COMMUNITY ACTION AND ANALYTICS GUIDE

INTRODUCTION

This Community Action and Analytics Guide was developed by the Michigan Action Learning Network (ALN) to serve as a framework for shared action by primary and behavioral healthcare partners. The ALN believes that innovation is fundamentally local and will be more successful when driven by evidence-based practices and processes. There is no recipe or specific definition for healthcare integration efforts; they range by focus, scope, and specific intervention. However, the ALN identified key actions that communities can use to organize, mobilize, and underpin care improvement efforts. This guide is offered as a summary of those key actions with analytics suggested for each action in order to strengthen the evidence base of integration efforts.

GUIDING PRINCIPLE: TRIPLE AIM

The ALN used the Institute for Healthcare Improvement's Triple Aim (www.ihi.org) as a guiding principle for integration because this approach focuses simultaneously on improvement in three dimensions of healthcare:

1. Quality and satisfaction;
2. Improved health of populations;
3. Reduced cost of care.

USE OF THE GUIDE

The Community Action and Analytics Guide is intended for use by primary and behavioral health partnerships as a framework for informed action. ALN members wish to share this guide and hope to learn from others who use it. Important: please consider this version a DRAFT. The ALN anticipates revising the guide based on the experience of users. If you decide to use the guide in your community, we would very much appreciate your feedback about the following:

1. How have you used the guide?
2. In what ways have you found the guide helpful in developing or deepening partnerships between primary and behavioral health providers?
3. Have specific Key Actions been particularly relevant to your community's efforts?
4. What ways has the guide been challenging to use?
5. What advice would you give another community about how the guide might be useful?

To provide feedback on the guide, please contact Matt Wojack at wojack@ceicmh.org.

ABOUT THIS GUIDE

This Guide was developed by the Michigan Action Learning Network on integration of primary and behavioral healthcare for children and families with support from the Department of Child and Family Studies, University of South Florida. ALN meetings were co-facilitated by Sharon Hodges (USF) and Suzanne Miel-Uken (Miel-Uken Associates).

For more information on the ALN and upcoming activities, please contact: Matt Wojack, wojack@ceicmh.org.

USF
UNIVERSITY OF
SOUTH FLORIDA
COLLEGE OF BEHAVIORAL
& COMMUNITY SCIENCES

STRUCTURE OF THE GUIDE

The guide prompts users to take specific key actions, supported by relevant data, in order to optimize their integration efforts. For each action, the guide prompts users to highlight the location and source of these data and identify processes for analyzing and using the data. In addition, key actions include examples of data and analytics that ANL members have developed in their use of the guide.

Key Actions		
The key actions needed to undertake a quality improvement initiative		
Data Needed	**Data Sources**	**Analytics**
Data that supports taking a key action	Location of the data that supports a key action	The methodology for analyzing and using the data; supportive processes

Data = qualitative and quantitative information used for reasoning, discussion, or calculation.

Analytics = the discovery and communication of meaningful patterns in data.

Data analytics can be used to describe an environment, optimize action, improve outcomes. The ALN recognizes that to be most valuable, data analytics must be driven by clarity about actions that support community innovation in primary and behavioral healthcare integration for children.

SEVEN KEY ACTIONS

1. Through a partnership among primary care and community behavioral health leaders, **select a specific childhood physical health condition** that offers significant opportunity for quality, satisfaction, and cost improvement.

2. **Clearly establish the connection between behavioral and physical health** for the identified physical health condition in childhood and throughout the developmental trajectory.

3. For your community (which you could define as a specific county, region, or state), **describe the population affected by the condition,** beginning with the demographics of the overall child population and including indicators such as the percentage of children in poverty.

4. **Describe the context for the specific population** of focus and physical and behavioral health condition, such as the current providers of care, their locations, and the delivery structures.

5. **Identify the evidence-based and emerging interventions and strategies** that could improve the quality of care for the specific population of focus and health condition.

6. **Select measures that will assess changes** in quality, satisfaction, and cost resulting from the chosen strategy.

7. **Promote the specific integration strategy** based on the considerations made in key actions 1 through 6.

Key Action 1. Through a partnership between primary care and community mental health leaders, select a specific physical health condition in childhood that offers significant opportunity to improve quality and satisfaction, health of population, and cost of services and supports.

Data Needed	Data Sources	Analytics
» Information about existing local partnerships to help determine if they could undertake a care improvement initiative of this nature. » Information about potential partners, not yet collaborating, who might be interested in such an initiative.	» Contacts for local collaborative bodies active in physical/behavioral health collaboration. » Contacts and potential partners who are already working on physical/behavioral healthcare integration initiative.	» Confer with existing and potential collaborative planning and improvement organizations and/or workgroups to determine if they can and would undertake a physical/behavioral healthcare integration initiative. » Establish a primary care and behavioral health partnership to focus on the improvement initiative. » Consider what health conditions are the local partners most interested in developing partnership around? » Why do partners believe these health conditions are important?

