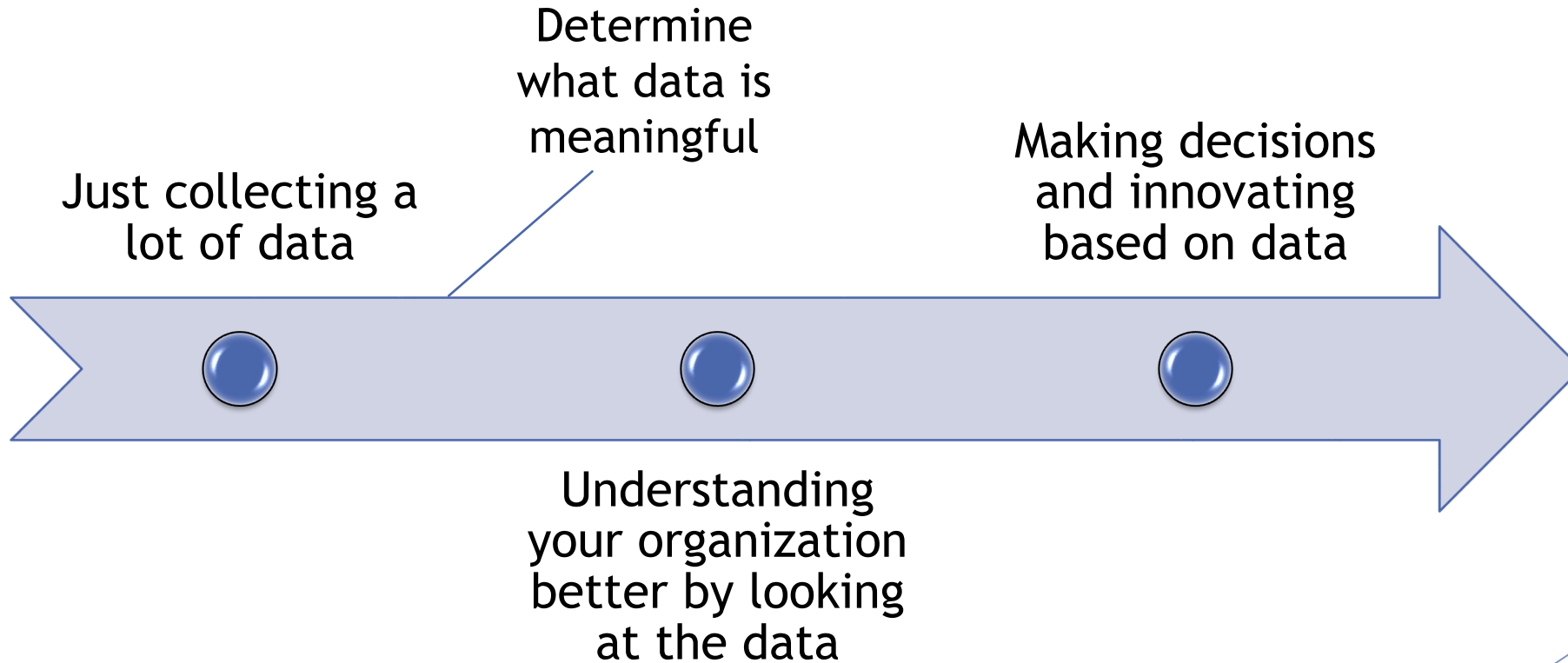# What data should I collect and how?

# The Answer…

- ▶ It depends.
- ▶ What is the aim? What is the measurable goal you want to achieve?

# Why have a performance-driven culture?

- ▶ Better for staff
- ▶ Better for people receiving services
- ▶ Better for your bottom line

# Data Lifecycle

Just collecting a lot of data

Determine what data is meaningful

Making decisions and innovating based on data

Understanding your organization better by looking at the data

# Example: Making People Better Agency

▶ Who We Serve: Adults age 18+ and over with a behavioral health diagnosis in Ulster county.

**PROS Program**: Comprehensive PROS with Clinic Treatment

**HCBS Services**: Psychosocial Rehabilitation, Habilitation, Pre-Vocational Services, Transitional Employment, Ongoing Supported Employment, Education Support Services, Empowerment Services, Family Support Training

# Making People Better Location:

- 179,225 Residents

- 12.8% of people live below the poverty level

- Demographics:

  - White 87.8%

  - Black or African American 7%

  - American Indian or Alaska Native 0.4%

  - Asian 2/1%

  - Native Hawaiian or Other Pacific Islander >0.5%

  - Two or more races 2.7%

  - Hispanic or Latino 10.1%

  - White, Not Hispanic or latino 79.7%

Source: www.uscensus.gov

# Making People Better Trends in Service Delivery

- ▶ PROS LOS is an average of 3.7 years
- ▶ 75% of people who attend PROS also receive CT services at MPB
- ▶ 65% of people who receive services at MPB PROS have a dual diagnosis
- ▶ 80% of HCBS referrals are for Empowerment services

