Celebrating Success: Wrap-Up Webinar

Value-Based Payment Practice Transformation Academy

Tuesday, July 17, 2018 11:30 a.m. PST

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Call Logistics

We recommend calling in **on your telephone**, but your can also use your computer audio option

Remember to enter your Audio PIN so others can hear you

Please mute your line when you are not speaking since we will have lines open throughout the call

This button should be clicked if you're calling in by telephone.

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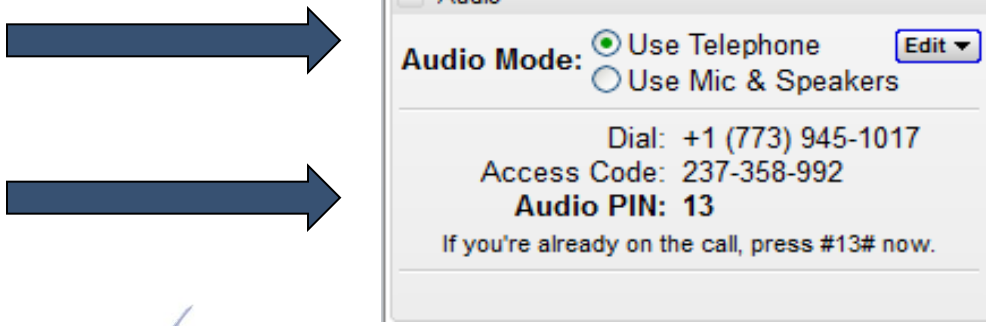

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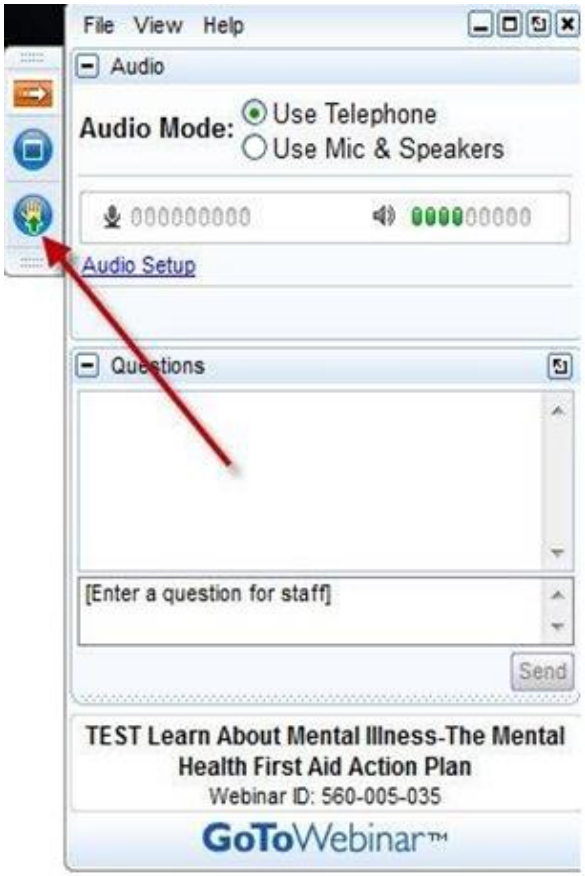
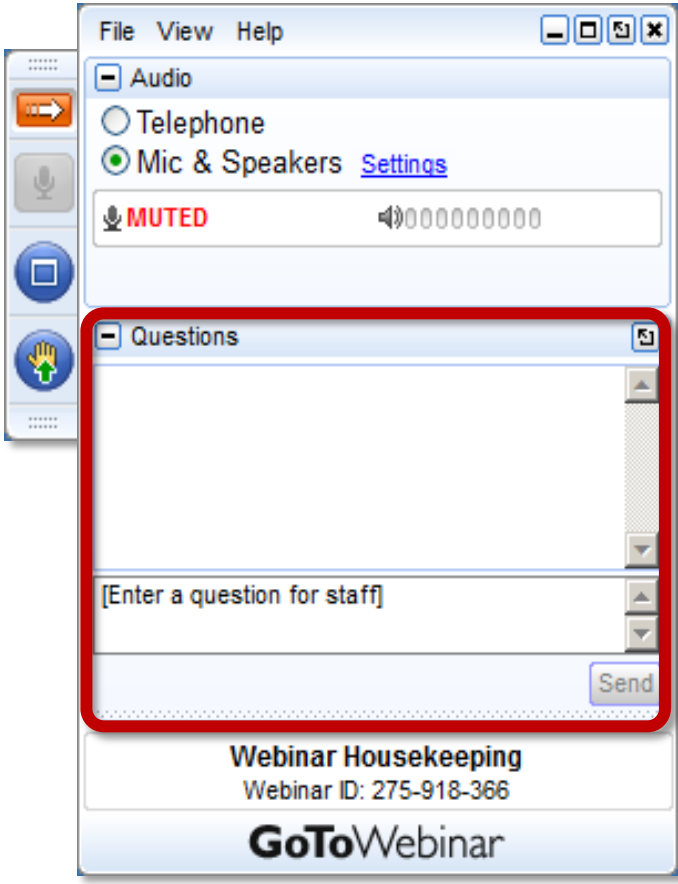
How to Ask a Question