Scenario		
Together, primary care and behavioral health partners use data and research findings to select a physical health condition with significant potential for quality, satisfaction, and cost improvement. Existing collaborative bodies and individuals who are already working on physical/behavioral health collaboration identify childhood asthma as a potential health condition for a population of focus.	Example of Data Sources » *Vital Statistics, Michigan Department of Community Health, or a local organization tracking of childhood asthma provides evidence of asthma as a population of focus.*	Example of Analytics » *Work with MDCH or any local tracking effort to obtain data for your community/county/region and for the state for comparison purposes.*

Key Action 2. Assess and make clear the connection between behavioral and physical health for the specific childhood condition

Data Needed	Data Sources	Analytics
» Research confirming that physical and behavioral health is interwoven for the identified condition.	» Use resources available through partners as data sources. » Use Google Scholar to search relevant research findings. » Consider partnership with university or other educational organization that has access to relevant research findings on physical and behavioral healthcare.	» The primary and behavioral health care partners review and use research data to prepare a brief description of the connection, which can be convey to all providers in the community.

Scenario

University partner conducts initial research on link between physical and behavioral concerns in childhood asthma.

Example of Data Sources

University partner identifies relevant literature indicating childhood asthma is critical to both physical and behavioral health:

» *Children with chronic illnesses are at increased risk of emotional and behavioral problems (Witt, et al., 2003).*

» *Increased rate of emotional and behavioral disorders in children with chronic illnesses suggests the importance of early detection of mental health issues in these children (Hysing et al., 2009)*

» *Children with behavior problems have higher asthma prevalence rates (Annesi-Maesano et al., 2013)*

» *Behavior problems may underlie poor treatment adherence for chronic health conditions (Verkleij, et al. 2011)*

» *Children with asthma are more likely to have comorbid ADHD (Blackman & Gorka, 2007, Fasmer, et al., 2011)*

» *Asthma treatment may play a role in externalizing disorders such as ADHD and oppositional behavior (Saricoban, et al., 2011)*

» *There is a potential link between infant onset eczema (also an indicator of asthma development) and ADHD (Schmitt, et al., 2010)*

» *Internalizing behavior problems are more severe in asthmatic children and youth when compared to a healthy reference group (Verkleij, et al., 2011)*

» *Evidence of association between asthma and behavior problems is increasing (Annesi-Maesano et al., 2013).*

Example of Analytics

» *Partners review literature and conclude that data substantiate the prevalence of asthma as a condition of concern in the community, ranking highest among all chronic childhood conditions in the state and in the geographic area of focus.*

» *Partners discuss findings, synthesize relevance to community, and use data as basis for community outreach and integration planning efforts.*

Key Action 3. For your county/region, describe the population affected by the specific health condition, beginning with overall population demographics.

Data Needed	Data Sources	Analytics
» Child population demographics, such as number of children age 0 through 17, percentage of children in poverty, etc. for county/region. » Prevalence of identified condition among children in your county/region and for the state as a whole. » Prevalence of hospitalizations for identified condition among children in your county/region. » Prevalence of identified condition among children served by community mental health providers.	» For each item of data needed, brainstorm with partners about county, state, and national resources available that describe the local population of children who are affected by the identified health condition.	» The primary care and behavioral health partners together frame the data request to the MDCH, including comparison between local county/region over time to the state as a whole on prevalence and hospitalizations. » Partners review the data on children served by community mental health, as well as prevalence and hospitalization data. » Partners prepare a brief description of the characteristics of the specific population of focus and convey to local providers.

Scenario		
Focus on asthma as physical and behavioral health condition continues, and data are identified for the categories listed above.	Example of Data Sources » *Population demographics: Census data – available online* » *Prevalence of asthma: Vital Records and Health Statistics, Michigan Department of Community Health (MDCH).* » *Prevalence of hospitalizations for asthma: Michigan Inpatient Hospital Database, MDCH.* » *Prevalence of asthma among community mental health providers: Community mental health program services database.*	Example of Analytics » *Partners determine the potential for a significant improvement in quality, satisfaction, and cost related to integrated treatment of asthma as both a physical and behavioral health condition.*

Key Action 4.   Describe the local and state context for a specific population of focus

Data Needed	Data Sources	Analytics
» Information about health care delivery settings (physical and behavioral) for children with the identified condition in the county/region. This can include health plans and setting where care is provided such as primary care clinics and/or community health centers. » Information about local and state policy relevant to the identified condition. » Number of children with asthma in the county who are served by both primary care and community mental health.	» Because partner understanding of local and state context for the identified condition may differ, it is important that they share information about data sources relevant to local and state context.	» Partners review information on the settings where primary and behavioral health care is provided in their county/region/state. » Partners develop a brief description of the current delivery settings for children with the identified condition.

