Measuring the Impact of Community Benefit Programs
May 4, 2016

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Executive Director
Objectives...Intent

- Provide an overview of perspectives on measurement as designer, teacher/coach, and grantee
- Overview of types of measurement and evaluation – linking them to activities, outcomes/impact
- Share examples – tools, communications, programs

-Open for Discussion, Questions...throughout
Introduction

-Bridget Hogan Cole, MPH
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- IHQC –
  -Learning Communities
  -Consulting
  -Initiatives
Learning Communities

• Since 2007, IHQC (through its BCCQ Program) has created multiple learning communities – participant-defined, applied learning laboratories for clinics, provider care teams to:
  – Engage in quality and process improvement trainings
  – Interact and share promising practices with their peers
  – Apply tools and techniques that will advance their own QI efforts
  – Prepare for an ever-changing healthcare environment

• IHQC focuses on moving health care delivery systems toward cultures of quality.
IHQC’s Applied Learning Model

**KNOWLEDGE BUILDING**
- Quality Improvement
- Process Improvement
- Leadership
- Change Management
- HIT Systems

**Peer-to-Peer Learning Opportunities**
- Collaborative environment
- Share lessons learned across teams

**Clinic Coaching and Support**

**QI Project**
Consulting and Initiatives

- **Specialty Care Initiative** – statewide support for 25 coalitions of community providers;
  - **Focus (aim)** - improve access to specialty care services, decrease inappropriate referral demand

- **Riverside University Health System** – 18 interdisciplinary teams (providers, administrators, frontline);
  - **Focus (aim)** - applying improvement techniques on projects supporting organizational strategic goals
Perspectives

- I come at this topic through multiple perspectives:
  - **Supporter/Collaborator** – the design of measurement, evaluation programs
  - **Coach** – learning communities; about ways to measure impact on work, how to present work
  - **Grantee** – creating measurement plans for grant-funded programs, responsive to the funder and the program’s (or initiative’s) vision
Evaluation –

The Why’s and The What’s

Why Monitor and Evaluate?

 ✓ Improve programs
   – Improve quality of services
   – Enhance planning
   – Provide direction to staff
   – Recruit talented staff and volunteers
   – Identify training needs

 ✓ Increase accountability to the public
   – Increase public confidence
   – Support fundraising efforts

 ✓ Assure best use of funds
   – Demonstrate program effectiveness
   – Identify excellent programs
   – Detect and address ineffective programs
   – Compare costs of similar programs

 ✓ Compare programs locally and across regions
When Should Evaluation Be Done?

- Planning
- Implementation
- Post-implementation

 IHQC INSTITUTE FOR HIGH QUALITY CARE
Primary Types of Evaluation

You do work. When you evaluate how well you do what you do, it’s called *process evaluation*.

Your work has results. When you evaluate the results of your work, it’s called *outcome evaluation*.

Lots of work produces multiple outcomes over time. This equals *impact*.

Source: Festen & Philbin. 2007
Logic Model Components

Inputs (Resources)
- Resources used by a program or project

Activities (Strategies)
- What a program or project does using its inputs to achieve its purpose or mission; the “verbs”

Outputs
- Direct products of program or project activities; measure how many; amount of service or product produced

OUTCOMES
- Changes in client knowledge, attitude, skills, behavior, or condition; benefits to clients

Impact

Process Evaluation

Outcome Evaluation

G. Northrop
Logic Model Components

- **Inputs**
  - Resources: money, staff, volunteers, equipment & supplies
  - Constraints: laws, regulations, funders’ requirements

- **Activities** (Strategies)
  - Services: shelter, training, education, counseling, mentoring, advocating

- **Outputs**
  - Products: classes taught, counseling sessions conducted, educational materials distributed, hours of service delivered, participants served

- **OUTCOMES**
  - Benefits for People: new knowledge, increased skills, changed attitudes or values, modified behavior, improved condition, altered status

G. Northrop
Data Analysis & Presentation

Process Evaluation

- Quantitative
  - # of meetings, trainings, etc.
  - Distribution of materials
  - Attendance records
  - Satisfaction ratings

- Qualitative
  - Timelines, key milestones
  - Improvement suggestions

Outcome Evaluation

- Quantitative
  - Trends
  - Comparisons between clients, patients, staff
  - View of statistical significance

- Qualitative
  - Impact on individual patients, clients, staff members
  - Limitations of methods, possible alternate explanations for findings

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e.g. – Specialty Care Initiative

**Inputs**

- Resources
  - Coalition Members
  - Project Mgt
  - Reference Materials

- Constraints
  - Collaboration across orgs, between providers

**Activities (Strategies)**

- Strategies
  - Embedded guidelines
  - Increasing PCP Capacity
  - Expanded Networks
  - Increasing Care Coordination