Prefer to write?

Type into the question box and click "send."



On the phone?

"Raise your hand" and we will open up your lines for you to ask your question to the group.

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Agenda

- Opening Remarks
- Journey through the Practice Transformation Academy
  - What We've Covered
  - Progress on VTA
- Organization Reflections
- Next Steps

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WA Council Opening Remarks

- Thank you to all!
  - Participating agencies
  - National Council faculty and coaches
  - Practice Transformation Support Hub
  - Funders: Healthier Washington/HCA/DOH, DBHR, Transforming Clinical Practices Initiative
- Impressive progress on VBP readiness milestones as reflected by the VTA scores.
- Rich array of stretch project focus areas and lessons learned.
- Congratulations!

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What We've Covered

- Risk stratification
- Data-driven decision making

- Organizational change
- Project planning

- Contracting
- Value propositions

And much more based on your individual stretch project and coaching calls!

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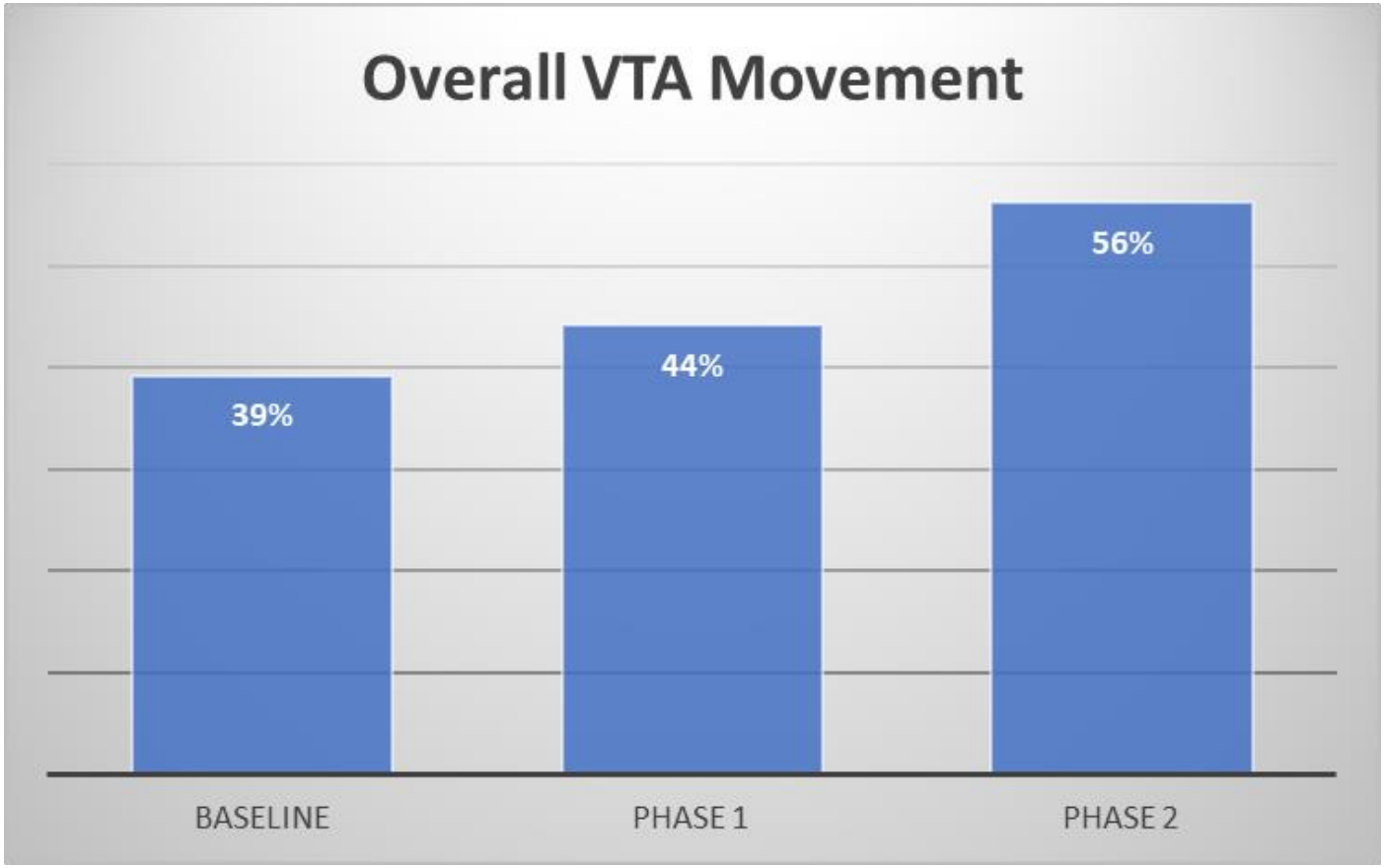
Progress on the Value Transformation Assessment (VTA)

