Closing The Loop: Measuring What Matters In Whole Person Care

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Speaker 1 0:00

All right, we're going to go ahead and get started. Thank you for being here in our last session, closing the loop, measuring what matters in whole person care. We are pleased to welcome Dr Michael Dennis, Chief Research Officer, and Jim Wallace, Director of Business Development at Chestnut health systems. They'll be up on stage in a bit. And then Stacy Coleman, Director of Quality Management, and Megan Lanier, director of corporate compliance at Coastal Family Health Systems. Thank you for being here. Dr Michael Dennis currently serves as the Chief Research Officer at Chestnut health systems. He earned his PhD in Psychology from Northwestern University with NIH and NIDA funded studies focus on addiction recovery, opioid use disorder, justice involved populations and evidence based implementation. He's a co developer of Recovery Management, checkups and evidence based approach shown to improve treatment engagement and reduce costly health care and justice system utilization, and led the development of the global appraisal of individual needs, a widely used clinical assessment system implemented by 1000s of agencies internationally. His work has been recognized with major national honors, including an idea Merit Award and the International Council of alcoholism and addiction Lifetime Achievement Award. Jim Wallace is the Director of Business Development at Chestnut since October of 2016 and has over 35 years of behavior over 35 years in behavioral health. Jim currently focuses on growing and fostering chestnut health systems, Business Development Service line as they relate to the agency's behavior health footprint in the Midwest, as well as their robust research institute lighthouse, which currently serves the entire United States, Canada and 16 countries internationally. Stacey Coleman serves as the Director of Quality Management for coastal health center, Family Health Center, where she leads organizational efforts to embed a sustainable culture of safety, quality accountability across a seven county service area. With more than 13 years of progressive leadership experience, she has designed, implemented and managed comprehensively quality assurance, performance improvement programs that support high reliability care and regulatory excellence. Under her leadership, all CFHC standalone clinics achieved initial level three, NCQA, PCMH recognition, and have successfully maintained recognition through the transformational annual reporting model. Megan serves as the director of corporate compliance at Coastal Family Health Center, where she brings more than 13 years of dedicated service and institutional institutional knowledge of the organization. As director of corporate compliance, Megan oversees a broad portfolio of responsibilities, including grant writing, organizational risk management and

service as the HIPAA and serves as the HIPAA Privacy Officer. She also provides leadership and oversight for the contracts, medical records, social services and credentialing departments, ensuring regulatory compliance, operational efficiency and high quality service delivery across the organization. Sounds really complicated, all right, so let's get into our discussion. Today. We are going to go over two case studies, one from coastal and one from Chestnut. Will there be some time for question and answer as we move through these, we'll do a quick stage reset in between their presentations. But why whole person care needs more than good intentions? So when we look at this idea of providing whole person care, we acknowledge that we're going to be integrating behavioral health, physical health, social needs, environmental needs, to ensure ideal outcomes for the people that we're serving, and there have to be systems. That's where the integrated care portion of the organizational model comes in to make sure that we have the workflows, the procedures to be able to make these outcomes happen. If we're going to follow this whole person approach. This includes integrating electronic health records, coordinating workflows and having clear communication channels so that we can meet these outcomes. Critical to that is the role of the performance feedback systems, which are going to be ideal for making sure that all of the outcomes that are being produced by this integrated care constantly reviewed and refined to continuously improve the care quality and the outcomes, ultimately creating accountability for the organization, as well as driving continuous improvement. So as an example, primary clinic partners with a behavioral health provider and a local service, social services agency to support patients with diabetes and depression, which is going to help to improve their outcomes, ultimately, both physically as well, from a behavioral health perspective, when we consider the idea of leveraging the data for integrated care, there are different elements of data. Data is. A really broad category, and when you think about the different elements that we need to focus on, you know, real time data is crucial. We heard earlier in some of the sessions, if you were here with us, that having the data available to make real time decisions is going to improve the outcomes. If you're relying on data that was published a month ago, you may be taking action on information that's old and causing friction between you and the members that you're serving. We want to be sure that integrated dashboards are occurring. If you have multiple service lines or services that are being provided within the organization, that multiple leaders and clinicians across departments have access to those dashboards so they can jointly take action on a shared individual that they're serving. We have interoperable platforms, so making sure that the EHRs are communicating if you're integrating with the Health Information Exchange, making sure that you have access to data from multiple sources, of course, having automated alerts so that you're notified when certain things are happening. Maybe if someone was in the emergency department being notified of that, because the member may not just think to notify you that that they were in the emergency department or received a specific point of care. And then looking at your analytics and integrating your social determinants about all of these factors are going to be really important into the consideration of how to leverage data to really improve that integrated care experience. And so closing that that loop from frontline to enterprise, we need to make sure that there are feedback structures to be able to get people that are providing the care the feedback, so that the care can be continuously optimized and improving the service experience for the person that is served. This is going to be including integrated dashboards having regular performance reviews for the individual that are providing the care, as well as looking at client related outcomes to ensure that you're achieving the outcomes that you're seeking and providing this whole person care model, and then again, really looking at this opportunity for continuous improvement. So with that, I will turn it over to coastal you.

