

Community–Level Health Care Reform & Multi–Stakeholder Collaboratives:

The Importance of Evaluation

Dennis P. Scanlon Ph.D.

November 11, 2009

Overview

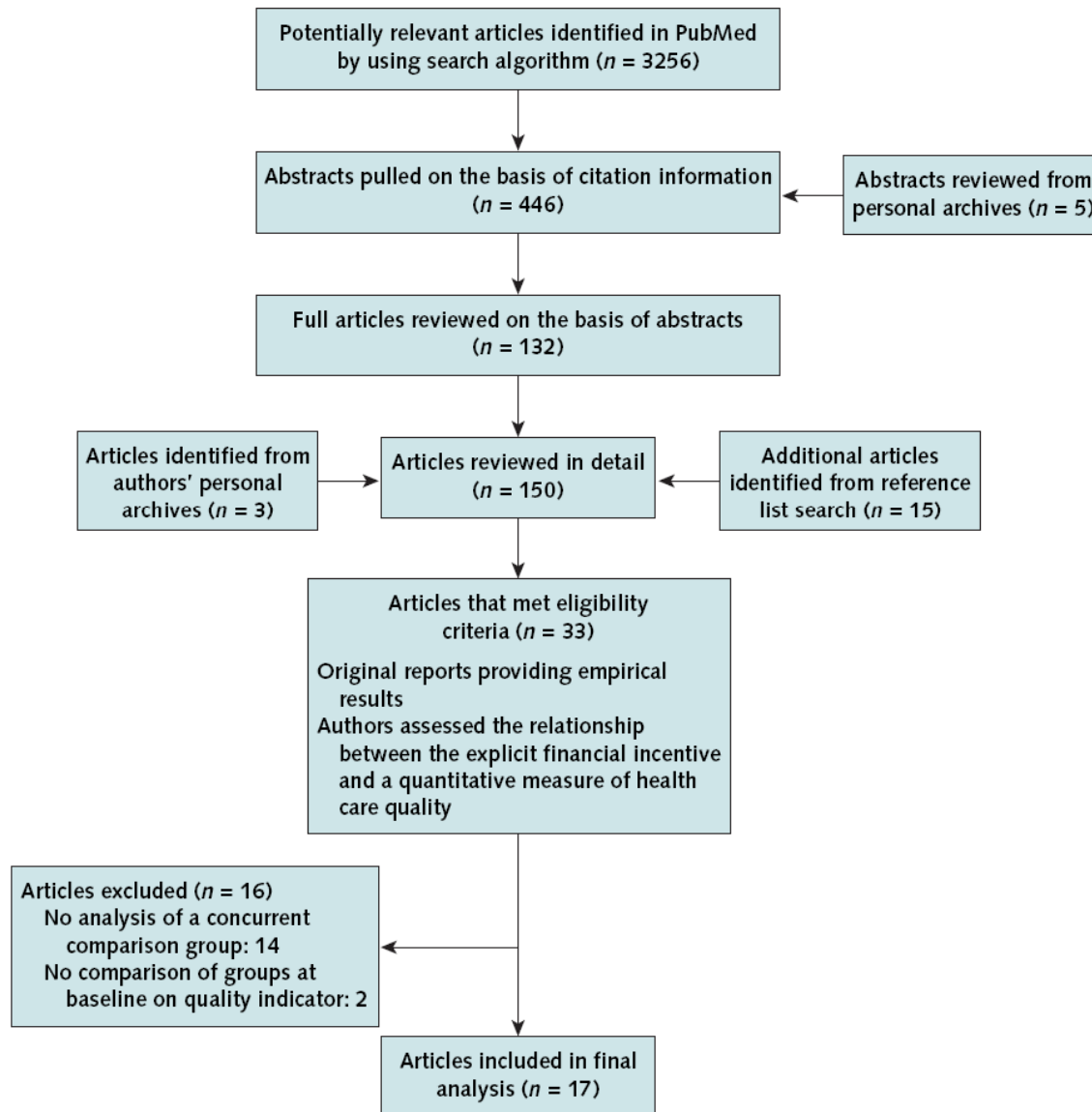
- ▶ Purpose of evaluation
- ▶ Critical Issues to consider
- ▶ Evaluating community health partnerships
- ▶ Examples:
 - Center for Health Care Strategies' (CHCS) *Regional Quality Improvement Initiative* (RQI)
 - Robert Wood Johnson Foundation's (RWJF) *Aligning Forces for Quality* (AF4Q)
 - Rochester *Diabetes Physician Recognition Program* (DPRP) incentive program
- ▶ Wisdom for the NBCH and CDC efforts

Lets Start With a Few Questions...

Anything common about answers?

- ▶ How many of you bought a product/service from vendor in the exhibit hall during the main conference?
- ▶ Did you believe the stories told by the presenters at the main conference?
- ▶ How many coalitions have fully implemented the medical home in your communities?
- ▶ How many coalitions have developed and implemented robust pay for performance programs?

Figure. Studies published between 1 January 1980 and 14 November 2005 and evaluated for inclusion in the systematic review of explicit financial incentives for health care quality.



Why conduct an evaluation?

- ▶ We are testing something in order to build the evidence base and to learn
 - So others can benefit from the results of your work
 - So you can learn from the work of others
- ▶ Because the funder requires it
- ▶ To find work for some poor academic researchers
- ▶ Be careful about what passes for evaluation
 - Data is dangerous and can be misleading
 - Presenters are enthusiastic
 - Funders and program sponsors often misrepresent their work
 - Not everything in JAMA, NEJM or other journals is good science
 - Program designers like to succeed – or like others to think they have been successful (how many presentations did we hear about failures over the last few days?)
 - Presenters have an ethical obligation to be honest about the degree of confidence in their estimates of program impact
 - Why should this be any different than for the approval of drugs?

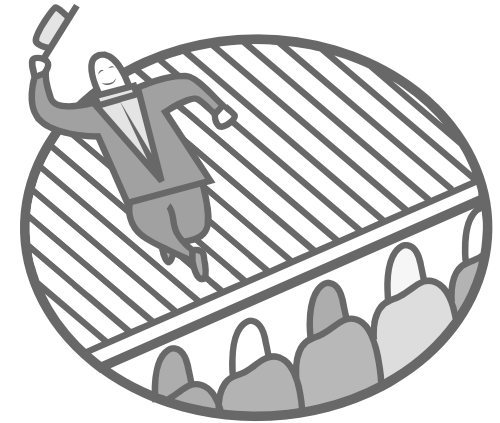
What Kinds of Learning?

- *How to improve the program*
- *What works under what circumstances*
- *An evidence base for:*
 - Social change
 - Practice in the field
 - Foundation grant making



Audiences for the Evaluation

- ▶ The Foundation Board of Trustees
- ▶ Grantees
- ▶ Foundation Staff
- ▶ Practitioners in the field
- ▶ Other funders and co-funders



Threats to Evaluation: The Stakeholders

- ▶ The funder
 - Pressure to succeed
 - Poorly developed theory of change
 - Limited evaluation resources
 - Evaluation as an afterthought
- ▶ The grantee
 - Pressure to succeed
 - Poorly developed theory of change
 - Limited evaluation resources
 - Lack of appreciation for evaluation
 - Main interest in boosting revenue or dishing out money
- ▶ The program's subjects
 - Often don't understand the value and importance of cooperating with an evaluation and thus don't participate

Threats to Evaluation: The Excuses

- ▶ “We already know the intervention works – don’t need to evaluate it”
 - Then why are you testing the intervention?
- ▶ “Not enough time to evaluate – we need to get the interventions implemented”
 - So what are you left with at the end?
- ▶ “We don’t have research expertise”
- ▶ “We don’t have enough money” or, “We don’t want to pay for the evaluation”
 - A legitimate excuse that requires discussion since evaluation is frequently underfunded

My Observations

- ▶ Funders say they are interested in learning but then apply pressure to succeed
- ▶ Lack of solid scientific evidence base or theory of change for interventions
- ▶ Time horizon is incredibly unrealistic
 - ▶ Assume coalition building is simple and a foregone conclusion
- ▶ Not enough money
 - Often grossly underfunded

Evaluating a Community Health Program?

- ▶ Research Question(s)
 - What are you testing?
 - See Goldfarb and Greenberg presentation
- ▶ Theory of Change – Logic Model
- ▶ Data Collection
 - Quantitative
 - Qualitative
- ▶ Analysis
- ▶ Disseminating Findings
 - Reports to sites
 - Reports to funding agency
 - Peer reviewed articles, research summaries, and presentations