Initial, Mid-Point, and Final VTA Comparison

Overall VTA Movement



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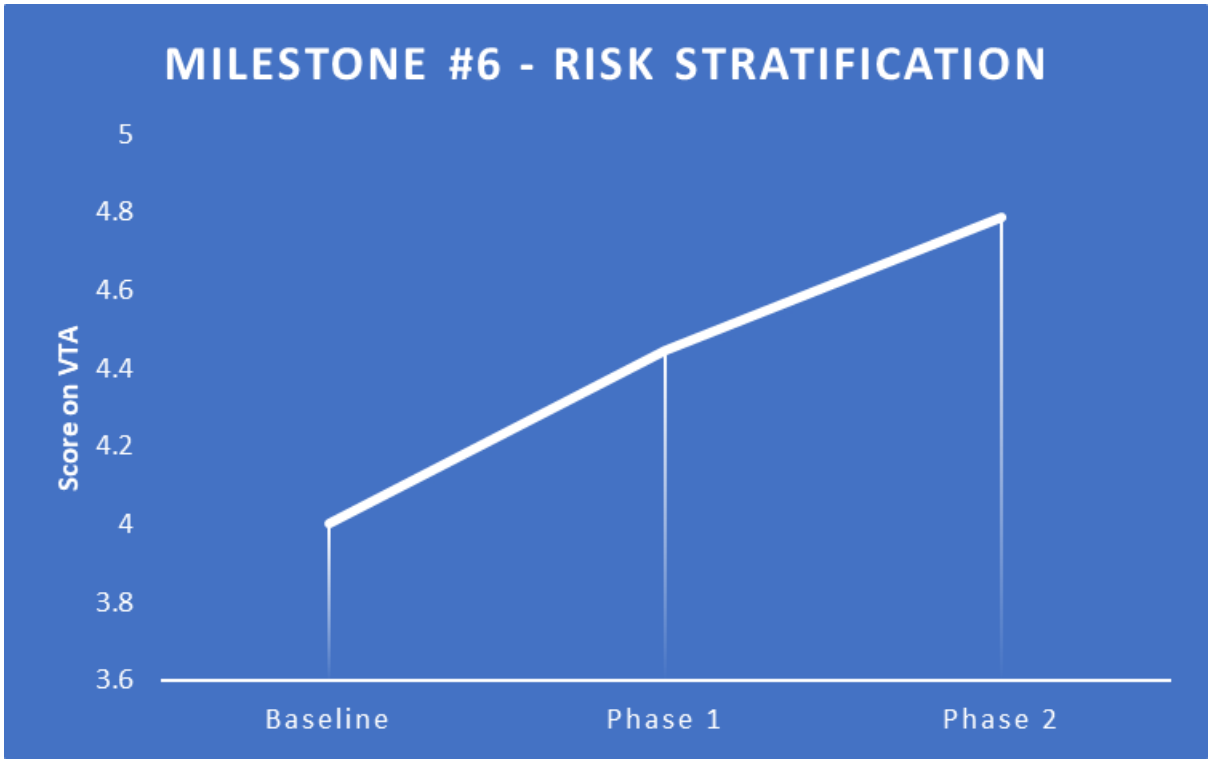
MILESTONE #6: Risk Stratification

Tracking of vulnerable patient groups that require additional monitoring and intervention