Speaker 2 7:06

My mic on. Okay, there we go. All right. So today, Stacey and I are going to walk you through a real world case study of how we approach KPI integration and multi disciplinary governance within an FQHC. So this isn't a theoretical framework or vendor solution or anything like that. It's an honest look at what worked, what didn't, and how aligning quality, compliance, finance, operations and all the other departments around shared KPIs changed how we make decisions as an organization. Our goal is that we want you to walk away with practical ideas that you can actually use, regardless of the size or maturity of your organization.

Speaker 2 7:56

There we go. Third time was the charm. So to give you some context, coastal Family Health Center is a FQHC, or federally qualified health center that serves a diverse and often medically complex population. We have seven counties that we serve along South Mississippi. Through our 49 sites, we offer a range of services, including primary care, behavioral health, psychiatry, dental, Optometry, radiology and enabling services, and we manage a broad payer mix to include self pay, Medicaid, Medicare, managed care and grant funds. We provide over 116,000 visits to 38,000 patients on an annual basis. And we also offer enrollment in special populations programs such as Healthcare for the Homeless or Ryan White for those who are HIV or AIDS positive. We are accredited by a joint commission for both our ambulatory and behavioral health programs, and as mentioned with Stacey's bio, we are accredited by the NCQA as a patient centered medical home or PCMH, like many FQHCs, we're balancing access, quality, compliance, workforce sustainability and financial viability all at once. Each of those areas has its own requirements and its own performance pressures. This complexity is really important when we look at our case study, because it directly influenced how our fragmented KPI approach became over time, and why integration became necessary rather than optional. So our reputation at Coastal Family Health Center for Innovation, quality and excellence are deeply rooted in our mission, our vision and our core values. Our mission is to provide quality, comprehensive, patient centered care to the community, regardless of one's economic status, our vision is to have significant impact on the communities that we serve and the health and well being. To this end, we work with others to ensure a creative and cost effective range of health and social services available to all our values, as you see here, are dignity, justice. Service, excellence and stewardship. We don't see our mission, vision and values as just statements on a wall. They're a critical anchor for this work. In particular, as we grew over time, we realized that some KPIs were being selected simply because they were required or just really easy to measure, but they didn't advance our mission. That created a lot of tension between what staff felt mattered clinically and what leadership tracked operationally. By intentionally tying KPIs back to our mission and values, we were able to reframe performance measurement as mission focused and mission support rather than just oversight. That shift helped us to reduce resistance increased staff morale and engagement, because people could see how the metrics connected to the work that they did on a daily basis. So when Stacy and I started at the same year in 2012, almost 14 years ago, we had about a third of the sites that we do now. So as we grew our structure as well as our performance monitoring evolve alongside that growth, but not always at the same pace or direction. Early on, informal tracking and department specific metrics worked reasonably well. Finance track, revenue, productivity, sustainability, operations focused on access, throughput, staffing efficiency and day to day activities. Clinical leaders and staff monitored quality through required measures and program reporting. Each of them were doing what made sense within their own department. We also had a designated risk management function that had incident tracking, patient safety concerns, looking at different claims and addressing those as they arose, which was essential to maintaining stability. But what we didn't have was a centralized, formal quality department, compliance department, with enterprise