Key Issues to Consider

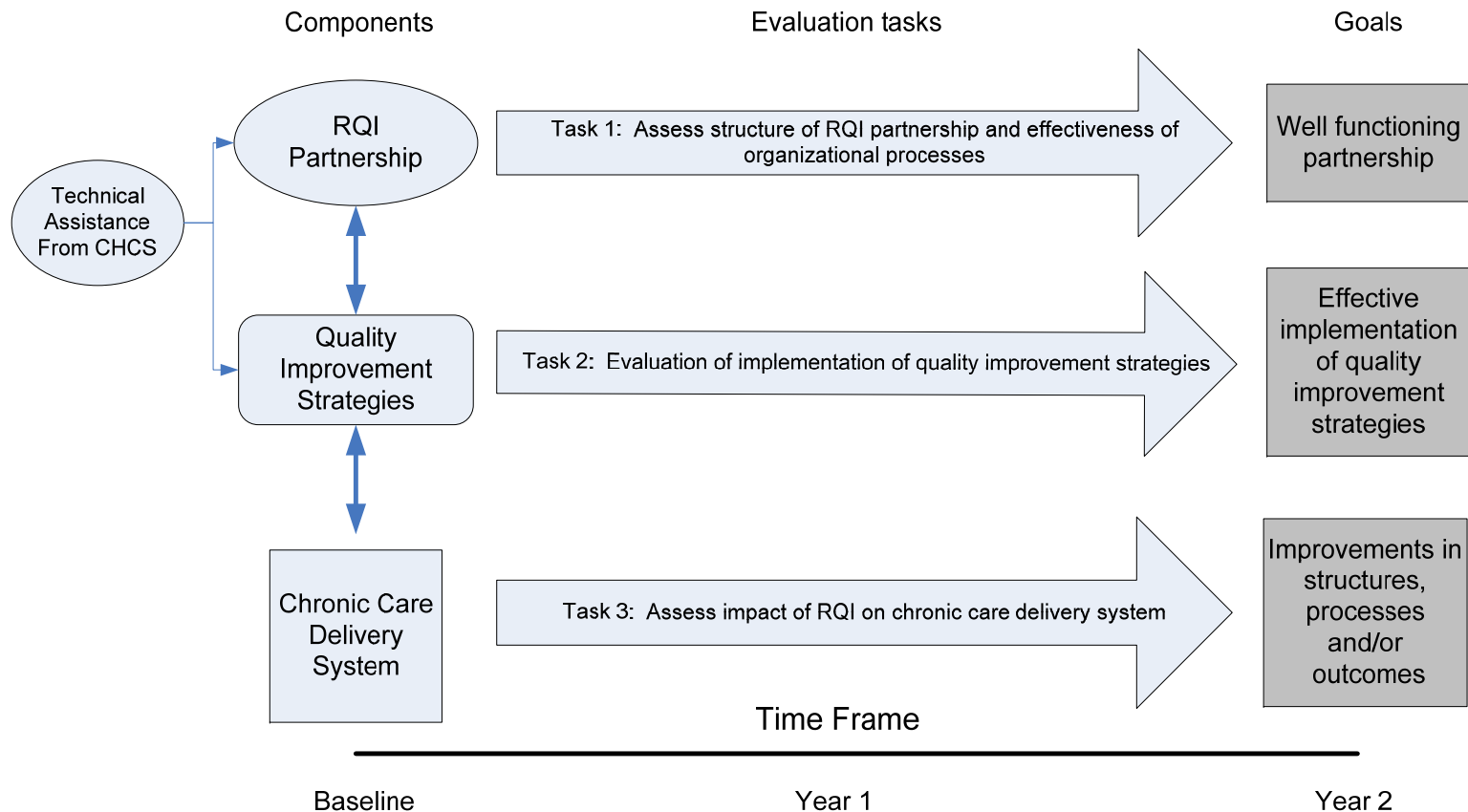
- ▶ Strength of evidence needed
 - Scope/funding for evaluation
- ▶ Time horizon
- ▶ Who's perspective?
- ▶ Cost of the intervention (aka CE)
- ▶ Theory of change
 - Assumptions regarding intervention strength and implementation
- ▶ Generalizability
- ▶ Scalability
- ▶ Finding research expertise
- ▶ Research protections

Some Examples of Evaluations of Community Partnerships / Multi- Stakeholder Collaboratives

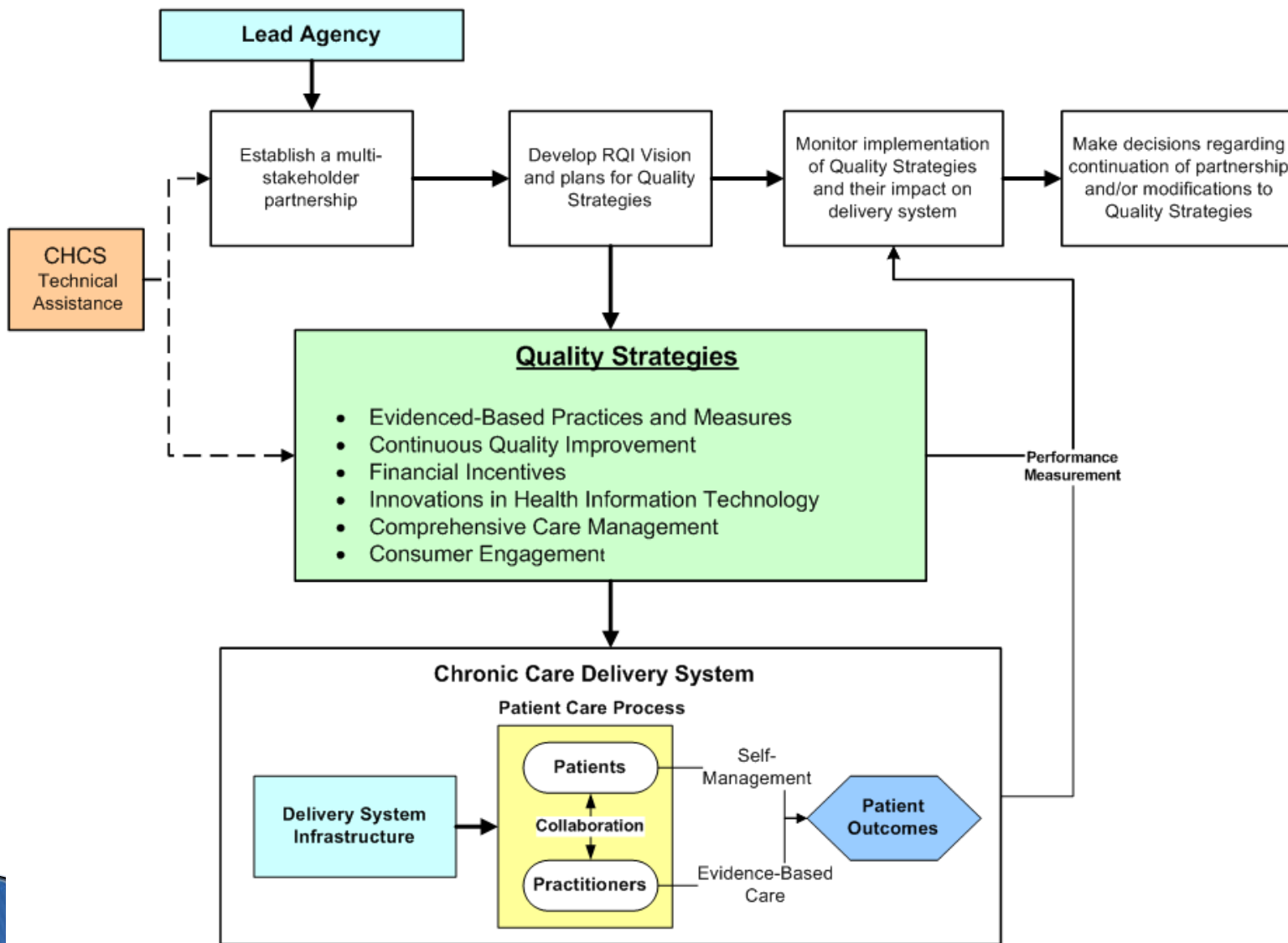
Regional Quality Improvement Initiative

- ▶ Sponsored by the Center for Health Care Strategies
- ▶ RQI Goal: “...leverage Medicaid's significant purchasing power to improve care for people with chronic conditions through partnerships with other health care leaders in four regions -- Arkansas; North Carolina; Rhode Island; and Rochester, New York
- ▶ Strategies for change
 - Cross-Payer Data Aggregation and Reporting of Performance Measures
 - Quality Improvement Infrastructure Development
 - Consumer Engagement
 - Realigning Resources and Creating Financial Incentives
- ▶ 2 year grant ending in July 2009

