CENTER *for* INTEGRATIVE HEALTH

insight to innovation

Convene.
Strategize.
Activate.

Developing Performance Measures for Performance Management and Continuous Improvement

Presented by:
Deitre Epps
CEO & Founder
R.A.C.E. for Equity, LLC

R.A.C.E. for EQUITY

RESULTS ACHIEVED THROUGH COMMUNITY ENGAGEMENT

Developing Performance Measures for Performance Management and Continuous Improvement

Monday, June 10, 2019

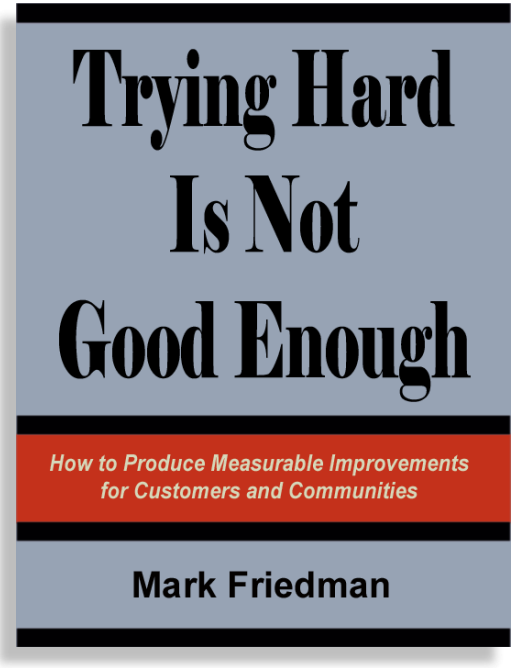
Presented by:

Deitre Epps, MS

CEO & Founder, Race for Equity

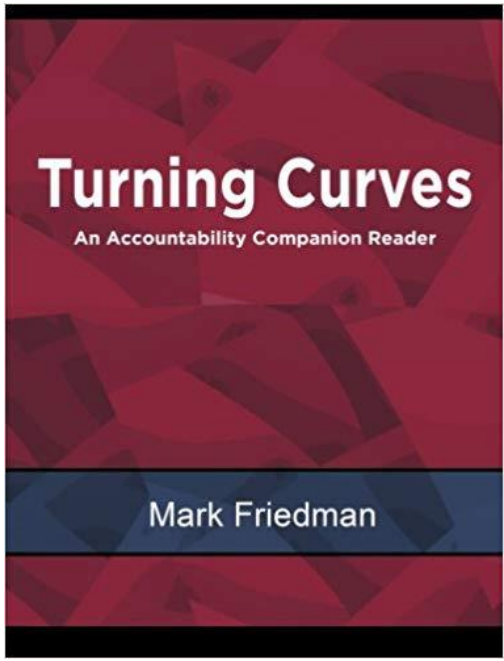
Training Objectives:

- Review a common language for distinguishing between program performance measures from community indicators
- Discuss how to develop program performance measures that identify: how much did we do? how well did we do it? and how are our clients better off?
- Review how to use data to track program results
- Review continuous improvement questions for performance management



Fiscal Policy Studies Institute

Santa Fe, New Mexico



Results Based Accountability

is made up of two parts:

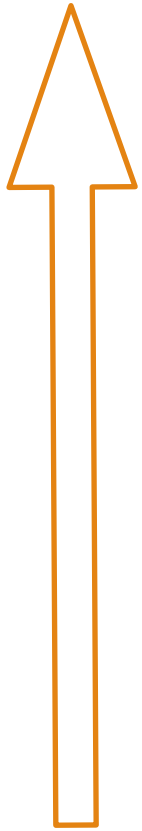
Population Accountability

about the well-being of

WHOLE POPULATIONS

All North Carolina children, youth and families

For Communities: Cities – Counties – States - Nations



Performance Accountability

about the well-being of

CLIENT POPULATIONS

Children, youth & families served

For Programs – Agencies – and Service Systems

DEFINITIONS

Population

Performance

RESULT or OUTCOME

A condition of well-being for children, adults, families or communities

Healthy Babies, Healthy North Carolinians, Healthy Aging

INDICATOR

A measure which helps quantify the achievement of a result.

Percent of low birth weight babies, % of adult smokers, Avg. life expectancy

PERFORMANCE MEASURE

A measure of how well a program, agency or service system is working.