level governance authority, so quality and compliance responsibilities were scattered. You know, multiple people had a piece here and a piece there. You know, it was managed collaboratively, but without a consistent organizational framework for standardized oversight. As a result, Performance Monitor monitoring matured unevenly. Departments developed KPIs based on their own needs, their own priorities, maybe external reporting requirements, individually the metrics were appropriate, but collectively, they weren't always aligned with each other. They didn't make sense when looking at the other departments, KPIs. So it meant we had data. We had a lot of data, but we didn't have a shared integrated structure to understand how decisions and finance and operations and quality and risk influence one another, that gap in governance and integration ultimately set the stage for the core problem that we'll discuss next. The core problem, as I said, was not that we locked data, it was that our data lived in silos. Departments were optimizing their own KPIs, sometimes unknowingly creating downstream impacts for other departments, for example, productivity goals could conflict with quality, documentation, timelines, access improvements could strain staffing models, compliance risks were not always visible until after the fact, leadership was often forced to choose between competing priorities without a shared framework for understanding what The trade offs were over time, this contributed to staff frustration, burnout and reactive decision making. One example of this was Stacy pursuing our PCMH accreditation, and this was supposed to take one year. It took nearly four because this department was prioritizing this measure. We would get really good at it. But then it turns out this department over here was prioritizing a different measure that conflicted with the original plan. So what did we do at this point? It came clear it wasn't effort or commitment. It was the structure how things were outlined. Our strategic response was to intentionally move away from function specific ownership of KPIs and toward an enterprise multi disciplinary model. Instead of quality, finance, operations, compliance and clinical leadership, each defining success independently, we brought those perspectives jointly together to determine what success should look like for the whole organization. This meant being very deliberate about what our KPIs were, we focused on identifying a core set of metrics that were not only required or measurable, but meaningful and actionable, and that reflected how one's area of performance directly influenced another. For example, access measures, documentation, timeliness, financial performance and risk. They were no longer viewed separately, but as they connected to each other components of a whole, we established clear governance around KPIs. Decisions about what to track, how often to review the data and how often to respond to trends, was no longer being siloed. Accountability then shifted away from individual. Individual to shared ownership with leadership, being responsible for understanding the trade offs and downstream impacts. Importantly, we were intentional about our culture. KPIs were positioned as tools to guide decision making, also looking at improvement, not as punitive measures. That shift helped to build trust and encouraged engagement across teams. This strategic response laid the foundation for creating formal quality and compliance functions, integrating risk management more proactively and ultimately building a better governance structure capable of supporting our continued and sometimes very rapid growth, the multi disciplinary organizational performance improvement committee, or OPIC, was established as a reporting and approval committee. So this committee reviews quality, risk, financial, operational measures, and serves as the approval body for policies and procedures, receiving structured reports from subcommittees. So this committee works to ensure enterprise alignment and prioritization. When all reports are governed by this committee and go straight to this committee, we're able to look at the effects that they have on each other, then we established the compliance and risk management committee. This was a subcommittee from OPIC established as a multi disciplinary team. It's a process focused committee that's responsible for conducting organizational risk assessments, reviewing incident reports and determining corrective actions and looking at trends. We also track risk related performance indicators, so we report upwards to OPIC in addition to leadership as a whole. Now

this definitely wasn't a flip the light switch change right? We had to approach it in phases over a 13 year period. First, we assessed what we were tracking and why. Then we aligned leadership around shared goals and clarified governance roles implementation, followed with reviewing cycles regularly and then make sure we had the feedback loops in place, we quickly learned that communication had to be constant and transparent. People need to understand not just what changed, but why. That is such a big motivator. When the staff understand the why behind why you're tracking a measure. Governance structure then evolved as we learned and you know what worked and where adjustments were needed. So once we integrated KPIs, we began seeing improvements that cut across departments access initiatives like annual wellness visits, chronic care management, remote patient monitoring and telehealth improve productivity and revenue, while also reducing no show rates.

Speaker 2 17:38

Improved cycle time and chart closure reduced staff burnout, stress and improved our audit risk. Financial Stability allowed us to reinvest in quality initiatives, rather than just operating in crisis mode consistently. And most importantly, leadership decisions became more informed because we could see cause and effect relationships rather than just isolated data points. Tracy,

Speaker 3 18:07

y'all hear me, you go all right. So now that Megan has convinced you that we have everything figured out, we can go home now, right? Absolutely not. So we brought in some consultants for 2026 so kind of backing up to 2020 late, 2025 those consultants came in and helped us to come up with a strategic plan. Within this plan, we aligned four oversight or four governing goals, amazing patient care, improving financial stability, improving staff experience and improving visibility in the community. So if you look at these focuses, they start to kind of bring these KPIs together. So if you look at AW vs for example, what does an AWV do? Is it part of productivity?

Unknown Speaker 18:58

Yes, no. Does it help improve quality care,

Speaker 3 19:04

bring in quality dollars, improve financial sustainability. How about improving staff experience? Absolutely happier patients. You're taking care of your patients, your staff is happier. You've got a workflow that you're working towards to help bring everything together and improving visibility in the clinics or in the community. Because now these patients that are taken care of for their awvs, they're telling everybody, Hey, I want to go to coastal. They're fantastic. They take care of me. They look at my health care for the year. They set up a plan for me. They look at all my care gaps. They really care. So now you're hitting all of these different areas within these KPIs. Okay, so then we worked with this consulting company to reach for the stars. And so we decided. Is, you know, we have a productivity monthly productivity for our nurse practitioners, up to 75 a month, and they struggle to meet 85% of that not a problem. Let's do three patients per hour. Now that is roughly for the seven hours that they're seeing patients that's about 420 a budget of 420 per year, per month. That's easy, because we're doing so well with our 275 so let's just

reach for the stars and say 420 now. And while we're at it, we're going to cut our patient cycle time from about an hour, hour and 30 minutes now to 38 minutes cycle time. Okay? And then 90% of our charges have to be completed at the end of the day. So this is what this consulting company refers to as dpi. Does anybody know what DPI stands for? Any any guesses? Dramatic performance improvement. And what we started thinking about, and after we said, well, this is never going to work. You know, our providers are going to be upset. Our patients are not going to get the care. This is never going to work. When we started thinking, well, it's going to boost productivity if we get in there and really help our staff, it's going to make their workflows more efficient, which is going to make them happier. So 90% of charge completion charges submitted by the end of the day. That's going to help our productivity, our financial sustainability, and I bet it's going to make our staff and providers happier. Now, why would it make them happier? You know, because now they're having to get things done quicker, but now 90% of their work is done by the time they go home. So now they get to be moms and dads when they get when they go home, they get to take part in their hobbies, take part in church functions, things that they wanted to do, that they couldn't do because they were bringing these charts home.