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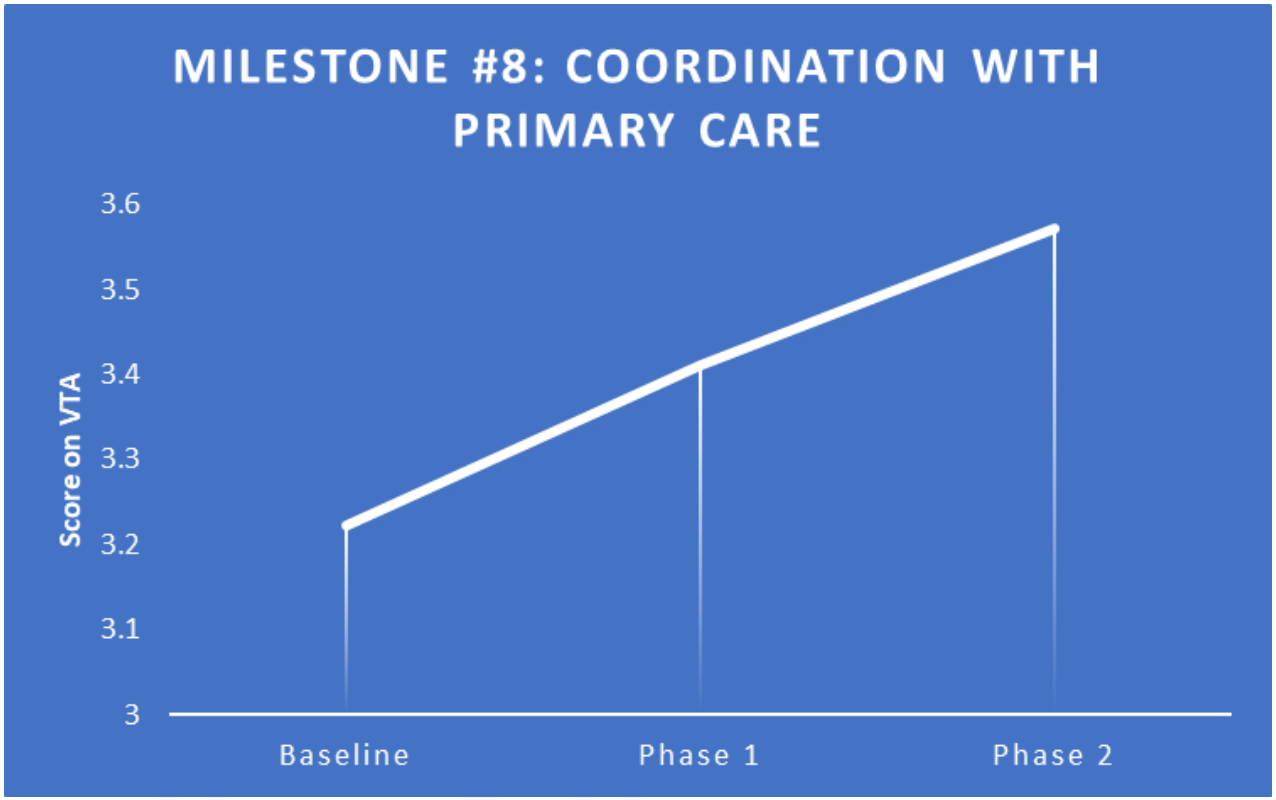