RQI Evaluation Model



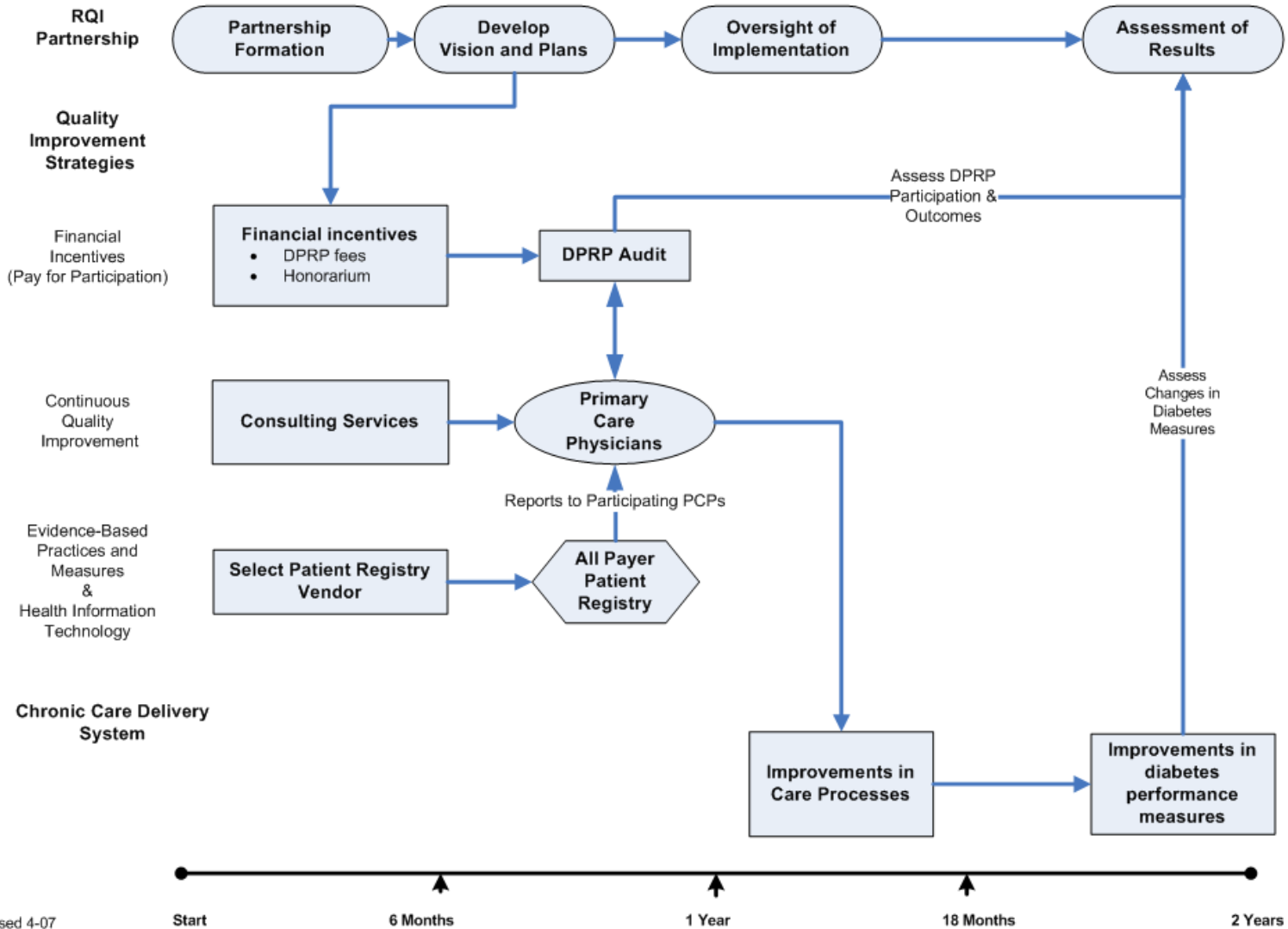
RQI Logic Model



Rev: 11-3-06

Rochester RQI Logic Model

Evaluation Level

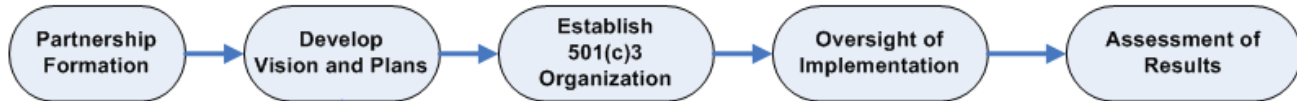


Revised 4-07

North Carolina RQI Logic Model

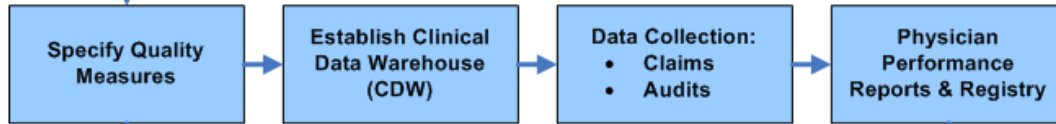
Evaluation level

RQI Partnership



Quality Improvement Strategies

Evidence-Based Practices and Measures & Health Information Technology



Continuous Quality Improvement



Chronic Care Delivery System



Feedback

Consulting Services

Comparative Reports & Registry Information

Version: 11_27_07

Start

2 Years

Arkansas RQI Logic Model

Evaluation Level

RQI Partnership



Quality Improvement Strategies



Evidence-Based Practices & Measures



Health Information Technology

Continuous Quality Improvement



Pay for Performance



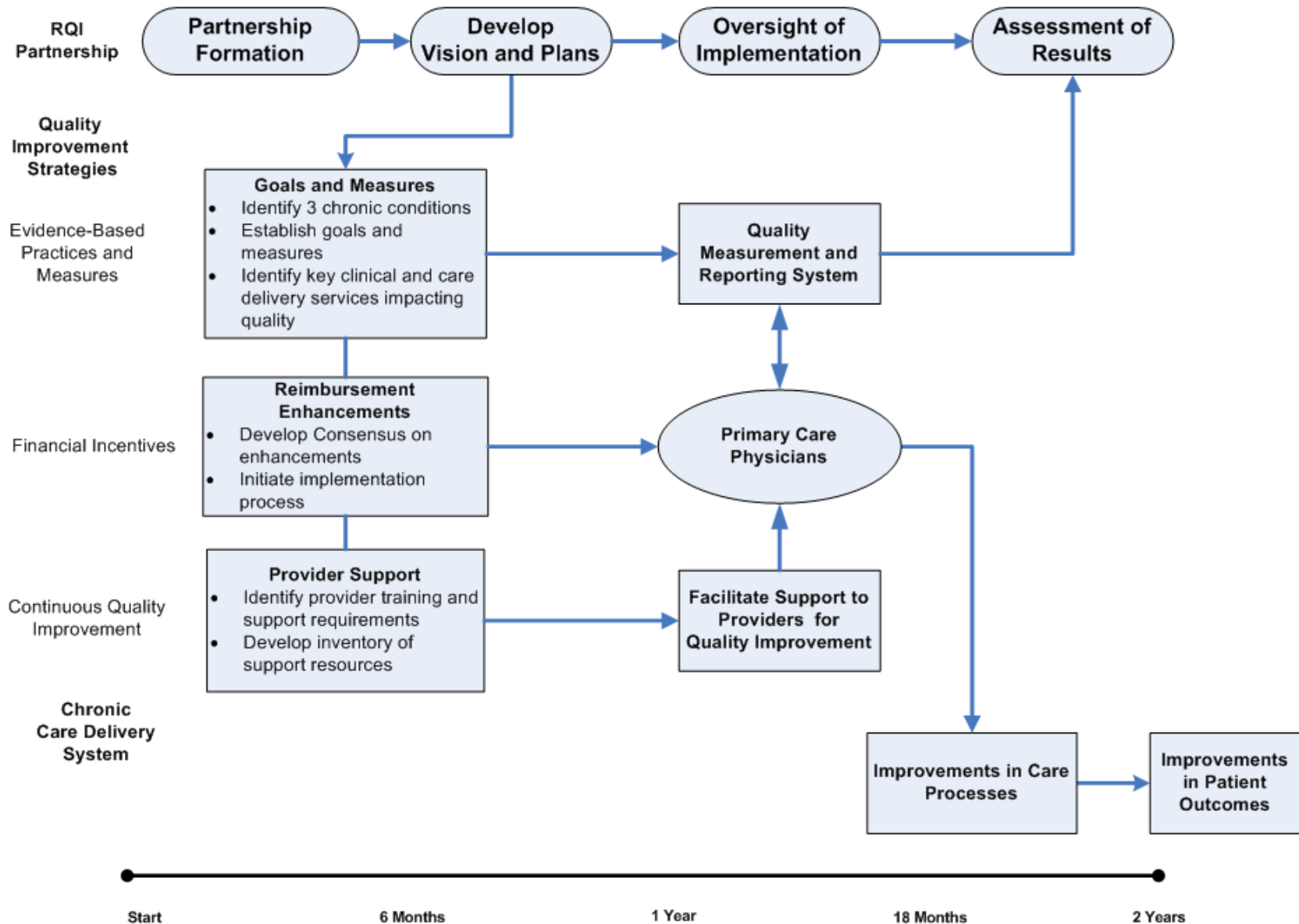
Chronic Care Delivery System



Feedback

Rhode Island RQI Logic Model

Evaluation Level



RQI Evaluation Methods

- ▶ Case studies
 - Key Informant Interviews
 - Web-based “Alliance Survey”
 - Tracking of RQI activities
 - Observations of a QI consultant (Rochester)
- ▶ Performance data
 - Rochester: Collected clinical performance data as part of their DPRP project

Rochester RQI Intervention

- ▶ RQI provided incentives to physicians to participate in NCQA's Diabetes Physician Recognition Program (DPRP)
- ▶ Incentives included
 - Honorarium of \$1000 per physician/per year of participation
 - Payment of NCQA's DPRP fees (\$350 individual/\$2,700 group)
 - Provision of consulting services to assist with quality improvement activities and DPRP application process
 - Provision of patient specific "registry" reports combining claims data from multiple insurers
- ▶ Intervention targeted 11 safety net primary care practices in the Rochester, NY vicinity

Diabetes Physician Recognition Program

- ▶ Developed by NCQA in conjunction with ADA to promote improvements in diabetes care
- ▶ Physicians may participate individually or as a group
- ▶ Participating physicians must audit 25 charts for results on 10 performance measures
- ▶ Performance measures are assigned weights and threshold values (see next slide)
- ▶ Physicians achieving a score of 75 or higher (out of 100) receive DPRP recognition

Objective of Study and Research Questions

- ▶ Objective: To assess the impact of a pay-for-participation program on primary care physician practices
- ▶ Research Questions
 - Was the program effective in recruiting physician participation? What factors motivated their participation.
 - Was the program effective in achieving improvements in diabetes care among the participating practices?
 - What were the characteristics of the physician groups receiving DPRP recognition?

Study design and data collection

- ▶ Exploratory case study
- ▶ Data collection
 - Physician performance data relative to DPRP indicators
 - Interviews with key members of the RQI leadership team and other stakeholders
 - Interviews with physician managers and QI specialists within participating practices
 - Participation in on-site RQI meetings and telephonic progress reports with site leader and CHCS staff
 - Observations from QI consultant using a standard data collection protocol

Results

- ▶ Eight of 11 invited practices participated
- ▶ 37 (47%) of 79 participating physicians received DPRP recognition
- ▶ Relative to DPRP performance measurement indicators, practices performed:
 - Well in LDL and BP control
 - Moderately well in HbA1c control, foot examinations and neuropathy assessment
 - Poorly in documentation of diabetic retinal exams (see next slide)

Percentage of physicians submitting individual DPRP applications reaching indicator thresholds in their first round of participation

Diabetes Recognition Measures	Threshold (% of patients)	% Meeting Threshold
HbA1c Control >9.0%	≤15%	60%
HbA1c Control <7.0%	≤40%	75%
Blood Pressure Control ≥140/90 mm Hg	≤35%	83%
Blood Pressure Control <130/80 mm Hg	≥25%	81%
Diabetic Retinal Examination	≥60%	13%
Smoking Status & Cessation Advice	≥80%	88%
LDL Control <100 mg/dl	≥36%	100%
LDL Control ≥130 mg/dl	≤37%	94%
Foot Examination	≥80%	60%
Nephropathy Assessment N = 52	≥80%	65%

What Do You Think of the Results?

Principal Findings

- ▶ **Caveat:** Lack of pre–post data, control sites and small sample size limits generalizability of our findings
- ▶ Physician leaders and QI staff noted the following motivations for participation:
 - 75% of practices noted that provision of incentives (primarily the honorarium) was a significant factor in their decision to participate
 - “...while the DPRP program was appealing, the honorarium greased the wheels in our decision process”.
 - All practices noted their desire to improve quality. The RQI provided a good opportunity to interact with peers and engage in quality improvement activities
 - All practices were interested in measuring their performance against nationally recognized indicators
 - Chart audit process provided an opportunity to do this using data from their own records rather than from external sources (data trust issue)
 - One physician manager noted: “While it was not our primary reason for participating (in the program) the prestige of having certification is appealing in and of itself.”