Speaker 3 22:03

So as we start talking about increasing the number of patients that we're seeing increasing or increasing the cycle times, you know, working on operations, finances, boring, where does quality play in that? So I went to our CEO, my hands on my hips, and I walked up to her, said, well, so we're just going to worry about productivity now. We're just going to worry about finances. We don't care about quality. Said, Absolutely not. And I want you to go and figure out how we're going to do it. So that's where we started looking at, how do we align quality with our strategic plan. Well, that's where our patient centered medical home model comes in. So we're using our care teams. We're using our huddles efficiently. We're using what this consultant firm calls the sheep Shepherd method. So we're empowering our nurses, our mas to have more control over the day so that the providers can do what buddy see patients. That's what they want to do. They want to see patients. They want to take care of their patients. So now they can do that because the nurses and new maze are more worried about making sure that the operational side is taken care of. So okay, so looking just at our strategic principles, quality can drive volume if we shift our focus from several separate KPIs to quality patient centered care, the QA Qi program and KPI should align with our strategic goals, instead of being separated patient centered care teams, workflows, improve efficiency and outcomes and focus metrics, prevent outcome fatigue. We had so much outcome fatigue before we had so many reports. HRSA came to see us, and we had these two binders just full of reports. They said, you know, y'all are one of the most data rich organizations we've seen. And I thought, Oh, wow, that's a compliment. I started thinking, what do we do with all this data? Because it's a lot of it. And then I started thinking about what a friend of mine told me, if everything's a priority, nothing is a priority. So what is a KPI is a key performance indicators. So how do you have a key performance indicator? If you have all of these different performance indicators, which one's key, which one is driving the health of your organization? Just one final area that we want to hit, the integration. So as I said, a little while ago, increase aw vs chronic care visits drive productivity and revenue RPM, telehealth services can reduce no show and increase access to care. So if you're looking at optimizing some of your tools to reduce no show and increase quality care gaps, or improve quality care gap. Partners. You know, these are some of the services, so looking at our digital health tools and optimizing them so that they work for our providers and not against our providers. Improve Cycle Time chart, closure decreases burnout, increases staff satisfaction. That's one of our overarching goals. Financial sustainability supports quality initiatives, which in turn increases revenue. What do we do when we increase revenue, we put it back into the system,

back into our staff and back into the quality of care that we give our patients. Strong quality outcomes, reduce clinical and organizational risk. Makes this lady over here very happy. Effective risk management protects compliance, improves our reputation and our funding. Patient and staff experience directly impact access, outcomes and retention and KP isolation is multi disciplinary, so integrated views give better decision making. So what are our lessons learned? If I knew then what I know now, communication is critical. So sitting down with your multi disciplinary teams, communicating your KPIs and coming up with the best ones to really hone in on the health of your organization. Data has to be meaningful. It's not enough to just do reports and measure things, you have to really understand what it does and how it's driving the decisions in your organization, and governance structures must evolve as the organization grows. So again, as we sit here, we don't have it figured out. We're still growing. We're still changing. Some things that we talk about today are going to work, some things may not. It'll be interesting to see what happens this time next year, and where we are and what what we've kept, what's changed, and then some of our takeaways. Break down department silos as early as possible. Get your department heads together. Really get them talking. Build governance before complexity overwhelms you. We didn't do that. We got overwhelmed. First, we worked in silo. First, we went at it over and over before we sat down and said, You know what, we're on the same team. We all want the same goals. Make KPI strategic, not just operational, use multi disciplinary forms for accountability and learning, and then last but not least, treat performance management as a cultural function, not just a reporting function.

Unknown Speaker 27:38

Does anybody have any questions for us,

Unknown Speaker 27:48

right?

Speaker 4 27:58

I'd love to hear you know it's increasingly with Whole Person Care, it's not just clinical care, it's social care that's taking place in the community. How are you all managing that data and marrying it with that clinical data to see what really matters?