**Outputs**

- Products
  - Guidelines
  - eConsult networks
  - MOUs
  - PCP CME sessions
  - Care Coordinator trainings

**OUTCOMES**

- Benefits for People
  - New specialty care options/resources
  - Decreased referral processing times
  - Increased adoption of guidelines
  - Increased/new knowledge

**Impact**
e.g. – Specialty Care Initiative

Process Evaluation

- **Quantitative**
  - # of referrals, by specialty
  - # of guidelines adopted
  - CME event attendance records

- **Qualitative**
  - Timelines, key milestones
  - Implementation dates for eConsult
  - Post-training satisfaction

Outcome Evaluation

- **Quantitative**
  - Decreased wait times to appointment
  - Decreased referral processing cycle time
  - Decreased no-show rate

- **Qualitative**
  - Improved access to specialty services – care, treatments, preventive screenings, etc.
  - Improved collaboration between providers
  - Increased care coordination, patient navigation
What makes this challenging?

- Resource constraints (time, reporting systems)
- Different requirements (funders, reg. agencies)
- Questions about validity (methods, data)
- Confusion around what, how, how much to evaluate
- Attribution – linking outcomes to activities
- Patient burden, interest, privacy
- Consequences of negative findings or that findings may be ignored
- Weak culture of evaluation (not valued, understood)
Tools We’ve Used

- To define the project, vision, aim
  - To focus on measurement
  - To communicate the impact
Tools We’ve Used

- To define the project, vision, aim
  - To focus on measurement
  - To communicate the impact
Aim Statement Examples:

By November 1, 2012, we will decrease the time to register and check-in for scheduled patients at our North Avenue clinic during the first two hours of the day.

When

Purpose/Focus

Who

What system/process

Where
SMART Statement Examples

(1) Increase percentage of prenatal appointments scheduled in the 1st trimester for patients testing positive for pregnancy from current baseline of 62% to 90% by June 30, 2016

(2) 100% of patients seen in both of our clinics who have abnormal PAP smears will be notified and have follow-up appointment scheduled within 10 days by August 1, 2016

(3) Increase the percentage of patients 18-75 years of age with diabetes (type 1 and 2) whose most recent test (occurring during the measurement year) showed a HbA1c control (<8.0%) from 65% to greater than 70% by the end of July 2016 and to greater than 80% by the end of December 2016
Clinic:

AIM Statement:

- Resources
- Activities
- Outputs
- Long Term

And

Outcomes (Short to Mid-Term)

Assumptions
Impact

= Long-term, lasting changes you expect (and hope) to see in the patients you serve and in your organization as a result of your project

• Examples:
  
  o Health care providers have the ability to access and use HIT in the treatment of their patients.
  
  o Patients are empowered to self-manage and evaluate their personal health status by receiving access to their medical information in a timely and comprehensive fashion, in a manner that they will understand.
  
  o Display a level of caring such that patients see us as their "medical home". Our patients reduce the number of visits to an ER due to unmanaged chronic disease conditions.
Outcomes

= Short and medium-term results of your project; what you hope will be the results of your activities

• Focus on realistic, tangible – *scope and scale* – outcomes
  o What can be accomplished in the time allotted?
  o What can be accomplished given competing priorities?
  o “Motivating” target without being *overwhelming*

• Examples:
  o Increase screening rate to 80%
  o EHR implemented and all staff trained
  o Point of care access to lab data and results
**ClinicSoCAL**

**AIM Statement:** By June 2016, ClinicSoCal will increase the % HTN patients w/ BP controlled from 43% to 60% through patient education and implementing evidence-based hypertension guidelines

<table>
<thead>
<tr>
<th>Resources</th>
<th>Activities</th>
<th>Outcomes</th>
<th>Impact</th>
</tr>
</thead>
</table>
| - Front Desk Staff  
- MA’s  
- Providers  
- EHR System  
- National Guidelines Clearinghouse  
- IHQC.org | - Training on self-mgt and motivational interviewing  
- Update HTN guidelines/checklists.  
- Track prescriptions for HTN patients  
- Interview staff  
- Test possible improvements | - Increase from 20 to 60% the % of HTN patients prescribed appropriate meds  
- HTN patients taking prescriptions  
- Increased % of HTN patients with Blood Pressure <140/90 mmHg. | - HTN patients have BP under control; healthier  
- High quality, efficient care  
- Greater patient satisfaction  
- Greater staff satisfaction |

**Assumptions:**
Providers and staff will be able to provide patient education during clinic visit; providing cost effective prescriptions will improve medication adherence; Data can be gathered about new prescriptions for HTN; Report can be generated about levels of BP control; Providers and staff are willing to test possible improvements and follow new processes.
Tools We’ve Used

- To define the project, vision, aim
  - To focus on measurement
- To communicate the impact
Measurement – Leveraging Data to Prompt Action
Demonstrate Impact

Why Should We Measure?