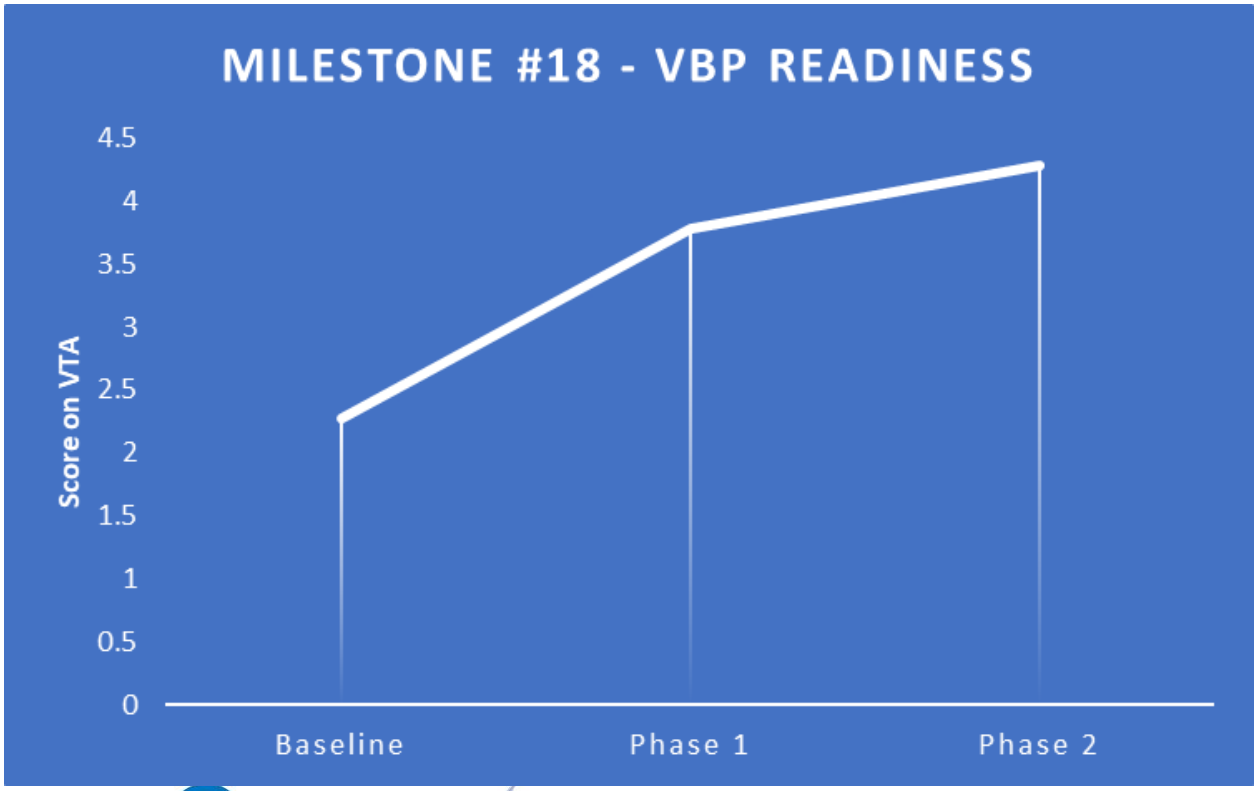
MILESTONE #8: Coordination with Primary Care