Key Issues to Consider

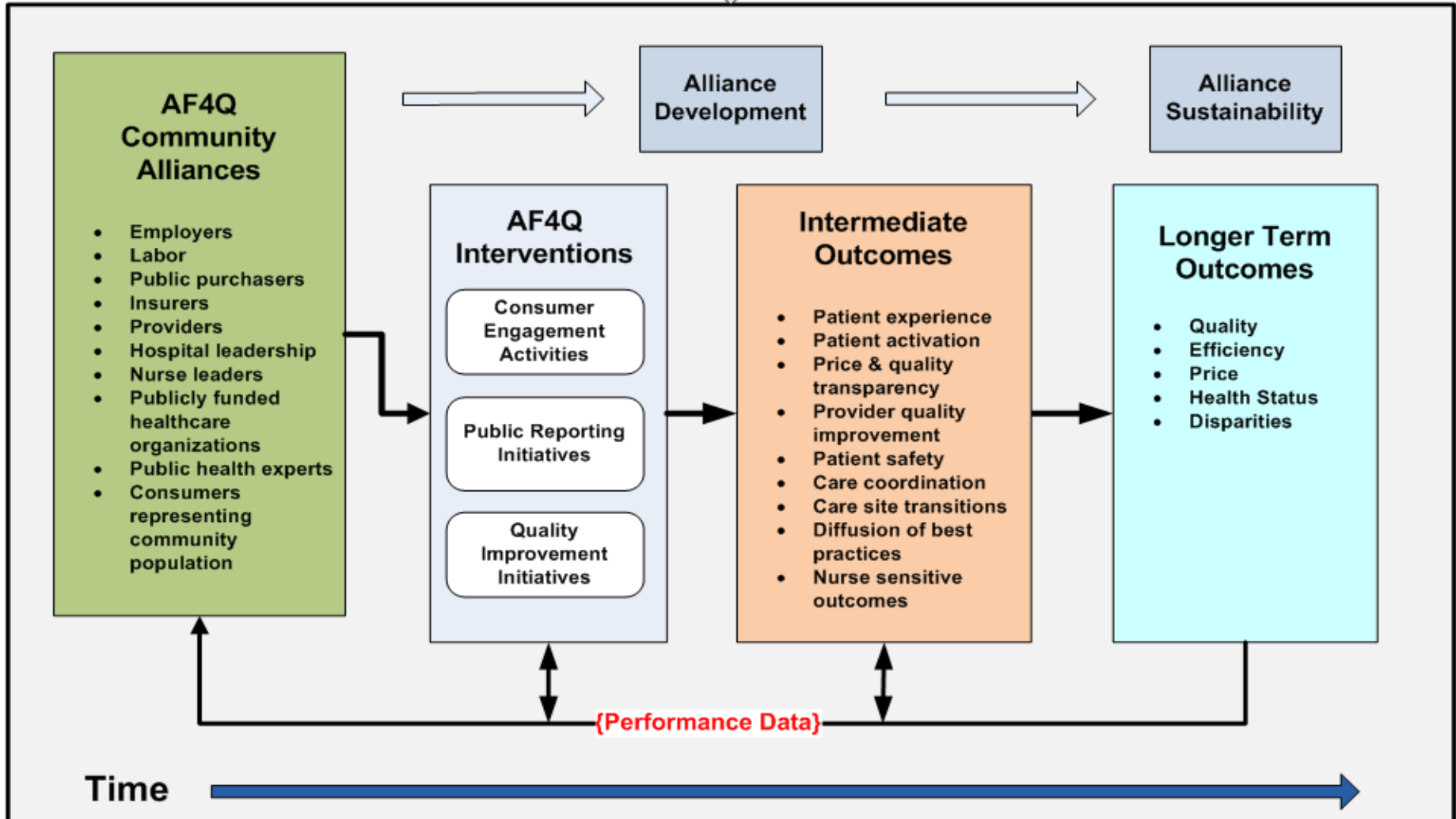
- ▶ Strength of evidence needed
 - Scope/funding for evaluation
- ▶ Time horizon
- ▶ Who's perspective?
- ▶ Cost of the intervention (aka CE)
- ▶ Theory of change
 - Assumptions regarding intervention strength and implementation
- ▶ Generalizability
- ▶ Scalability
- ▶ Finding research expertise
- ▶ Research protections

RWJF's Aligning Forces for Quality

- ▶ Goal: Multi-stakeholder collaboratives as catalyst for change in local health systems
- ▶ Interventions: Funding, technical assistance, data
- ▶ Key Focal Areas / Drivers:
 - Public reporting
 - Consumer engagement
 - Quality improvement
 - Disparities reduction

AF4Q Logic Model

Historical Context and External Environment



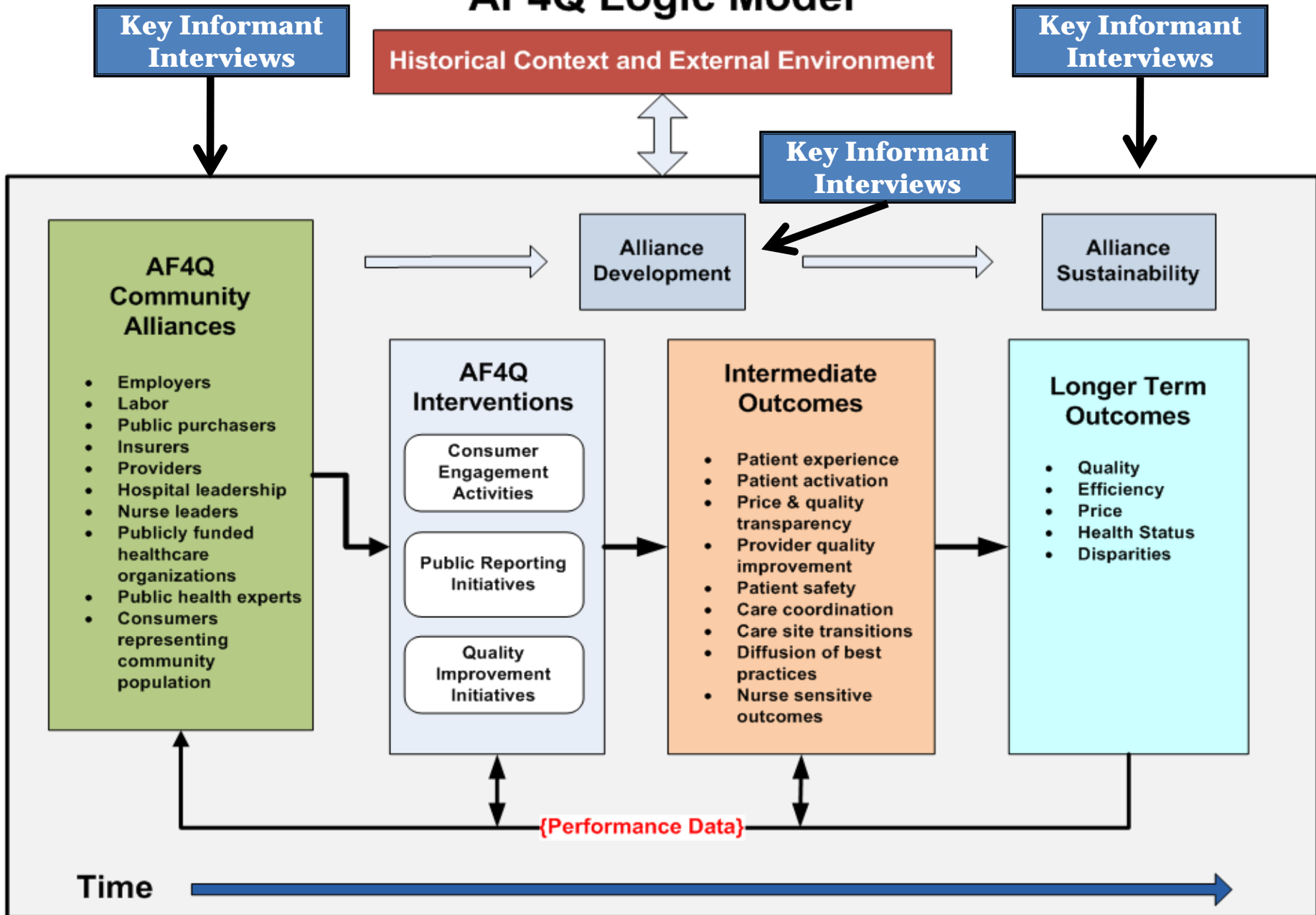
Evaluation Data Collection: Covering the Logic Model

- ▶ Alliance Survey
 - Web survey of stakeholders on governance issues conducted every 18 months
- ▶ Consumer Survey (2007–2008, n=8,079)
 - Chronically ill in 14 communities + national sample
 - Diabetes, hypertension, heart disease, asthma, depression
 - Care experiences, public reporting, engagement in care
- ▶ Physician Survey (2008–2009, n=1,809)
 - Small and medium size practices in 14 AF4Q communities + national sample
 - Use of care management practices and QI incentives

Evaluation Data Collection

- ▶ Key informant interviews of stakeholders
 - Site visits (2006–07; 2009–10); follow up calls every 6 months
 - Vision, governance, activities resources, barriers
- ▶ Tracking (ongoing)
 - Alliance composition, activities, market context
- ▶ Secondary sources
 - Dartmouth Atlas
 - H-CAHPS