Three types:

1. How much did we do?
2. How well did we do it?
3. Is anyone better off? = **Client Results (or outcomes)**

Finding and Using A Common Language

Result: A condition of well-being for children, adults, families and communities

Indicator: A measure which helps quantify the achievement **of a result**

Strategy: a coherent set of actions with a reasonable chance of achieving the result

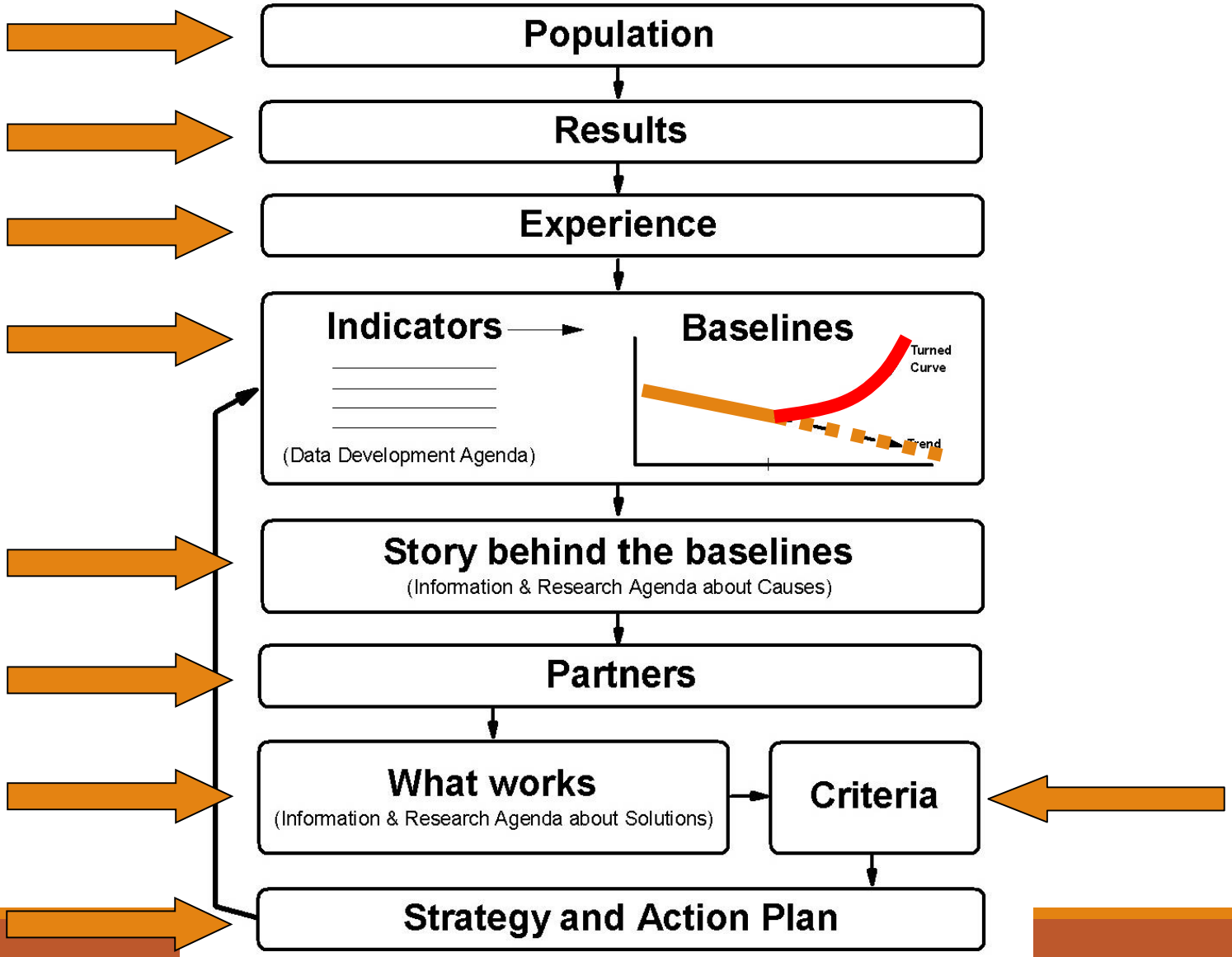
Performance Measure: a measure that quantifies the achievement of a result for clients of a program, agency or service system

Equity: the just and fair inclusion into a society in which all can participate, prosper, and reach their full potential.