# A quality improvement method

What is the outcome or process you want to improve?
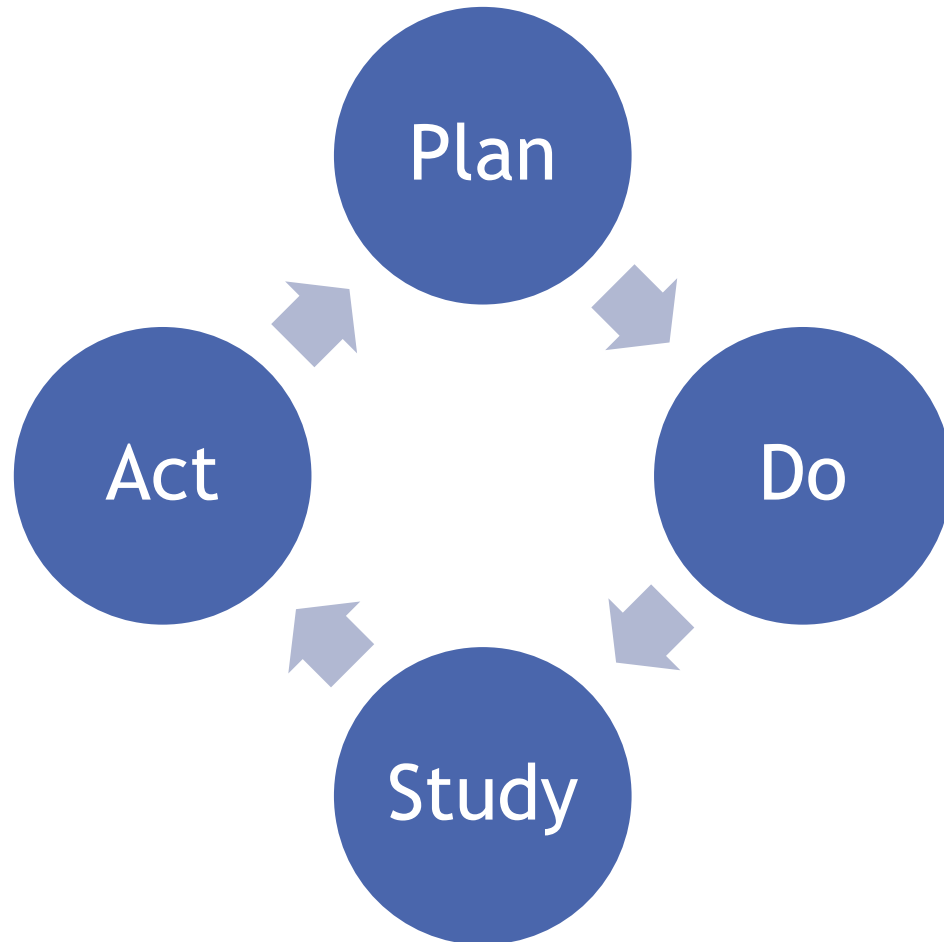
# PDSA

► **PLAN**

  ► Seek to understand the causes of the problem and generate possible solutions

  ► Select a change to test. What do you think will happen and why?

  ► Develop a plan of action, including a plan for collecting data and measuring impact of change.

# PDSA Continued

- **DO**
  - Put your plan into action
- **STUDY**
  - What happened? Review data and summarize findings.
  - Unanticipated challenges/barriers
- **ACT**
  - Keep/Change/Toss

# Making People Better Example

▶ The percentage of people who attend IRP Planning sessions

Goal: 90%

Actual: 70%

# PDSA Cycle 1

- ▶ PLAN

  - ▶ Problem: People enrolled in MPB PROS don't always keep IRP Planning session appointments, which results in late IRP reviews.

  - ▶ Change: Utilize phone call reminders two days before the appointment.

  - ▶ Theory: An increase in the number of IRP reviews that are written and signed on time.

# PDSA Cycle #1 Continued

- ▶ **Plan continued**
  - ▶ <u>Data collection:</u>
    - ▶ Coordinators use the calendar in their EHR and document appointments for IRP planning sessions. IRP planning sessions are documented via progress notes in the EHR (kept and missed appointments).
    - ▶ PROS coordinator makes reminder calls two days before the scheduled appointment.

- ▶ **Do**
  - ▶ PROS coordinator carries out the plan and enters required data into EHR (documents kept and missed sessions). PROS coordinator also documents reminder calls made via a call log.

# PDSA Cycle #1 Continued

## ▶ Study

- ▶ After 90 days, PROS team reviews data. PROS coordinators saw that the show rate for IRP Planning sessions increased to 83% after implementing reminder calls .

- ▶ Challenge: 10% of consumers didn't have working phone numbers.

## ▶ Act

- ▶ Since target for this cycle was not achieved, the PROS will make another change, start PDSA Cycle #2 to test another strategy to move % even higher towards the goal of 90%.

# How can I get started?

- **Who? Workgroup:**
  - Individuals that may be impacted by PDSA cycle for their input
  - Those with the data
  - Leadership that has authority to make decisions on PDSA findings AND can ensure implementation of the "DO"
- **What?**
  - PDSA cycle on **ONE** step at a time
    - Ensures you are attributing change to the correct variable
  - PDSA cycle on a Pilot group first
- **Timeline?**
  - Short Cycles (2 weeks) for rapid decision making
    - This can be a challenge in the Behavioral Healthcare field

# Choosing Goals

- How do we define what we want to change/improve?
- What tools can we use to plan the goals and the changes to achieve them?

# Choosing Measures

▶ How will we measure our progress to understand if we are having an impact?

▶ Use existing sources

▶ Keep it simple, be practical: The do-ability test

▶ "Counting stuff" (pre-post, trends over time)

▶ Can you manage it?

▶ Can you sustain it?

# The NIATx Model

People

▶ Executive Sponsor:

    ▶ Senior admin

    ▶ Helps to remove barriers

▶ Project Leader:

    ▶ Lead and coordinate

▶ Change Team:

    ▶ Who will work on the project?

# NIATx Model Continued

- Rules:
  - Use existing resources
  - Measure change
  - Sustain the change

rules

# Tools and Resources

- NIATx **www.niatx.net/home**
  - **Conducting a Change Exercise**
  - **Change Project Form**
- CMS **https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/PDSACycledebedits.pdf**
  - **PDSA Cycle Template**