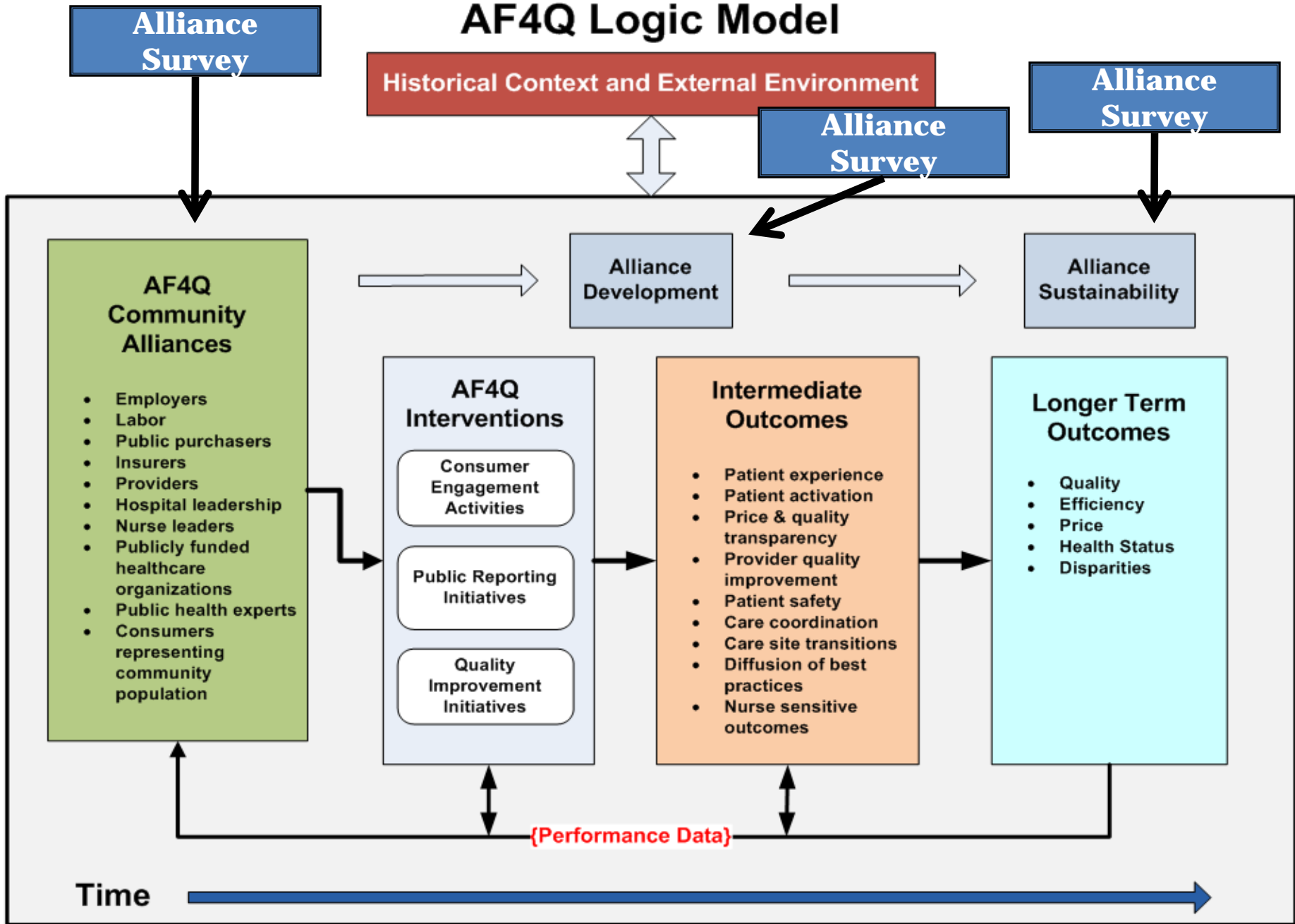
AF4Q Logic Model



Key Informant Interview Data

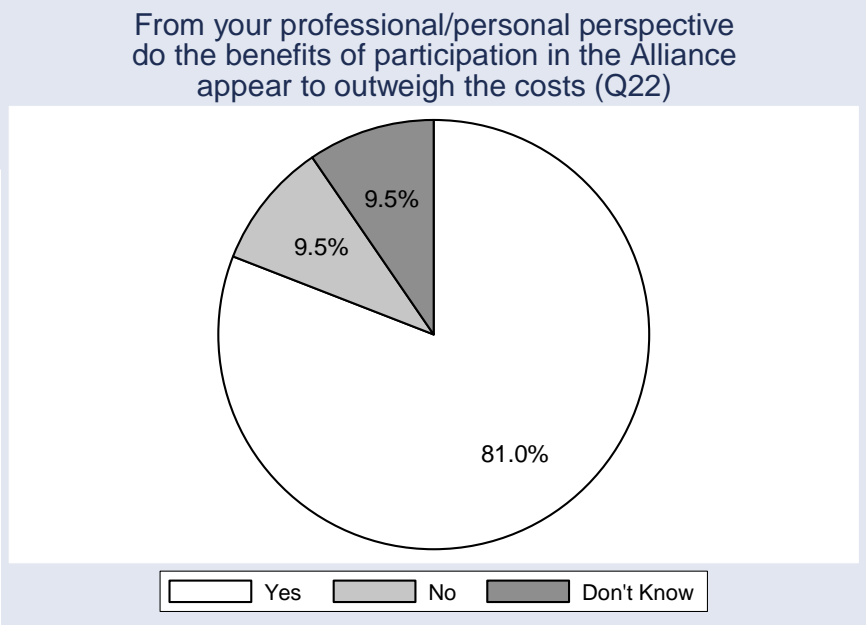
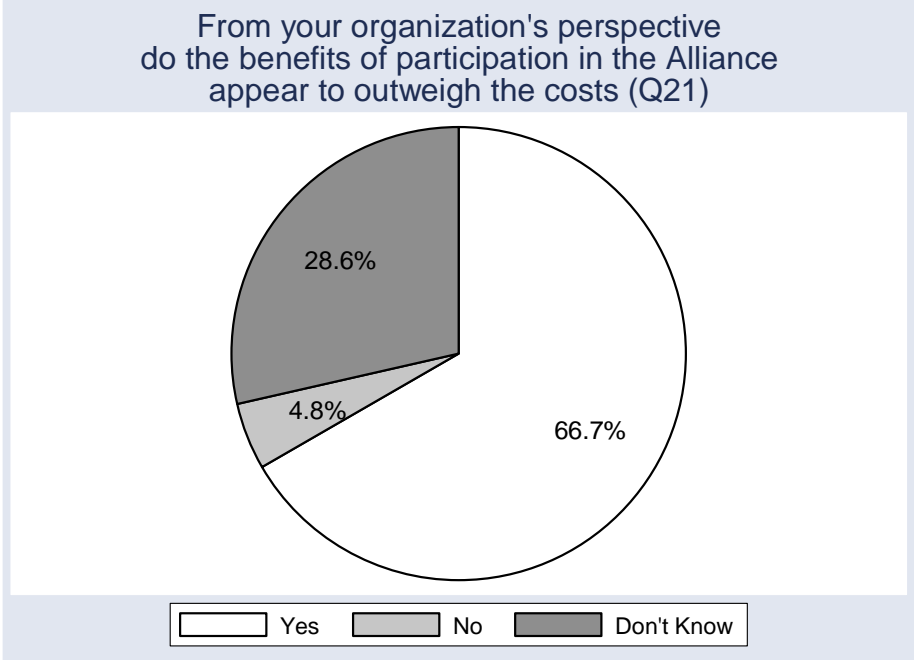
- Site visit data
 - Round 1 complete and being analyzed
 - Topical & Conceptual coding completed (n=275)
 - Currently being analyzed using Atlas.ti
- Alliance Director 6 month follow-ups
 - 20 completed to date
 - Interviews with Alliance leaders every six months
- Site expert interviews
 - Periodic conversations with leads for PR/PR, CE, QI and new AF4Q focal areas