Practice works with the primary care practices in its medical neighborhood to develop criteria for referrals for episodic care, co-management, and transfer of care/ return to primary care, processes for care transition, including communication with patients and family.



MILESTONE #18: VBP Readiness

Practice considers itself ready for migrating into an alternative based payment arrangement.



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Milestones Showing Most Improvement Throughout Project

% Improvement from Baseline	Milestone
26.63%	**Milestone 12** - Practice uses an organized approach (e.g. use of PDSAs, Model for Improvement, Lean, FMEA, Six Sigma) to identify and act on improvement opportunities.
26.54%	**Milestone 11** - Practice has developed a vision and plan for transformation that includes specific clinical outcomes and utilization aims that are aligned with national TCPI aims and that are shared broadly with the practice.
22.31%	**Milestone 18** - Practice considers itself ready for migrating into an alternative based payment arrangement.
20.72%	**Milestone 10** - Practice has a system in place for patient to access their care team 24/7.

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Milestones Showing Least Improvement Throughout Project

% Improvement from Baseline	Milestone
3.88%	**Milestone 8** - Practice works with the primary care practices in its medical neighborhood to develop criteria for referrals for episodic care, co-management, and transfer of care/ return to primary care, processes for care transition, including communication with patients and family.
5.11%	**Milestone 15** - Data systems/patient records
6.22%	**Milestone 9** - Practice identifies the primary care provider or care team of each patient seen and (where there is a primary care provider) communicates to the team about each visit/ encounter.
8.02%	**Milestone 20** - Funding sources and resources