Inclusion: the degree to which diverse individuals are able to participate fully in the decision-making processes within an organization or group

Population Accountability

Getting from Talk to Action



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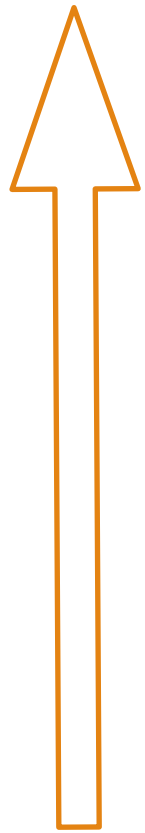


Performance Accountability

about the well-being of

CLIENT POPULATIONS

Children, youth & families served

For Programs – Agencies – and Service Systems

Accountability and Quality

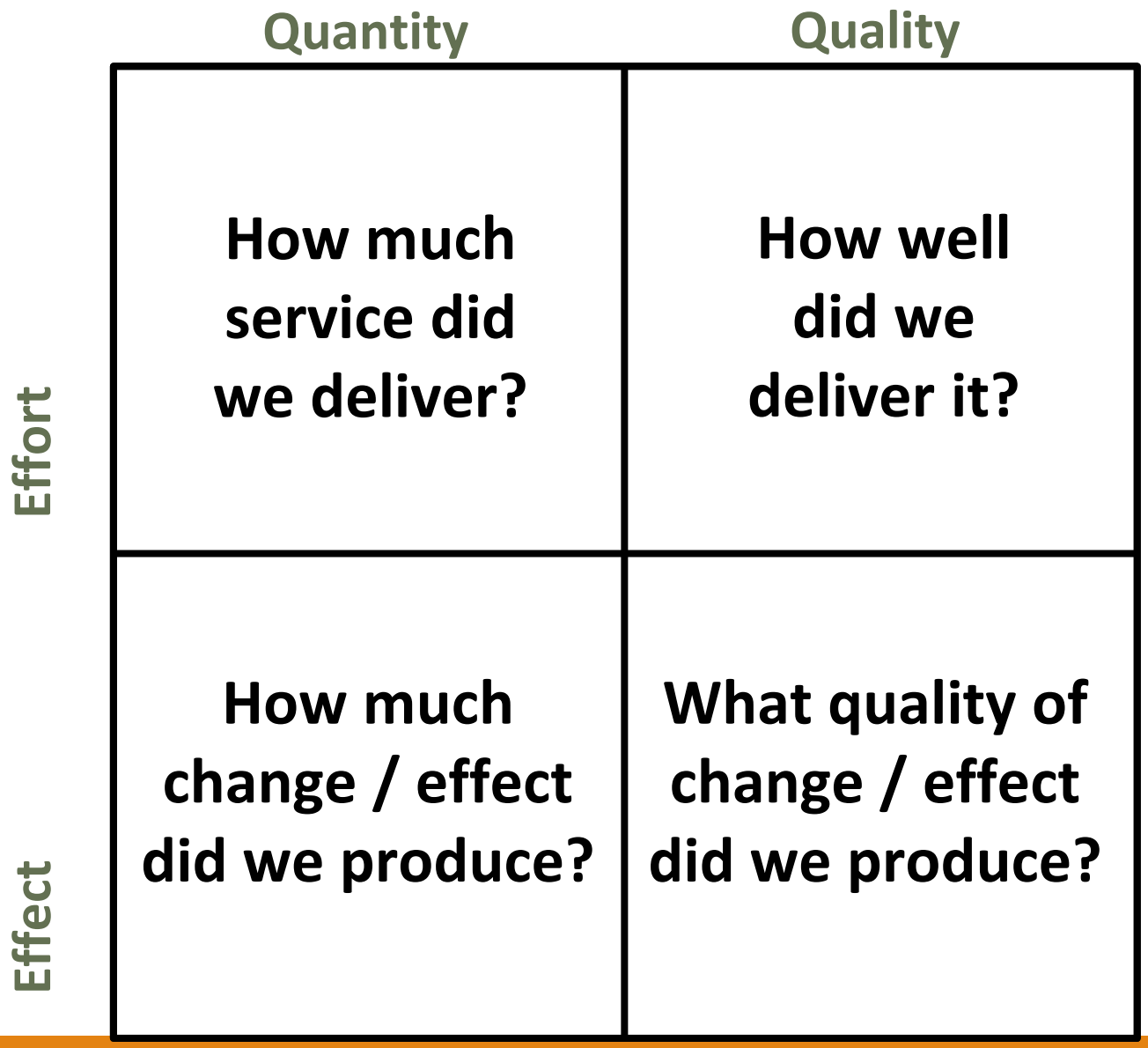
- The Department will establish a common set of quality measures as a key mechanism to ensure BH I/DD Tailored Plan accountability to the Department.