AF4Q Logic Model

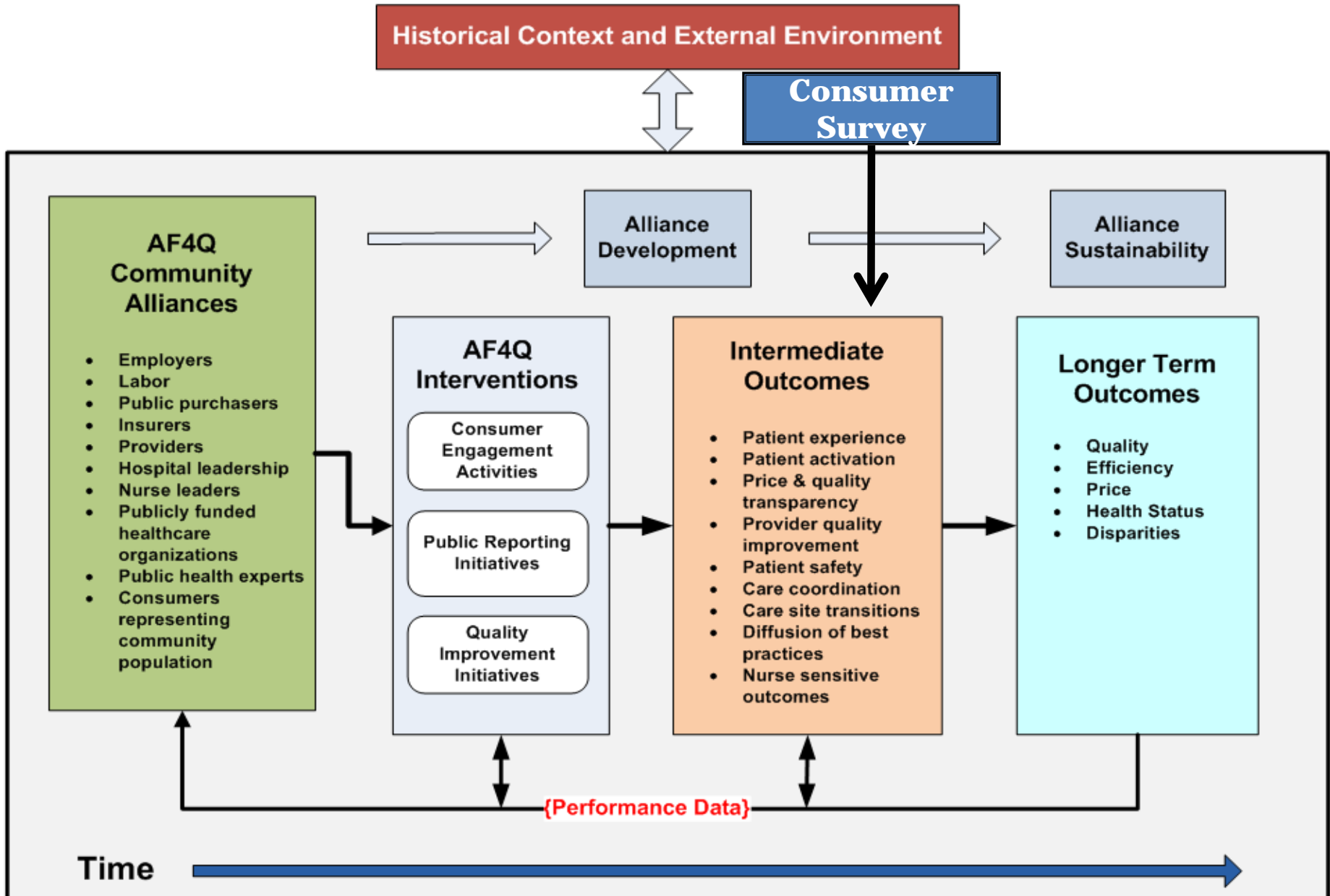


Benefits of Alliance Participation

Source: AF4Q Seattle Alliance Web Survey



AF4Q Logic Model

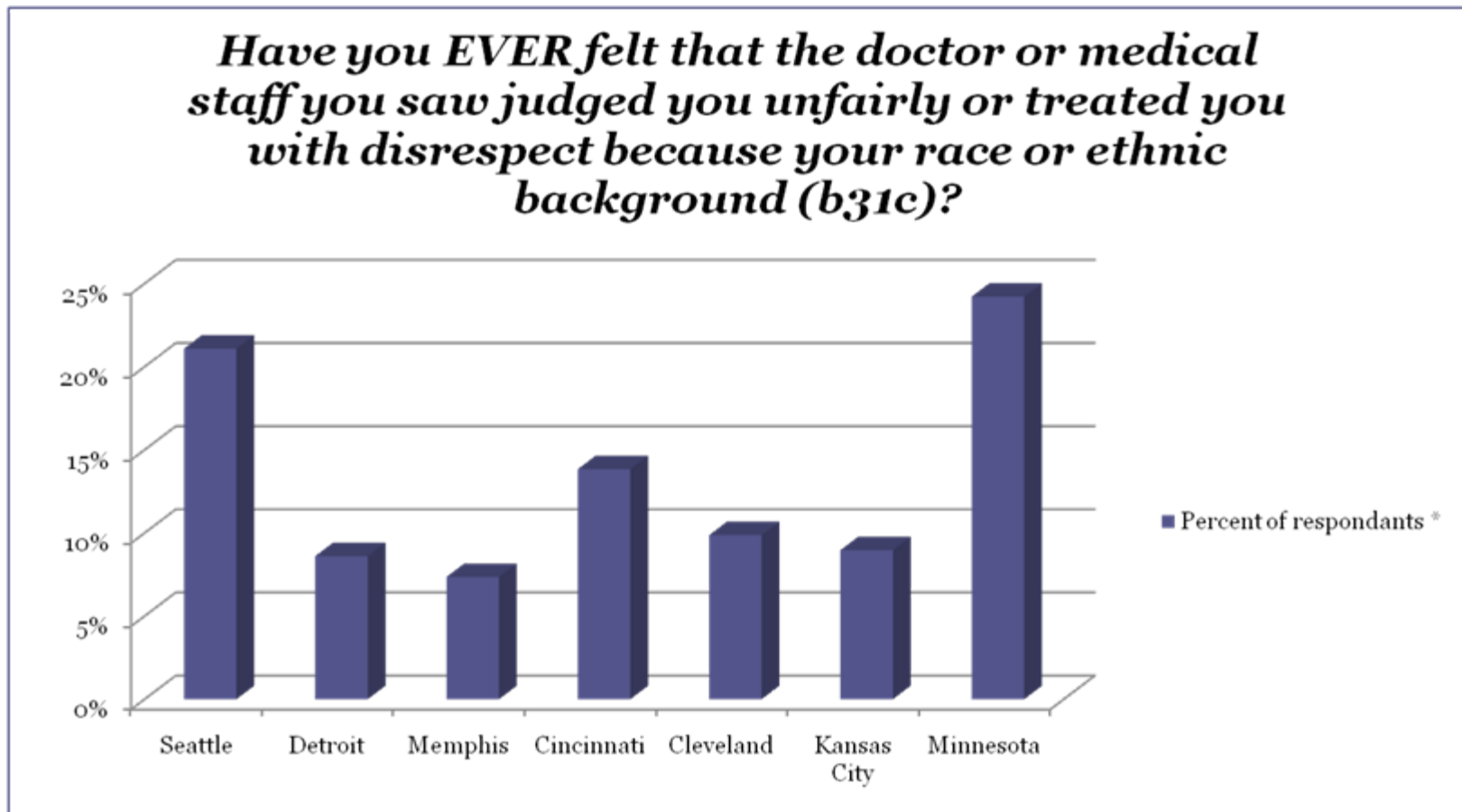


Respondents report coordination of care problems

<i>In general, do you think that coordination among all of the different health care professionals that you see is a (b12):</i>		
	Major Problem*	Minor Problem
Seattle	11.0%	21.7%
Detroit	10.2%	14.5%
Memphis	9.0%	20.2%
Wisconsin	5.9%	19.0%
Cincinnati	6.4%	19.1%
Cleveland	11.6%	17.2%
Kansas City	15.9%	16.2%
Minnesota	6.9%	21.1%

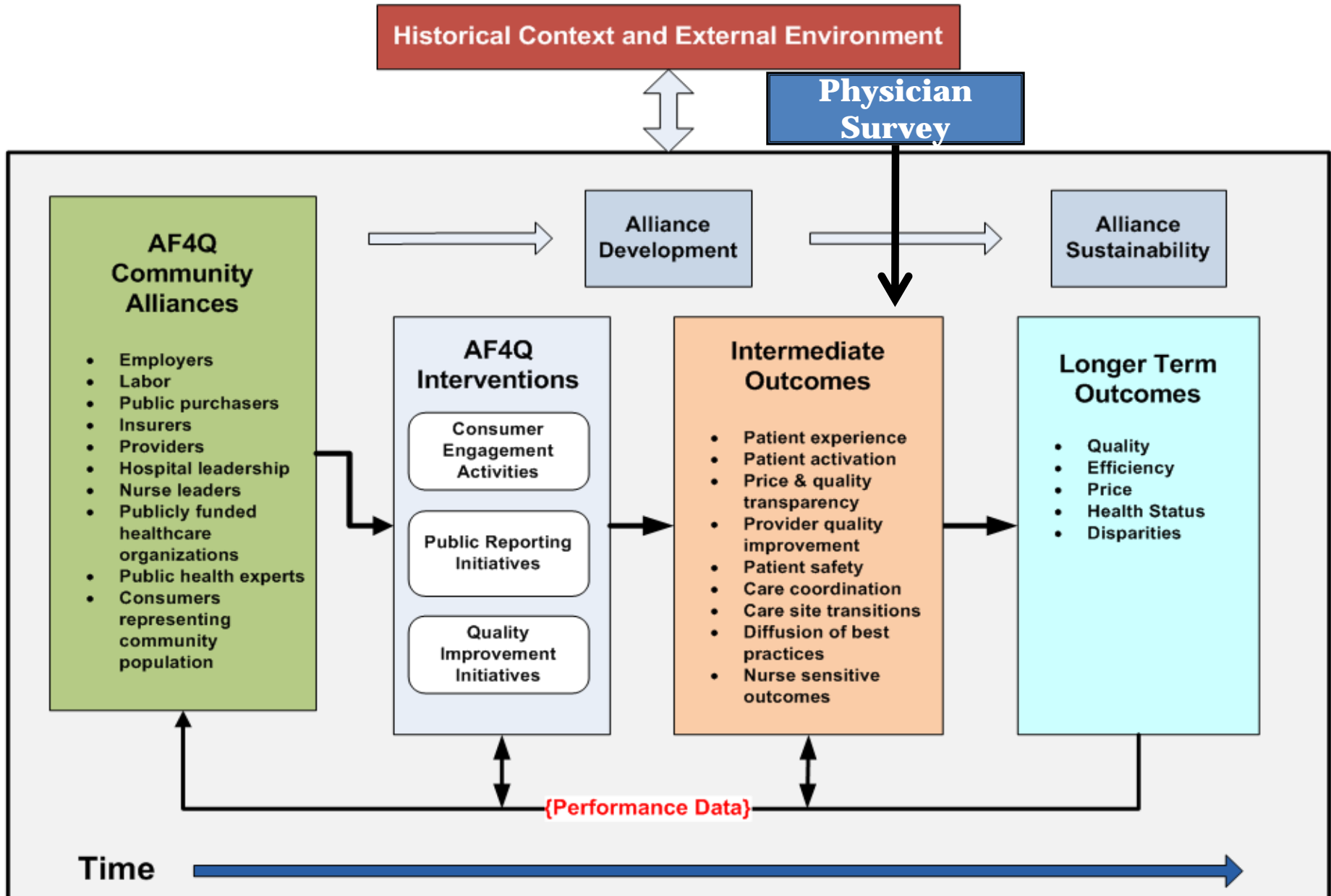
* Other response options include "Not a problem at all" and "Don't know"