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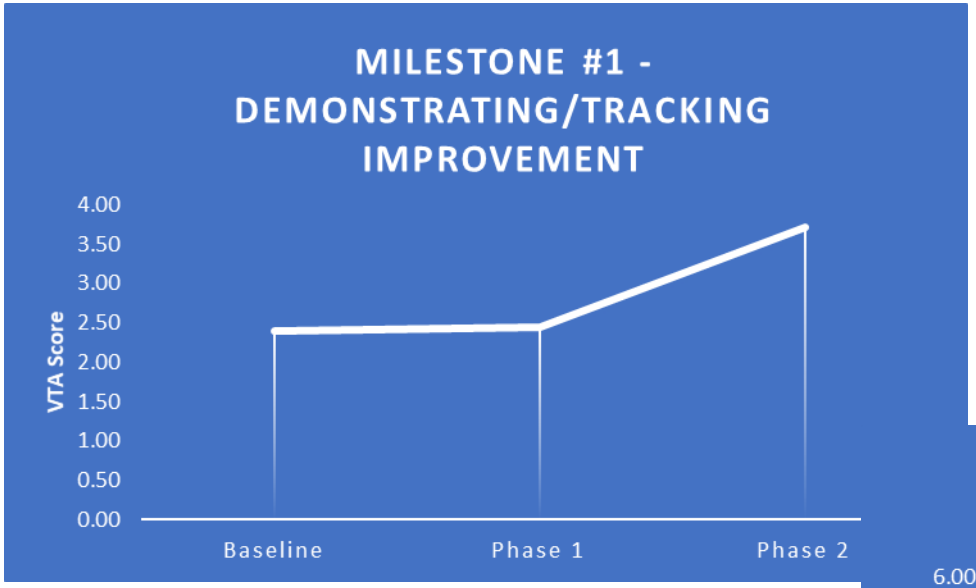
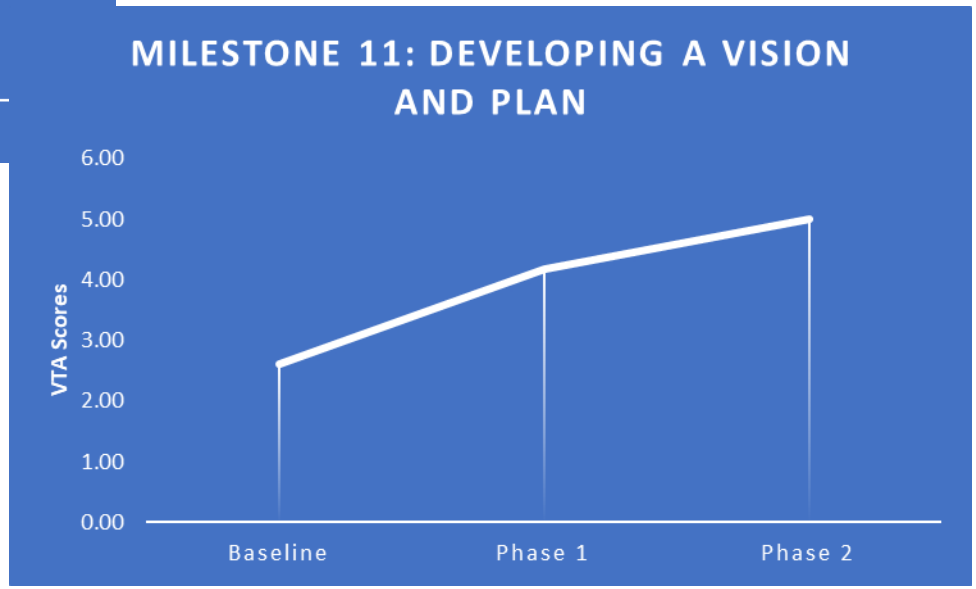
Other Notable Successes





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ORGANIZATIONAL REFLECTIONS

Organizational Reflections

- Accomplishments
- Lessons Learned
- Sustainability Plan

- Logistics:
  - Each organization will have four minutes to present
  - Will notify speakers when one minute is remaining
  - Will advance slides for you and unmute your line

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Valley Cities Behavioral Health

Accomplishments

- Developing Care Pathways Logic Models and Unit Cost Analysis
- Establishing Operations Metrics and Reporting (EMR executive dashboard)
- Establishing Client Pathways Metrics and Reporting
- Developing Value Based Map for KC IPA
- Project Management Implementation Plan for Agency

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Lessons Learned

- Aligning metrics and care pathways with initiatives defined by the BHO versus our program requires knowledge of MCO vision
- Targeted staff training to support understanding their role in the process will be critical
- We need longitudinal data to know agency outcomes by care pathway to negotiate VBP contracts for stratified populations

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Sustainability Plan

- Training care teams and developing standards of practice
- Building out from Executive Dashboard
  - Director, Manager, Clinician Dashboards to inform and define transformation to value-based payment

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Catholic Charities

Accomplishments

- Used the Value Transformation Assessment as a baseline for healthcare transformation.
- Integrated these measures into our Quality Management Plan (QMP) which was adopted by the Board of Directors for division wide implementation.
- Started construction on an integrated (primary care, behavioral health and substance use treatment) center in Wenatchee.