Data (process)  Information (outcome)  Communication (impact)  Action (investment)
# Measurement – Leveraging Data to Prompt Action

## Three Purposes For Measurement

<table>
<thead>
<tr>
<th>Audience</th>
<th>Research</th>
<th>Accountability</th>
<th>Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scientific Community, Evaluators, Academics</td>
<td>Customers, Board of Directors, Funders, Regulatory Entities</td>
<td>Internal to the Organization</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Purpose</th>
<th>New Knowledge</th>
<th>Reporting, Assurance, Basis for Comparison</th>
<th>Understand Processes, Inform Change,</th>
</tr>
</thead>
</table>

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<thead>
<tr>
<th>Characteristics</th>
<th>Slow, Complex, Precise, “Blind”</th>
<th>Summarized, Comparative</th>
<th>Rapid, Simple, Motivating</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Sample Size</th>
<th>Large, “Just in case” data</th>
<th>Relevant, 100% of what is available</th>
<th>Small, sequential samples, “Just enough”</th>
</tr>
</thead>
</table>

Measurement –
Leveraging Data to Prompt Action

-Cross-over of measurement purposes –
  -“Accountability” measures can be leveraged to be “Improvement” measures
  -Recognize the distinction of one-time “snap shot” (accountability) vs. continuous tracking (improvement)
  -e.g., Diabetes measures
    -Accountability = Total Number of DM patients with an HbA1C < 8
    -Improvement = % of DM patients with an average HbA1C < 8, target 90%
Measurement – Leveraging Data to Prompt Action

- Measurement for Improvement should
  - Be meaningful – support and inform the Aim, the QI work
  - Be attainable – information that you can get, tool, worksheet, software
  - Be useful – don’t focus on perfection, will the measure help
  - Be focused on learning NOT judgment
  - Be displayed, communicated, interpreted and most importantly – acted upon
Creating the Measurement Plan

• The Measurement Plan becomes your tool for training, communication, and creating consensus.

• Key Elements of the Measurement Plan:
  – Measurement Definitions
  – Baseline Data – Starting Point
  – Target Goal
  – Data Collection/Gathering Plan – and reporting plan
Tools We’ve Used

- To define the project, vision, aim
  - To focus on measurement
  - To communicate the impact
Effective Communication is Key

- Send the right message
- To the right people
- From the right sender
- At the right time
- Using the right vehicle
How We Communicate Matters

SHARE INFORMATION

General Publications
Flyers
Newsletters
Videos
Articles
Posters
Intranet

Personal Touch
Letters
E-mail
Social Media

Interactive Activities
Telephone
E-mail
Meetings
Seminars
Site Visits

SHAPE BEHAVIOR

Face-to-face
Opinion Leaders
One-on-One
Mentoring
Counseling
Shadowing

Adapted from Ashkenas, 1995
Measurement – Leveraging Data to Prompt Action

Run Charts

Change – Appt. Reminder Calls

No Show Rate

Goal
Measurement –
Leveraging Data to Prompt Action

Bar Graphs, Pie Charts

3rd Quarter 2011

- Men
- Women
- Children (0-18 yrs)

Measurement –
Leveraging Data to Prompt Action

Bar Graphs, Pie Charts

3rd Quarter 2011

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OTHER EXAMPLES

Q&A
e.g. – Riverside County HS

**Inputs**
- Resources
  - Exec Support
  - Capacity Building Sessions
  - Team engagement
- Constraints
  - Time to implement
  - Data access

**Activities (Strategies)**
- Strategies
  - Med Rec
  - Cycle Time
  - Cancer Screenings
- Activities
  - Trainings
  - PDSAs
  - Huddles
  - Data Tracking

**Outputs**
- Products
  - Standardized forms
  - Redesigned clinic workflows
  - Adopted evidence-based guidelines
  - Communication pieces

**OUTCOMES**
- Benefits
  - Increased patient med rec – on right meds
  - Decreased clinic cycle time – improved access
  - Improved screening rates – early detection
  - Improved team engagement

**Impact**
e.g. – Riverside County HS

Process Evaluation

- **Quantitative**
  - # of staff involved
  - # of trainings, projects
  - % forms completed

- **Qualitative**
  - Timelines, key milestones
  - Post-training satisfaction

Outcome Evaluation

- **Quantitative**
  - Increased % of patient med rec.
  - Decreased clinic cycle time
  - Increased screening rates

- **Qualitative**
  - Increased staff capacity with tools, screening guidelines, etc.
  - Improved collaboration between providers, teams
  - Improved patient care/case stories – access, preventive screenings, etc.
Thank You!

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