Scenario

	Example of Data Sources	Example of Analytics
The partnership describes the current providers of care, locations, and the delivery structures, paying particular attention to the differences between current structure and their vision for this structure when applying Triple Aim. » *Health care delivery settings in the county/region for children with asthma, including health plans and settings where care is provided, such as primary care clinics and/or community health centers (Michigan Medicaid Program, MDCH)* » *Number of children with asthma in the county who are served by both primary care and community mental health (Medicaid Program and health plans; community mental health)* » *Process mapping and articulation of access, eligibility, and actual asthma interventions offered by various providers including articulation of children who eligible and not, how services are accessed, and services provided.*	*Partners identify and compare potential data from sources such as:* » *Michigan Medicaid Program MDCH* » *Michigan Community Mental Health Authorities and Agencies*	» *Partners work with identified sources of data to obtain data on the location of care for children with asthma who are served by health plans and community mental health.* » *Using these data, partners develop a description of the current service delivery structure and settings for children to serve as baseline information about population context for asthma care in their community.*

Key Action 5.　Identify evidence-based and promising interventions and strategies that can improve quality, satisfaction, and cost of care for the identified population of children in the community who are served by both primary care and community behavioral health providers.

Data Needed	Data Sources	Analytics
» Examples of evidence-based and emerging interventions that have demonstrated or show promise for demonstrating progress toward integration of primary and behavioral healthcare in treating the identified condition.	» Partner knowledge and experience. » Evidence-based practice databases. » Research literature. » State and federal resources about integration. » Data on success of home and community-based care.	» Partners review data and extract findings on evidence-based and emerging interventions appropriate for children with asthma. » Partners select intervention(s) appropriate to integrated care for the identified condition.

Scenario

Partners identify strategies for integrating primary and behavioral healthcare that have demonstrated or promise improved outcomes in treatment of asthma.

» *Examples of asthma treatment models that provide primary and behavioral healthcare in a single setting so that families have easier access to services and resources.*

» *Examples of asthma treatment models that provide behavioral health referral and consultation to families who receive primary care services for asthma.*

» *Examples of enhanced coordination, alignment, and linkages across primary health conditions that might be applied to local integration of care for children with asthma.*

Example of Data Sources

» *Information on integrated asthma care gleaned by partners from professional conferences, newsletters, and colleagues.*

» *Research literature demonstrating success of integrated primary and behavioral healthcare for asthma.*

» *SAMHSA-HRSA Integrated Health Solutions: http://www. integration.samhsa.gov/integrated-care-models/behavioral-health-in-primary-care.*

» *Community Mental Health data on outcomes achieved by home and community-based care.*

Example of Analytics

» *Partners review data on integrated asthma treatment models and work collaboratively to identify barriers to the enhanced coordination, alignment, and linkages required for implementation.*

» *Partners select model(s) of integrated care that they believe will achieve the Triple Aim.*

Key Action 6.   Select measures that will assess changes in quality and satisfaction, health of the identified population, and cost.

Data Needed	Data Sources	Analytics
Improved Quality and Satisfaction: » Data on user perceptions of quality and satisfaction with integrated care for identified health condition. » Data on health plan patient satisfaction with care for the identified health condition.	**Quality and Satisfaction:** » Data reported by health plans » Patient surveys	» Partners confer with MDCH and health plans and review the literature to identify existing measures of quality, satisfaction, and cost. » Partners make use of existing data sources whenever possible. » Partners select and recommend measures that will assess the results of the improvement strategy.
Improved Population Health: » Longitudinal data on treatment outcomes for the identified health condition. » Longitudinal data on prevalence of identified health condition.	**Population Health:** » Michigan Medicaid Program, MDCH » Vital Records and Health Statistics and the Inpatient Hospital Database, MDCH	
Reduced Cost of Care: » Evidence of reduction in cost associated with ER visits for non-emergent treatment of identified condition. » Evidence of increased use of primary care physician for treatment of identified condition rather than reliance on Emergency Room.	**Cost of Care:** » Michigan Medicaid Program, MDCH	

Scenario		
Partners consider how to measure progress toward Triple Aim with regard integrating care in the treatment of asthma. *Improved Quality and Satisfaction:* » *Existence of asthma care plans with specific goals that include behavioral health interventions* » *Provider report of satisfaction with integrated asthma care* » *Family report of satisfaction with integrated asthma care* *Improved Population Health:* » *Reduction of asthma prevalence (e.g. more than 4 asthma medication dispensing events OR more than one hospitalization where asthma is the primary diagnosis OR more than 4 outpatient visits)* *Reduced Cost of Care:* » *Tracking of ER visits for asthma.*	Example of Data Sources *Improved Quality and Satisfaction:* » *Health plans, plans of care* » *Provider survey* » *Family survey* *Improved Population Health:* » *Vital Records and Health Statistics, MDCH* *Reduced Cost of Care:* » *Inpatient Hospital Database, MDCH*	Example of Analytics » *Partners review data and select appropriate measures.*

Key Action 7.   Partnership promotes the specific integration strategies that have been selected based on the considerations made in Key Actions 1 – 6.

Data Needed	Data Sources	Analytics

Specifics of Key Action 7 are currently under development by ALN members

Scenario		
	Example of Data Sources	Example of Analytics