- All quality measures for BH I/DD Tailored Plans will align with and build on the Department's Quality Strategy, which will be updated to include BH I/DD Tailored Plans and which primarily emphasizes outcomes for beneficiaries over process measures.

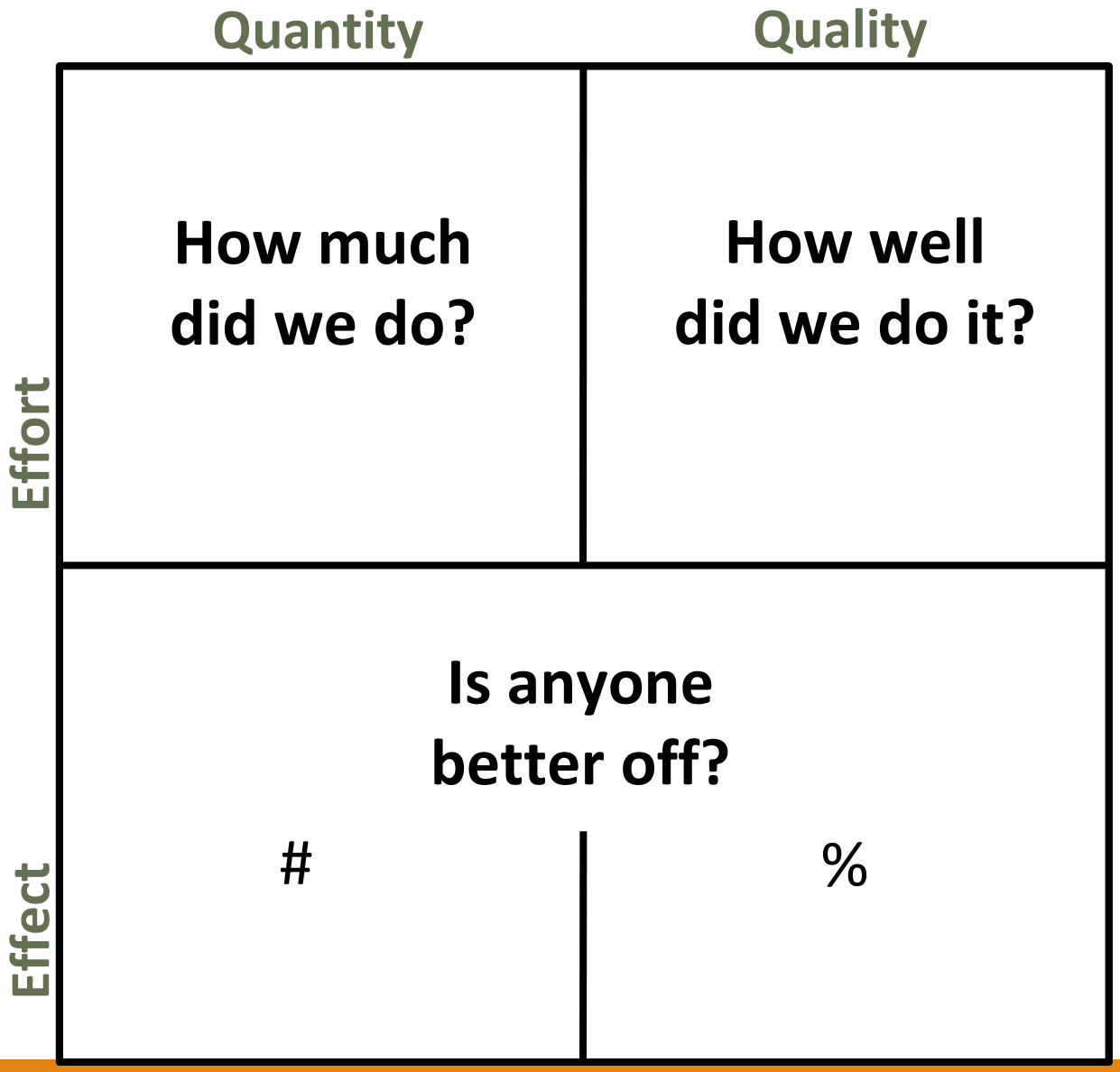
- Outcomes such as beneficiary choice, independent living, employment and community participation will be considered alongside clinical quality measures.

https://files.nc.gov/ncdhhs/TailoredPlan-CareManagement-PolicyPaper-FINAL-20180529.pdf