Speaker 3 28:14

Well, we have implemented our social determinants of health, also social drivers of health out there, and we have found that it's been tremendously valuable in helping us to see what our patients need. We've had a health care for the homeless program for several years, so we were able to integrate that side, but we've also been able to see how transportation needs have shifted, and we've been able to pull that data and allow our social services representative to contact those patients. We've even made that a part of our no show message that comes out of a patient. No shows. Hey, we noticed that you've no show today. You know, what are some of the areas or why did you no show? Was it transportation? Did you just not get a reminder? Was it a work conflict? So just anything that we can do to try to help meet our patients where they are, that's a

Speaker 3 29:16

good question, and we're still trying to figure that out. We've had some competitions. We of course have a productivity bonus for our providers and for the locations. We have providers that will shift different locations, but we want to make sure that whatever location they're in when they meet their productivity, that that staff also gets a bonus. Our CEO has once told us that she loves writing bonus checks so anytime we can bring in more quality. She left to surprise us with a bonus at the end of the year. Some of the other things we've done, our value based care contract had a grant for us to do a competition for diagnosis resolution so that the providers that had the highest scores, the top five highest score. Has got $500 gift cards. I love to do little competitions just to see what our staff knows about the quality and operational KPIs to where they'll get a gift card if they answer the question. So we'll go through use minty me, and they'll those with the highest scores will get a little gift card. I'll send out, sometimes just a quiz and say, Hey, if you can answer these questions, you'll get a gift card. We do biannual compliance assessments where staff our locations with the highest scores will get gift baskets, and a lot of the stuff comes out of the pockets of the different directors just to try to help our staff to be more engaged.

Unknown Speaker 30:49

Any other questions? All right. Well, thank you so much. Applause.

Unknown Speaker 31:05

They are dynamics.

Speaker 5 31:32

All right, how's everybody doing? I get a handheld mic because my presentation is going to be short and sweet. That's kind of the opposite of how I really am. I'm not really short and I'm not really sweet. Mike's going to do most of the talking. We want to invite you, and Mike may mention it when he gets up here, if there's a question as we're talking, because there's a lot of information that we're going to go over, raise your hand. I think we got time, and we're going to watch the time, but this can be a dialog versus a monolog, and you know, we can, we'll do a Q and A at the end, but if there's a question that just is striking you, that might help the group out as a whole, ask that question. I'm going to give a quick overview of chestnut, and then I'm going to turn it over to Mike, and he's going to talk a little bit about why we're here. So chestnut health systems. We provide behavioral health services, primary health care services, which the CCBHC, the FQHC, federally qualified health centers. I'm not supposed to use acronyms, so certified community behavioral health centers, primary care treatment. We do that in the Midwest, in Missouri and Illinois and out in Oregon now, and that's kind of what I've been doing since I've worked for chestnut. For the past 10 years, I've been their business development director. Really focused on that business development arm, but we have an applied behavioral research evaluation and training center that our Chief Research Officer has been a part of for many, many, many, you know, half a century, I'm not even exaggerating many, many years that does work across the United States and Canada, all the provinces of Canada, and then internationally. And I think in perspective, one of the things we're supposed to talk about at the end is lessons learned. I'll tell you one of the lessons I've learned just being down here sitting

in Keynote with CJ Davis and David Guth, if you were in that keynote this morning, he talked about internal integration, and the fact of how they connect their clinical leadership with their with people with business backgrounds, and I don't know that we, I don't know a lot of agencies that do that, and they've even internally been siloed. And here, here's the it's the research scientists and the business development guy come to Clearwater, and here we are, and this is this open minds conference is a litmus test in terms of how we can work better together, because Mike speaks a whole different language than I do, and that's really a lesson that I've learned in this integration process that just came to mind. Chestnut has been joint commission accredited for many, many years, and just kind of again, restating the focus today will be on some of the things that we're doing at Lighthouse. And Mike will talk about some service cascades, but we have about 100 staff that work all over the United States, and about $15 million of revenue we do applied research, program evaluation, infrastructure support and then training and technical assistance. Again, I know just enough to be really damn dangerous. I've been with chestnut 10 years, but I really just started working with Mike for about the last two months. If that's not siloed, I don't know what is, but here's the new chapter that we're going down. So I'm excited to be able to be in venue. Like this, and meet individuals like you all and see where there's synergies and opportunities to integrate and collaborate, and that collective impact is something that's really important to me. And then just briefly, and this slide, I think, in PDF, the links aren't live, but we have Mike did a great job with putting this slide together, and so in the PowerPoint, we can get these out. But we have got assistant training centers all around the United States. Our gain coordinating centers in Tucson, Arizona. We have our Evidence Based Practice Center in Bloomington, Illinois, just care family coaching center out in Eugene, Oregon, and I, again, I'm just enough to be dangerous, but I'm really wowed by our work with the Indian affair Bureau and Native Americans through our National Native Center of Excellence. So a lot of different things. And right now I'm trying to, like, where do things fit? Where do Where are people interested? How can we work together and collaborate, and I'm here to learn. I feel like I just need to come back down and sit because I'm learning from Mike as he's talking in real time, and I'm going to turn it over to you. Dr Dennis,