Sizeable variation in the reporting of unfair and disrespectful treatment



* Black and Hispanic

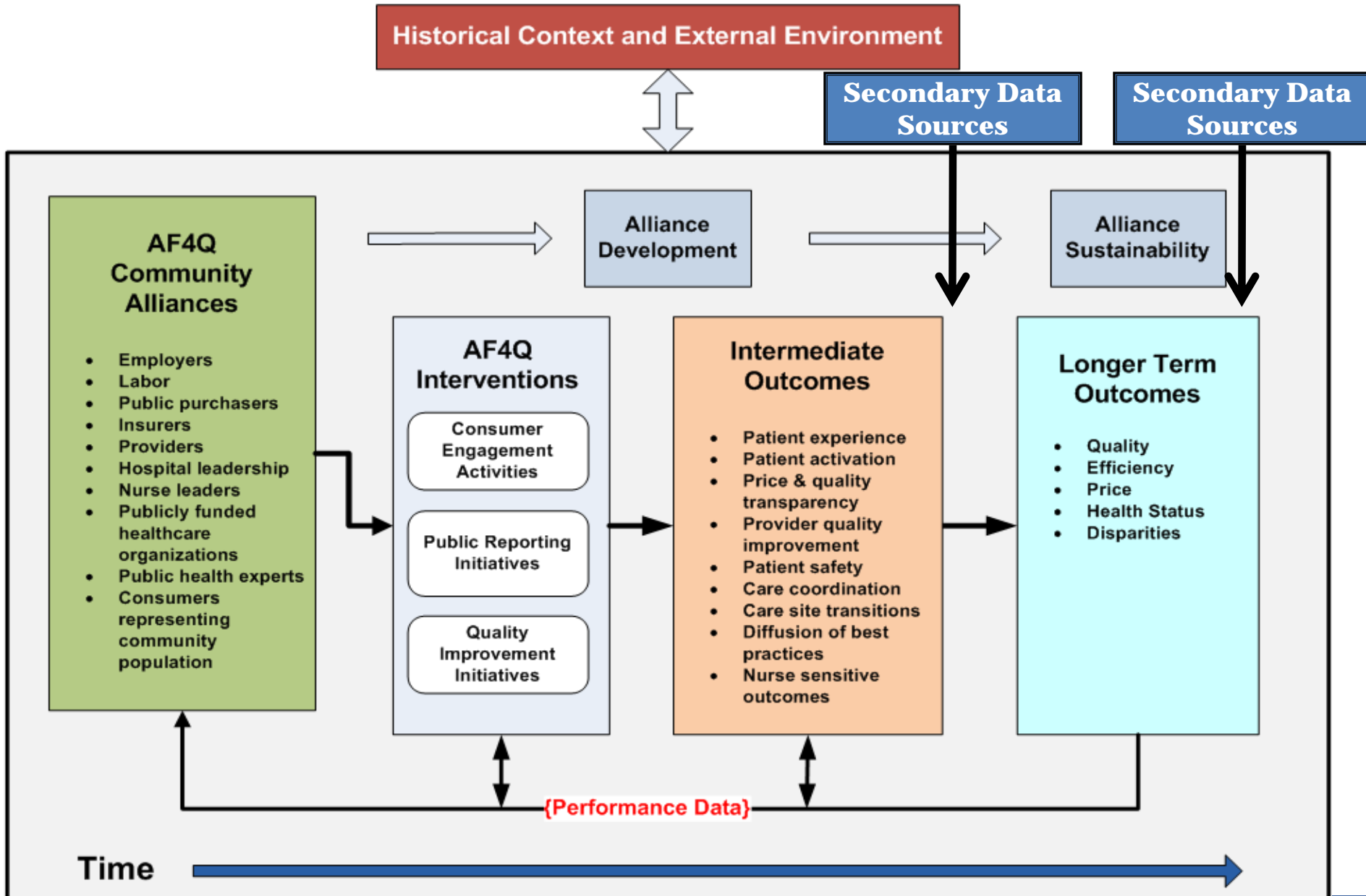
AF4Q Logic Model



Care Management Processes (CMPs) for Asthma Care

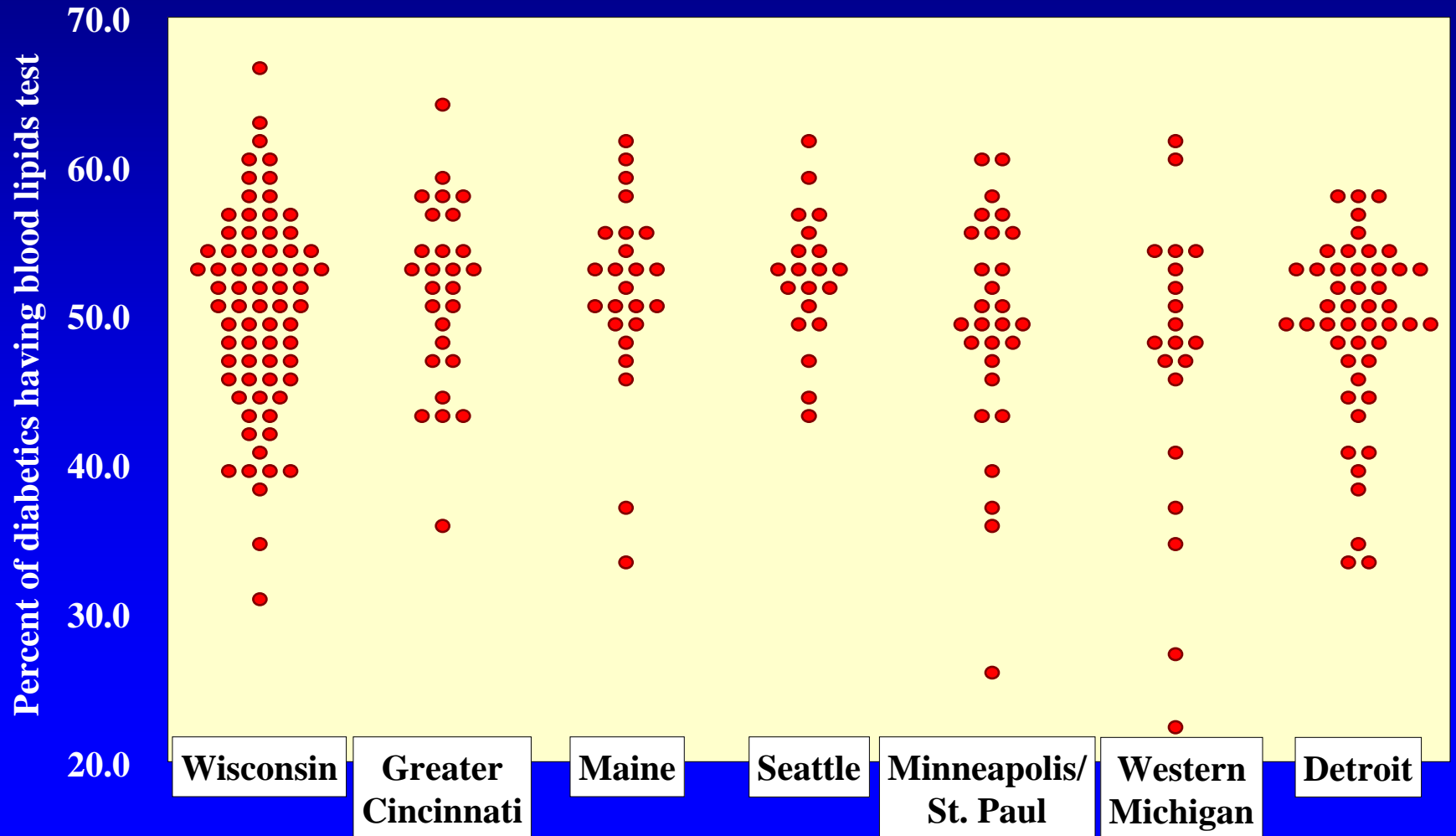
Sites	Electronic Registry	Guideline-Based Reminders	Physician Organization (PO) Gives Data to MDs	PO Sends Care Reminders to Patients
Site A	25.0%	41.7%	50.0%	25.0%
Site B	22.2%	50.0%	88.9%	0%
Site C	50.0%	77.8%	70.0%	40.0%
Site D	44.4%	44.4%	44.4%	33.3%
Site E	25.0%	33.3%	33.3%	25.0%