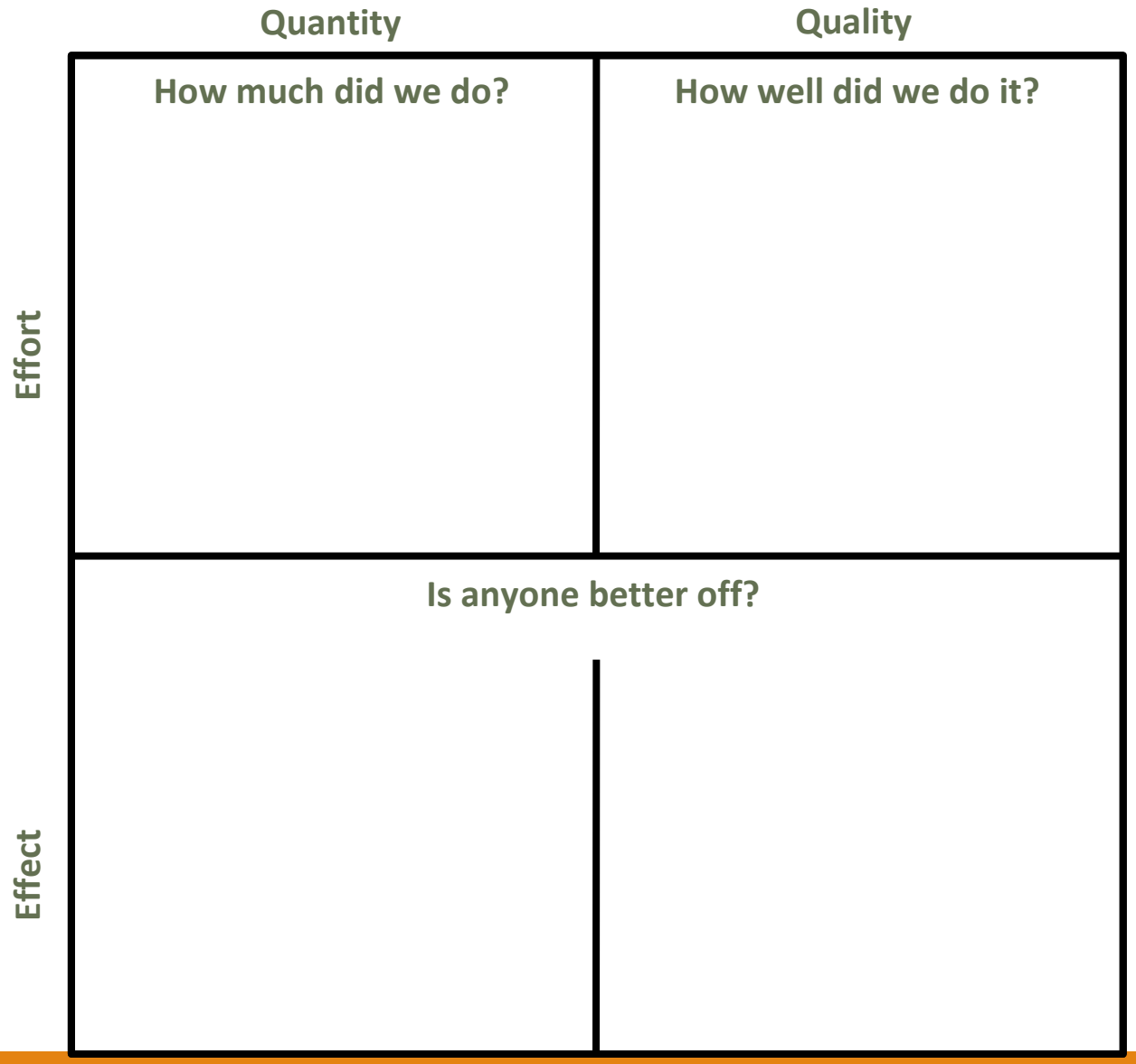
Performance Measures



Performance Measures



Performance Measures for Contract Performance



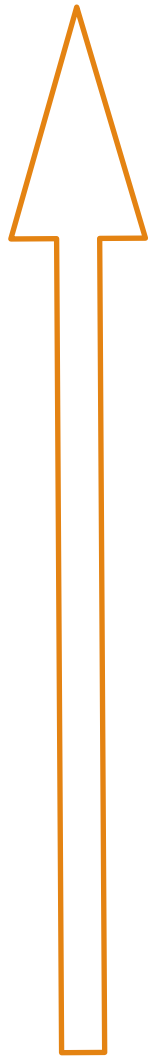
How much do we do? (*# quantity of effort*)

Who are our clients*?

- # children (by age)
- # youth (by age)
- # adults (by age)
- # older adults (by age)
- # staff

What groups of clients do we have?