Speaker 6 36:13

can you hear me? Okay, all right, so I think this applies to most of the people in the room, at least that are clinical organizations. You got some challenges using data to improve whole parts and care. Increasingly, many of you come from larger and more complex systems of care, crossing service lines, locations and types of agencies, your disjointed record systems sometimes and communication patterns can get siloed, and they don't necessarily talk well to each other. That can be staff, that can be record systems where there may be more than one EHR, there's increasing demands on you from payers to screen for refer and follow up on multiple issues, not just one thing at a time, multiple pathways and patterns of care that are hard to track. People can come in with no wrong door and then get referred up and down and over and sideways and come in and out over years. It gets complicated to understand and see that there's an overwhelming amount of data from electronic medical record systems, much of which is just scanned report, free text, some of which is missing, or you get massive binders full of reports that are hard to digest. This is your life, manual processes for screening and referral and tracking and summarizing, deciding where to focus leadership's attention. I'm in the C suite, so I have this problem. Stuff comes up every month. I get a stack an inch and a half thick, and it's like, what do I focus on? That's not my division reports. My division reports are three inches thick, but that's just the summary that I get. So what I thought would be useful would be to take an appropriate technology technique that we use in our research, we use it in program evaluation, and we try to help people use this for when they go to implement a new

evidence based practice. It's called the service cascade method. Have any of you ever seen a publication or report on a service cascade?

Unknown Speaker 38:32

Okay, I won't ask. How many of you have done it.

Speaker 6 38:36

This is a method for understanding movement across healthcare or social service systems along a desired pathway. The model was first developed in the context of diabetes and infectious disease care, and has been adapted to systems of care for behavioral health disorders. It is used for understanding how well a system is functioning, identifying gaps and shortfalls in the current processes, suggesting potential causes for the gaps and how to address them, and evaluating the success as you attempt to do improvements. And I'm going to try to show you actual examples before I do that. These next two slides are just theoretical. The rest of them are all real data, and I'll go through real examples. But in general, service cascades tend to have multiple steps that fall into what's my target population. Am I going to screen everybody in school, everybody coming out of the county jail? Am I going to be taking all of the intakes, I'm going to screen them, or have some way to determine who has need. It could be a person, but screening is typically at the front door, the more likely way to do it, of the people that come through in your target population, how many actually. Have need for services, for whatever you're looking at, did you refer them or link them to care? Did they initiate that care? Did they engage? Now I come from substance use treatments, so for us, engagement is two sessions past and taken 30 days. It's pretty low bar, and then continuity of care, which is, are they staying engaged for at least more than 90 days? Now, if you look at this, when there's gaps up in the beginning, a missed opportunity for identification might be if you use a very informal process. So for instance, if the only way somebody gets flagged for suicide is that they tell you that they need help for suicidal thoughts. That's a pretty bad mechanism for identifying suicidal risk. If you put in a standardized screener, you're going to typically get a higher rate. But whatever the process with a screener or a fixed set of questions you ask. If you don't implement the process for identifying the problem, it's hard to identify the problem. How accurate that process is is the next bar, which is maybe only half the people have the need maybe one out of five, right? If you then lose them on the later parts of the Cascade. That's where we've dropped the ball. We had somebody in need, in the process, in the population, and we didn't refer them. They didn't initiate, we didn't link. They didn't stay. When you think of this is next. Couple of slides are from a study for the state of Connecticut looking at child welfare for their safe fr programs. They have multiple programs, and there's hundreds of possible ways of moving through this child welfare system, but like a conceptual model, a flow chart or like a logic model, what we're trying to do in a in a cascade method is say, what do we want to happen? If I got together the team leaders and we agreed, what's the process that we want to happen? Well, they get a referral. They get screened for need. The referral is coming from social welfare. The screener is looking for substance use disorder. If they have it, they make a referral decision. They get the caregivers agreed to services, and then the caregiver initiated, and then they got engaged. So it's that's the desired process. There's lots of ways they could branch off a reasons, but this is what we want to happen. This is real data. From here on out, it's all real data. And what you see here is that this system was great at getting off the people referred, they were great at screening everybody. Was pretty rare, and this even was going included during part of covid, they still screened them. That wasn't a problem. The need. The need wasn't

too bad. It wasn't overwhelming. But that's a property of the population. But then there was this drop off as you move to the right. Notice that the need for SBIRT if you screened in primary care for alcohol or drug disorders, the average rate is about 12% if you, on the other hand, screen with a better screener. Here, we're getting about 38% it's impossible at the moment to separate what's because it's the Child Welfare population, but you could if you were not happy with the rate of what you expected. But this need identified. This is still a big drop off, and for the cost of screening, one of the things you could consider is, should I only be screening for alcohol, only for alcohol or drugs, or should I also be Screening for Mental Health? The cost to screen the population was trivial, but I lost the fact that a large chunk of that other group had mental health needs, and they didn't bother to screen for it.