AF4Q Logic Model

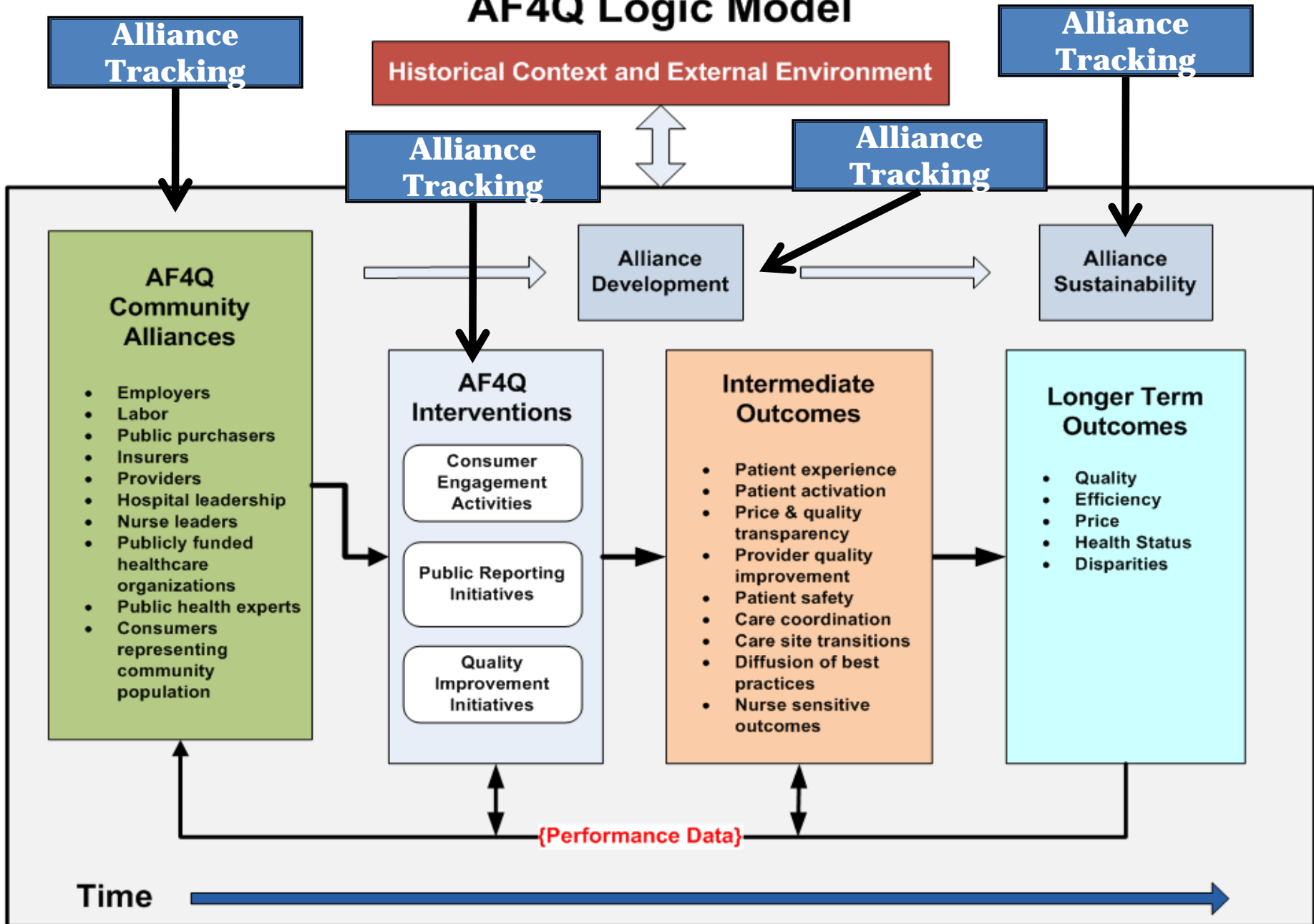


Dartmouth Atlas Data: Diabetic Lipid Testing

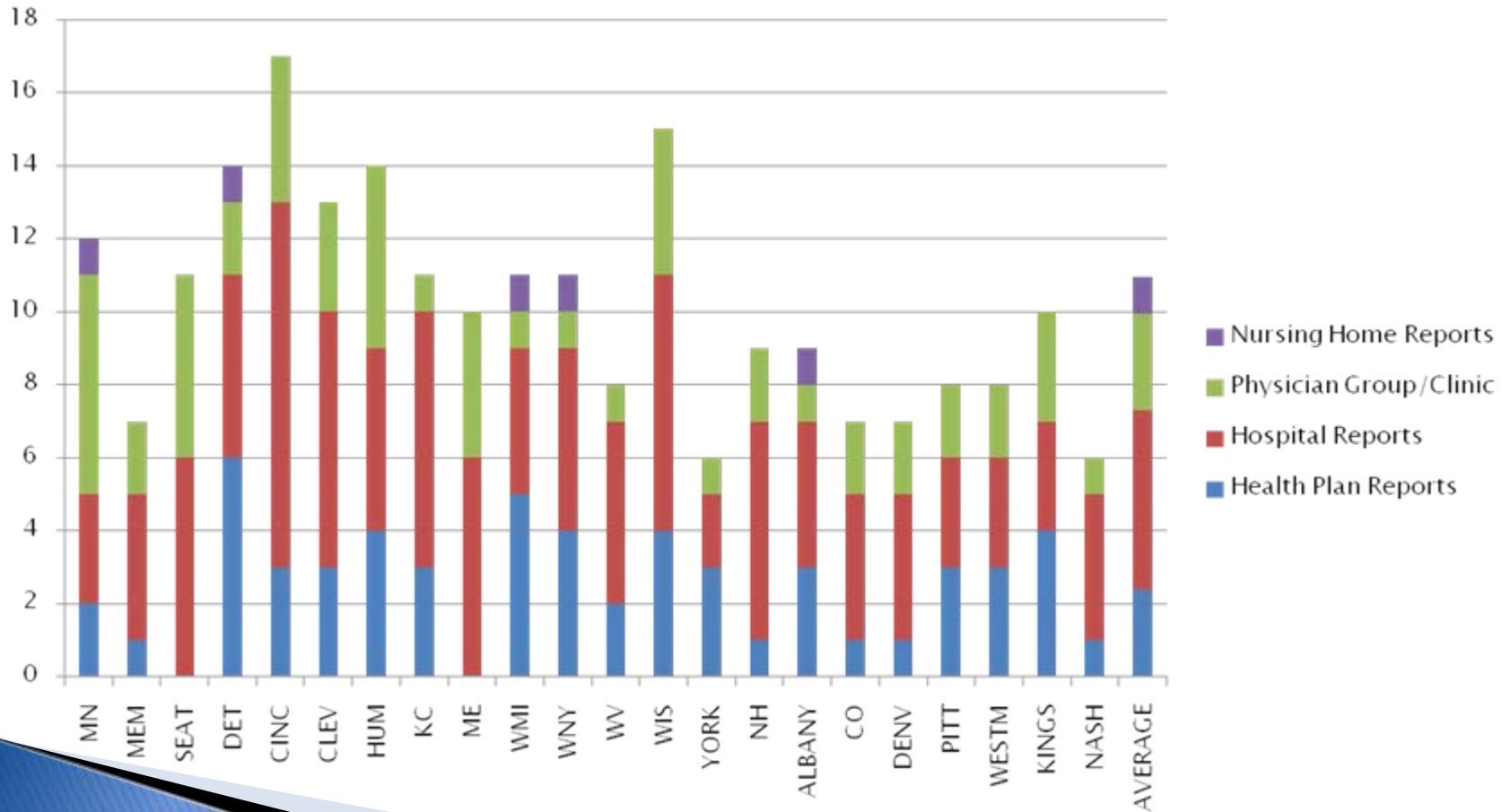
Percent of diabetics having blood lipids tested in sites with 20+ hospitals with 500+ patients



AF4Q Logic Model



Quality Reports by Community



Key Issues to Consider

- ▶ Strength of evidence needed
 - Scope/funding for evaluation
- ▶ Time horizon
- ▶ Who's perspective?
- ▶ Cost of the intervention (aka CE)
- ▶ Theory of change
 - Assumptions regarding intervention strength and implementation
- ▶ Generalizability
- ▶ Scalability
- ▶ Finding research expertise
- ▶ Research protections

AF4Q: Early results

- ▶ Evaluation web-site:

- (<http://www.hhdev.psu.edu/chcpr/alignforce/>)

- Community snapshots
 - Research summaries
 - Research articles and reports
 - Presentations
- ▶ Reports to the AF4Q sites summarizing key results of each of our surveys (Consumer Survey, Physician Survey, Alliance Survey) with benchmarks
- ▶ Site leaders have used these results for board presentations and to guide decision making in selecting new strategies

PENNSTATE



THE COLLEGE OF HEALTH AND HUMAN DEVELOPMENT



Center for Health Care and Policy Research

Aligning Forces for Quality Evaluation

A field analysis of the progress and impact of the Robert Wood Johnson Foundation's 15-community initiative to improve health care quality

Funder: [Robert Wood Johnson Foundation](#)

Grant Period: 03/01/06 - 10/31/11

The [Aligning Forces for Quality \(AF4Q\) initiative](#) is a long-term, comprehensive effort to provide resources, expertise and training focused on accelerating quality improvement in [15 communities](#) across the nation and is the signature program in the Robert Wood Johnson Foundation's \$300 million commitment to improve the quality of U.S. health care. The AF4Q Evaluation project, based here at Penn State, will provide impartial research and evaluation expertise for the AF4Q initiative. Particular emphasis will be placed on measurable progress in the realms of consumer engagement, quality improvement and public reporting, and disparities reduction.

The Aligning Forces for Quality Evaluation team will research and provide

Search for In

Search

About AF4Q Evaluation -

Evaluation Team

Domains

- Consumer Engagement
- Public Reporting
- Quality Improvement
- Disparities Reduction

Data Collection

- Alliance Survey
- Consumer Survey
- Key Stakeholder Interviews
- National Survey of Small and Medium-Sized Physician Practices

Publications and Presentations

- Community Snapshots
- Research Summaries
- Research Articles and Reports
- Presentations

Health Care and Policy Research

Aligning Forces for Quality Evaluation

Publications and Presentations

Community Snapshots

All the reports below are in [.pdf format](#).

[Cincinnati](#)

[Cleveland](#)

[Detroit](#)

[Humboldt County](#)

[Kansas City](#)

[Maine](#)

[Memphis](#)

[Minnesota](#)

[PugetSound](#)

[South Central Pennsylvania](#)

[West Michigan](#)

[Western New York](#)

[Willamette Valley](#)

[Wisconsin](#)

Evaluation Team

Domains

- Consumer Engagement
- Public Reporting
- Quality Improvement
- Disparities Reduction

Data Collection

- Alliance Survey
- Consumer Survey
- Key Stakeholder Interviews
- National Survey of Small and Medium-Sized Physician Practices

Publications and Presentations

- Community Snapshots
- Research Summaries
- Research Articles and Reports
- Presentations

About CHCPR

Research Strengths

- Aging
- Disparities
- Performance
- Insurance

Projects

Publications

Resources for Researchers

Advice for NBCH and CDC

- ▶ Impact and Learning – How to Most Effectively Use Available Resources?
 - Several small projects or a single larger project?
 - Single multi-site project designed with broad coalition participation to ensure relevance
 - Exploits variation across communities along many dimensions
 - Health care supply differences
 - Utilization variation
- ▶ Include evaluation expertise early on in project planning
- ▶ Exploit lessons learned along the way

The Contested Boundaries of American Public Health

Edited by

James Colgrove, Gerald Markowitz, and David Rosner

Rutgers University Press

New Brunswick, New Jersey, and London

The Limits of Relying on Employers in an Intersectoral Public Health Partnership

With the multiplication of factories the improvement in the lot of the laboring man has become a vital question of the day. . . . The health of society in general is both directly and indirectly menaced by insanitary conditions in any industry.

—C.F.W. Doehring, 1903

America's businesses and employers have the opportunity to promote health and prevent disease and disability in their own workforces. Employers are also a critical source of health care payment for personal health care services. Furthermore, because businesses are closely involved with communities, they can collaborate in partnerships that monitor, identify, and address community health problems.

—Institute of Medicine, 2003

The two epigraphs, written a hundred years apart, illustrate the often schizophrenic view of employers in the history of public health. On the one hand, employers have been blamed for numerous public health problems, ranging from injuries resulting from unsafe and unsanitary working conditions in factories to poor air quality in cities—an undesirable byproduct of manufacturing and commerce. On the other hand, many analysts have recognized that personal and community health is directly tied to income, housing, and health insurance benefits, which are supported by jobs provided by employers and a strong tax base in communities. While it is perhaps not surprising that employers could be viewed as both villain and champion in the eyes of special interest groups and the media, this schizophrenic view has also characterized public health policy circles. For example, the Institute of Medicine's landmark 1988 report, *The Future of Public Health in America*, hardly mentioned employers, yet they received their own chapter and were identified as key public health partners in the IOM's 2003 follow-up report, *The Future of the Public's Health in the Twenty-first Century*.

Questions / Discussion?