- **Mental Health Consumers**
- **Substance Abuse Consumers**
- **Developmental Disabilities Consumers**
- **Language proficiencies**
- **Types of disabilities**
- **Literacy levels**
- **Cultural needs**
- **Age and age-specific or other targeted learning skills or capabilities; and**
- **Ability to access and use technology.**



How much do we do? (*# - quantity of effort*)

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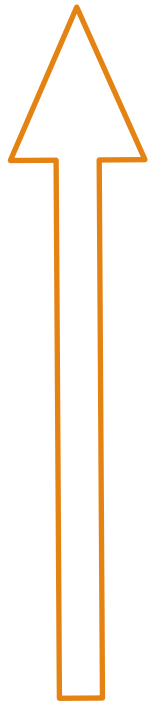
RESULTS ACHIEVED THROUGH COMMUNITY ENGAGEMENT

What are critical services that we offer?

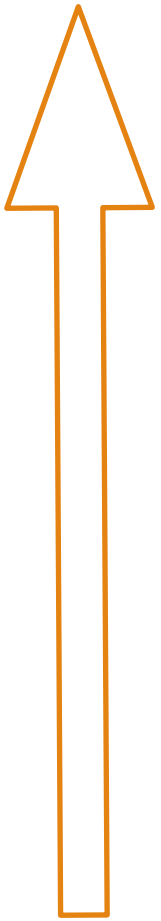
- Care visits
- Dental visits
- Coordination of care
- Health Plan
- Personal Doctor visit
- Specialist visits
- Body Mass Assessment
- Annual Dental Visit
- Dental Sealants
- Chlamydia Screening



How well did we do it? (% means *quality of effort*)

How do we know we're delivering services well?

- % staff who received annual training, as required
- **% who got non-urgent appointment as soon as needed**
- % of beneficiaries who got care for illness/injury as soon as needed
- **% who got help needed from doctors or other health providers in contacting child's school or daycare**
- % of beneficiaries 18–74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year
- **% of beneficiaries 2–20 years of age who had at least one dental visit during the measurement year**
- % of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.



Is anyone better off?
(# quantity of effect)

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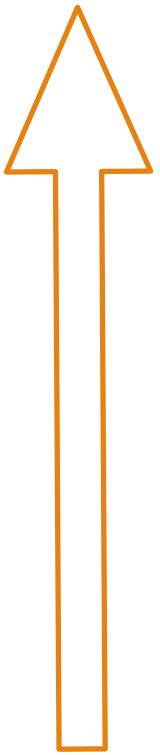
What number of people have improved outcomes? What changes do we see:



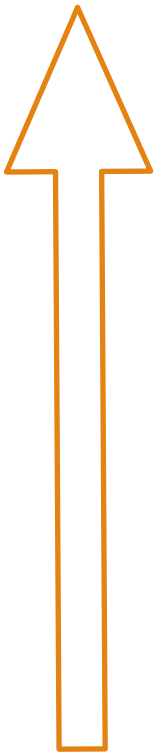
- Total number of hospital admissions for chronic conditions per 100,000 Home Health beneficiaries age 18 and older
- For members age 18 and older, the number of acute inpatient stays during the measurement year that were followed by both an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission

(Remember BACKS: better off outcomes"
Behavior, Attitude Circumstances, Knowledge / Skills

Is anyone better off?
(% quality if effect)

What percent of people have improved outcomes? What changes do we see:

- Percent of beneficiaries 19–64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least eighty percent (80%) of their treatment period.
- Percent of patients ages 18-85 who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year



(Remember BACKS: better off outcomes"
Behavior, Attitude Circumstances, Knowledge / Skills

Performance Measures

The Matter of Use

1. The **first purpose** of performance measurement is to **improve performance.**

2. **Avoid** the "performance measurement equals **punishment" trap.**

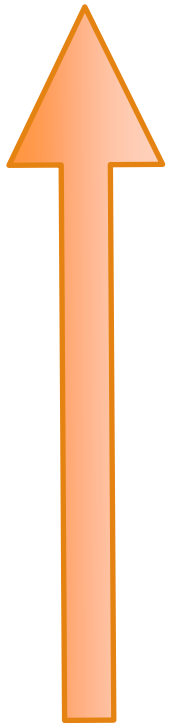
- Create a healthy, collaborative environment.
- Start small (with Rapid Assessment within 90 days)
- Avoid comparisons among programs