Speaker 6 44:11

Here we go. One of the things we looked at in referral was from the screener, again, short screener, we identified in the low, moderate, high severity in an SBIRT protocol, lot of people just give positive reinforcement. You might give them brief advice, or you might refer we identified that some who appeared to have nothing in self report were getting referred to treatment. Okay, and some of those who that's that top bar, we had also identified that some who looked like they had need were not getting referred. Now, why did the staff do that? Well, it turns out the State System of Care had no way for staff to indicate why they didn't follow the prescriptive recommendation. So one of our recommendations was simply to create a box where they could say why they deviated, because they may have a legitimate reason. They're already in treatment. I have a collateral report, our psychiatric report or something else, but we the data system, did not allow the acknowledgement of exceptions, and yet, clinically, we want exceptions. We want the person to do critical thinking. So that was an example where one of the gaps in the inconsistency was identified. Really was just that we were trying to, you know, like the top bar here is expected. We thought they'd put 100% in there, but it didn't. So we identified gaps in the data system. Sorry, I am there we go. I can also take the same cascade across the top and look by the six regions in the state of Connecticut. And you can see there that the purple, which is lower than what we would like.

Unknown Speaker 46:03

Region three has a problem.

Speaker 6 46:07

My performance is being driven primarily by one region, and in fact, that region was actually doing something that was counter intuitive. They were sending the most severe people to the least intense type of treatment, and they were sending the people who had virtually no problem to the most severe, high intensity program. It made no sense, but the state couldn't see it, because the state only looked at the data across the total cascade instead of by region. Here's another one example from the same report, multi dimensional family therapy and recovery support. This is with adults with children, young children, in the social welfare system. And here you can see very high rates of retention along the cascade. This is one that's working great. We're really keeping them there. But on the backside there notice that instead of just going out four weeks or 12 weeks, they wanted to see a longer set of retention in us, substance abuse treatment in general. In the United States, about 50% are gone in six weeks, and about 80% are gone in 13 weeks. This is a more intensive in home based care or family therapy. So part of their

proposal was to look at higher rates of retention. So there we broke it out more so that here we didn't change the base for every step. We just divided them all of engage. You don't have to do it one way. You don't have to always do it by staff. You can do it different ways. And just trying to show you some different examples, here's another one, which is recovery management support, which is another evidence based practice. It's primarily post care. It's post residential, post outpatient, but it's continuing care, and they will stay in working with a person for up to 12 months post discharge, and they're trying to keep them in recovery and or if they have a relapse, get them back to services. And you can see here again that there's a pretty decent threshold. Their biggest problem is up there at the hand off that whenever, when somebody makes a referral to them, they often don't get it. They get a piece of paper, but there's not enough information to contact the person. The person doesn't want to talk to them whatever. They lose a lot at the front door, but once they get them in the door, they're largely able to keep them this is just a time series, a survival chart, looking at how long can they keep them in if they get to that point of engagement. And you can see here, since this is a continuity of care over a year, you really do want to see them hanging out there for six months at least. And you do see that another example, this is from 36 counties across the United States in which we were screening people, juveniles in probation, juvenile probation, and trying to divert them into substance use for mental health services. And you can see here, we kind of divided it up into three panel, what happened inside the doors of the criminal juvenile justice system, what happened during the transition, and then what happened over on the treatment side, and like a juvenile drug court, these are partnerships. These are groups of multi disciplinary team that's crossing over all these different institutions, not just different disciplines, different institutions and funding streams. And you can see here that there's, as you're moving to the right, you're getting more kids transferred. This study in 36 counties was done only with records data. There's no live reports, there's no interview, there's no separate follow up. Well, one of the problems with records data is missing data. So. Or bad data. And so the point that I wanted to do show you here was with the hatch marks, what happens if I if we replace the missing data? The consequence, if you don't think about it, you say, Oh, well, if I replace the missing data, everything gets better, not really, because the denominator and the numerator are changing. So depending on where the missing data is, the performance can move around. This is because it's called a Markov model. There's a chain when you if you increase more people at the front end, you're going to get more people in the denominator as you move to the right. And so missing data can have pretty big consequences if you're trying to rely on records data and you haven't gotten your records data to be complete. This is another example of a implementation study out of Columbia University we collaborated on. This is screening for suicide risk in juvenile probation. You can see, again, it's a system of care. So we're going across from left to right, from juvenile justice system to community mental health. You can see in the lighter of the two, the grayer blue box. Those are what it was in the year before we implemented after, we implemented eConnect, which is basically a tablet based screener, a gain screener, on a tablet that they're taking out and screening people, juveniles in the community probation officers are doing it. It automatically scores. It automatically identifies where to refer them to a commute to local community health. It's the it's the crisis. Who has ever got the crisis contract for suicide intervention, but the juvenile justice probation officers don't know what that is, so it tells them what to do and how to do it, and they're able to link it. And you can see, when we implement it, we're able to get more people through to the back end. What's interesting is that, in the beginning, need goes down,

Unknown Speaker 52:01

because in the past, they had a thing that said,

Speaker 6 52:06

have your is your life challenging. That's when they were referring to mental health, versus now they're referring for mental health because somebody is suicidal or has internal mouth, depression, anxiety, trauma. It makes more sense. So the screener before was unfocused, and then really at the back end, this is what you want to see, is you want to get more people in. And this is the cascade. Is the percent retained, but it's it's up because it's two different cohorts, the light blue is the year before and the dark blue is the year after. So it can use it experimentally, and do you want to?

Speaker 5 52:53

Yeah, so again, takeaway points, and I think this kind of ties into my selfish takeaway that I talked about it in the front end, but using cascades helping on focusing on our sub population and preferred pathways, it helps with leadership. Focus helps with better integration of our electronic health records, quality of care and so Mike like lists all these bullet points out, this is a little bit a different language for me, and as I and I don't I don't feel so bad because as a clinical guy, got a Master's in Counseling, and I've done behavioral health whenever, when he asked, how many people are familiar with service cascades, I didn't see anybody raise their hand, and I'm glad, because I wouldn't have raised My hand either, because that's a research, research institute method. That's something that he's been doing well. And when we had the opportunity to come speak at open minds, it's like, okay, what you're doing well. Is there a way for that to translate for good clinical care, that we can increase our outcomes with our integrated care, is there opportunity with that? And so again, I think that that's kind of my takeaways in terms of utilizing and how that utilization of service cascades might translate into your book of business, and whether it's IDD or mental health or substance use treatment. And again, that's the whole reason we're here today, kind of trying to figure out how moving together, we can better partner with folks like you in this room.

Unknown Speaker 54:30

So I do want to say I told Mike,

Speaker 5 54:35

do not put that last slide in, because we're not going to have time. You're going to overwhelm these folks. But it's 452 I think we if you just spend a couple minutes on a slide, he's pretty excited about and kind of mad at me where I said, don't use it. But I'm going to go to that slide right there. Do you want to just touch on that real quick? And then we'll do cute question and answers.

Speaker 6 54:55

If you have any. This slide came out last week from the journal Nature. Future. This has over 180 authors to this slide. It's over a million records, human genome, brain scans and symptom reports, and it shows that most of the 14 most common behavioral health from IDD to autism to schizophrenia substance use are in a small, tiny section of the human genome. They're all in the same place. They co vary dramatically. So very most of the people you see have more than one diagnosis. They have more than

one issue. Maybe it's clinical, maybe it's homelessness or transportation, but it's very rare for you to see a person with just one problem. Okay, this is why, because it's actually in one place in the brain. It's in one place in the human genome. And you know, when they're doing more and more stuff with the brain, not just with like Parkinson's and inserting electrodes and depression, but they're also starting to now use ultrasounds, where they can actually operate in the brain with sound and change the brain and change withdrawal patterns and addiction, that's sort of one of the cutting edge things in addiction, is reducing the rate of opioid overdose by using sound waves in their head, right? It's all in the same places in the brain, the genome and the symptoms and the that structure there. Without getting into the detail, it's basically the clustering and borderline in there and schizophrenia are sitting together on the same factor, the alcohol, the cannabis, the opioids. They're all sitting together on the factors that they group the way DSM groups them. Okay, it's just sort of an interesting thing. But last week, behavioral health research changed with this article, and if you were in school, somebody was joking this morning about how long a doctor's training last used to be 1727, years now, doctors trainings already out of date in months, right? Because the rate of knowledge just keeps growing. Surpassed in psychiatry, that's a sea change. They just change. You can now see in the brain where different disorders are you can see the symptoms. You can see them in the human genome that produces a whole new set of problems that like, what if the insurance companies find out right then they're going to mess with the risk. So it is complicated, but I'll stop there. I did want to actually go back to the to the prior presentation to just talk about how these cascades relate. Remember what we talked about, communications, a multi disciplinary team. Cascades are a way of focusing everybody on the common process and finding out that common thing. We talked about, getting out of silos and getting integrated

Unknown Speaker 58:01

key performance indicators, KPIs,

Speaker 6 58:04

that's good. That's right. But then what? How are you going to improve the system of care? It's hard to improve a system of care while you're looking at a mountain of data. Sometimes it is useful to go back to one population, one problem and follow it through the system, but doing it with good communications and a multi disciplinary team, does that make sense? So it's it's not going backwards, it's going forward even more in that direction, but, but taking it any questions? No.

Unknown Speaker 58:45

Five o'clock somewhere.

Speaker 6 58:48

I'm just saying we'll be here for a little while. If anybody has a question later.

Speaker 1 58:58

You both All right. Well, thank you, Dennis, Jim, Stacy and Megan for this wonderful presentation today and for joining us. And thank you a special thanks to Allura health for sponsoring all of our talks here in this track today. Remember today's session will be recorded in.