Continuous Improvement with Data-driven decision making

"Turn the Curve" Thinking for Performance Management

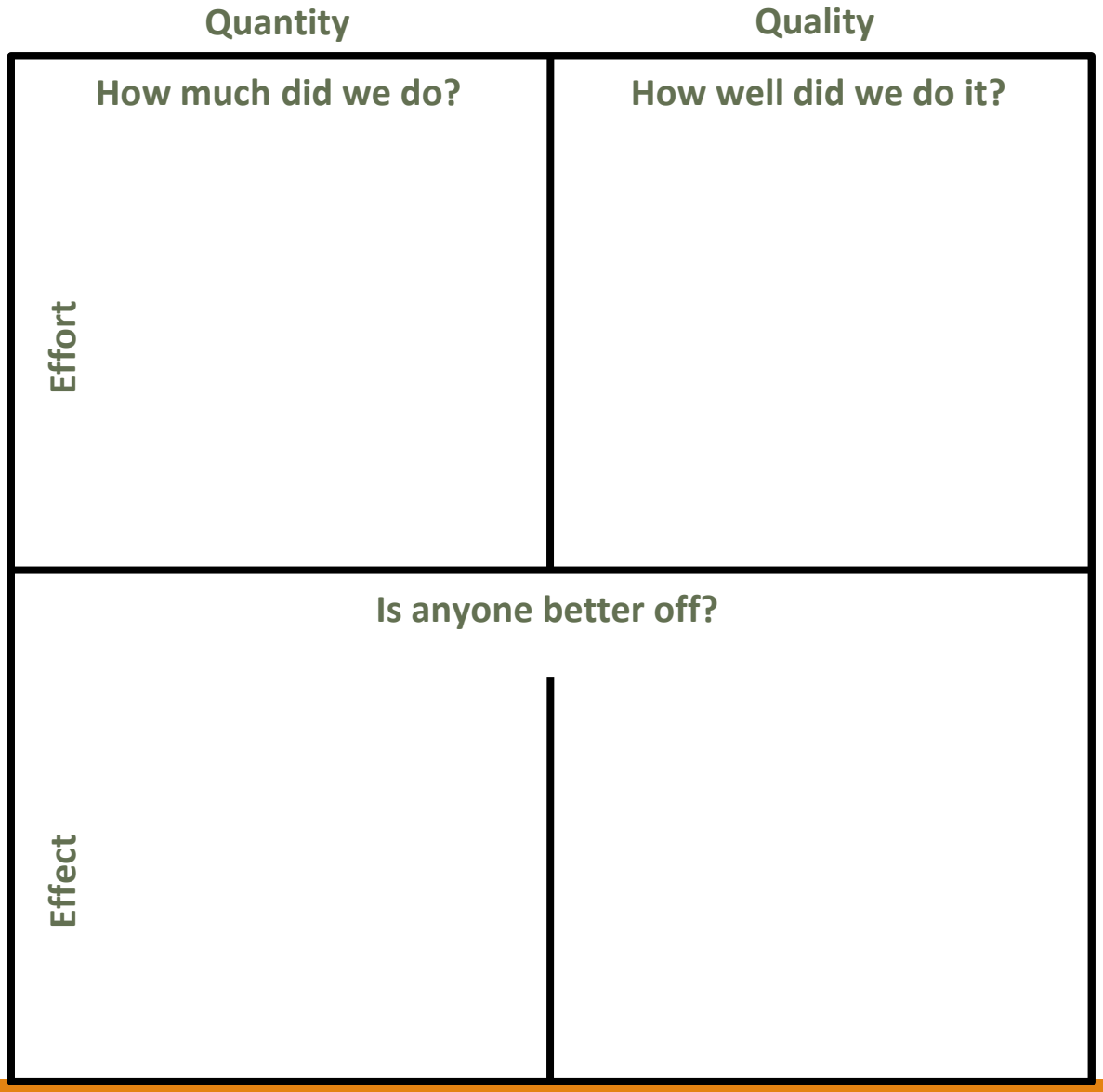
- How are we doing? *(disaggregate the data)*
- What's the story behind the data?*(with all voices included)*
    - Factor analysis (contributing and restricting factors)
    - Five Whys
- Who are the partners that have a role to play (*in addressing the prioritized factors)?*
- What works? *(brainstorm ideas for partners to address the factors)*
- What is our action plan? (SLVR* and *community-led)*

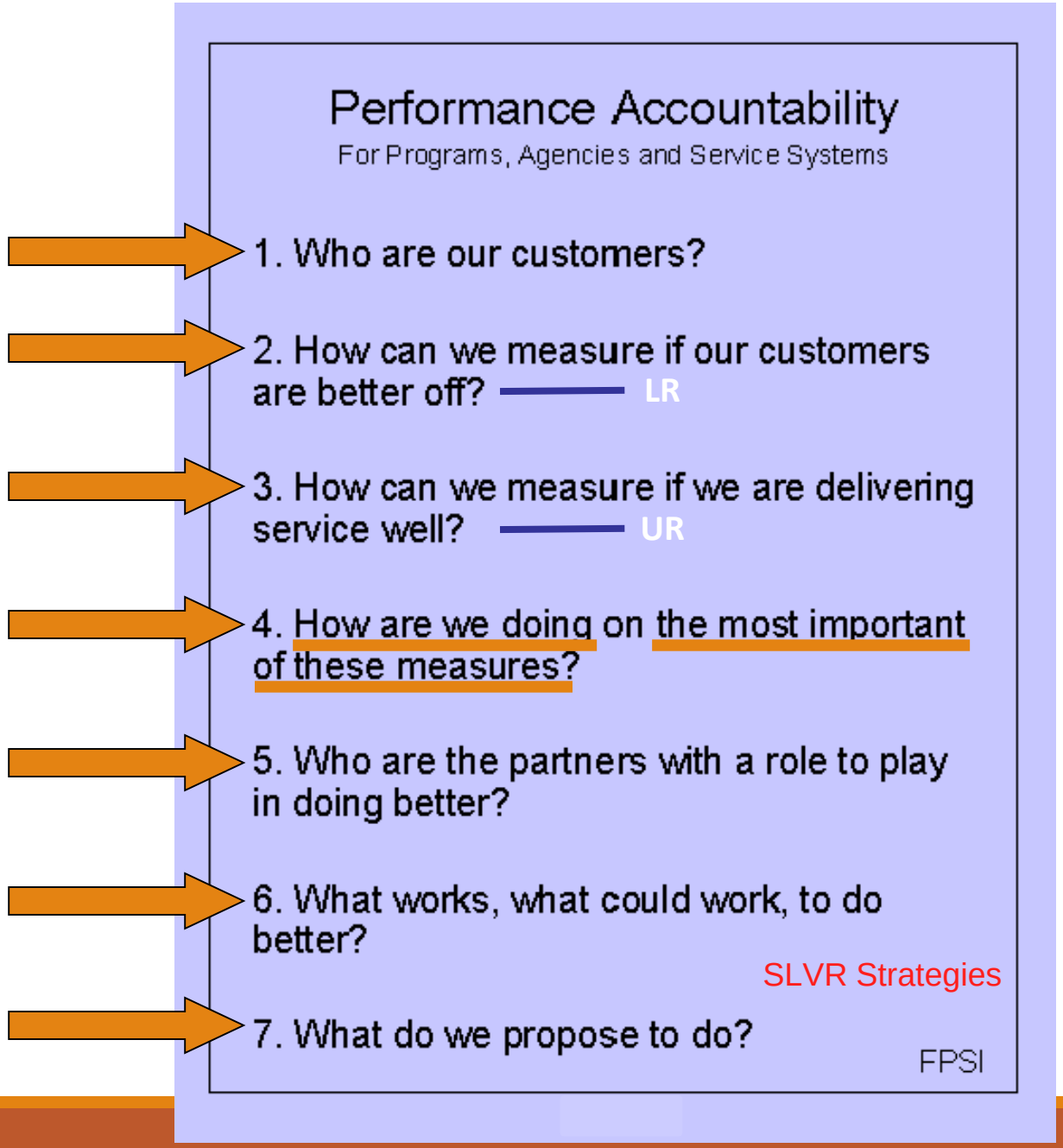
**SLVR: High in Specificity, Leverage, Values, and Reach*



Questions?

Performance Measures: Where are we now?





- Specificity
- Leverage
- Values
- Reach

THE LINKAGE Between POPULATION and PERFORMANCE

POPULATION ACCOUNTABILITY

POPULATION RESULTS

Healthy Babies

Rate of healthy weight babies

Healthy North Carolinians

NC Heart Disease Death Rate

Healthy Aging

Percent graduating from high school on time

Contribution relationship

Alignment of measures

Appropriate responsibility

PERFORMANCE ACCOUNTABILITY

Federal Health Home

# of care visits	% who got non-urgent appointment as soon as needed
# patients ages 18-85 who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year	% patients ages 18-85 who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year

Patient outcomes

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For more information on achieving health outcomes with Results Based Accountability(™)

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