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Lessons Learned

- Data drives decisions and is needed to demonstrate our value proposition.
- Its important to build consensus and communicate to staff what healthcare transformation is and their role.
- Plan long-term. We've developed a Quality Management Plan that is focused on changes with the division over the next three years.
- Set achievable goals

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Sustainability Plan

- Integrated clinic opens in September 2018
- Implementation of our stretch project, “Patient Registry.”
- Embedded data analysis into the development of projects on the front end.

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Catholic Community Services of Western Washington

Accomplishments

- In relation to your stretch project and value-based payment transformation, what have you achieved over the last year? This can be both quantitative/measurable (e.g., metrics) and qualitative outcomes and accomplishments.
- Recognized the importance of being able to clearly demonstrate outcomes that are in line with the Triple Aim.
- Selected a new EHR that will better support data analysis.
- The new EHR will be fully implemented by January 1st, 2019.

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Lessons Learned

- What lessons have you learned from planning for and implementing your stretch project that you intend to apply to future value-based payment practice transformation efforts?
- The importance collecting data that demonstrates the value of clinical work as we enter into integrated and values-based model.
- The importance of sharing data with staff.
- The importance of quantifying data and setting benchmarks for improvement.

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Sustainability Plan

- What are your next steps for your stretch project and for your organization's transformation to value-based payment?
- We are in the midst of developing and configuring a new EHR, and we plan to integrate many of these data elements and assessment tools into the system. We also plan to develop patient registries and care pathways based on standard risk assessments.
- In addition, we are working to develop strong relationships with neighboring primary care/pediatric care providers in effort to increase bi-directional care for clients served.

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Compass Health

Accomplishments

During 2018, Compass Health has been improving internal systems (new electronic health records and financial accounting software) in order to define, capture, measure, and report outcomes and accomplishments. This is a transformational change for Compass Health.

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Lessons Learned

As our organization was working through the stretch project, the planning tools were helpful.

- The roadmap was well written, easy to follow, and included helpful links.
- The value-based payment practice transformational planning guide is a useful tool and will be a great resource going forward.
- Overall, walking through the stretch project/care pathway development, root cause analysis, and key metric and input data was helpful in the overall process.

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Sustainability Plan

Compass Health will continue to assist with reducing untreated substance use disorders in our adult mental health population. This will continue to be a goal for our organization. The tools learned will be helpful for successful collaboration and treating whole person health.

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Downtown Emergency Service Center (DESC)

Lessons Learned

- Diving into the project we discovered pressing issues that needed to take priority.
- Things may not always take off as planned and we need to implement a more agile project management style.
- We spent too much time anticipating and focusing on staff reaction to service intensity requirements. We failed to seek buy in from effected staff earlier on in the process.

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Accomplishments

- Identified service intensity protocols for case management staff.
- Created a new process and policy for data staff to ensure benefits are renewed on time.

Sustainability Plan

- Focusing back on the original project plan and taking the project to scale.
- Finding innovative ways to track and define what is considered a successful outcome for our population base.
- Collaborate with King County HealthierHere on their transformation projects to ensure appropriate measures and outcomes are established for the population we serve.

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Frontier Behavioral Health

Accomplishments

- Have jointly identified, and begun to implement, strategies for integration with physical healthcare partners, including how to address issues related to privacy, technology, care coordination, sharing of information, client engagement and referrals.
- Have begun to track and analyze re-hospitalization data.
- Are in the process of selecting a data analytics vendor.
- Have engaged a consultant assist in development of costing models for various services.

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Accomplishments (cont'd)

- Regular communication with leadership, management and other staff as appropriate related to preparation for IMC and VBP.
- Have been very engaged in our region's Accountable Community of Health processes, including accessing Medicaid Transformation funding.
- Have implemented a Open Access Improvement project to ensure individuals are better prepared for treatment, decrease the no show rate for the first outpatient appointment, and to determine if individuals are successfully completing treatment within an appropriate time frame.

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Lessons Learned

- The immediate need for reports that captures specific data to drive decision making.
- Having a dedicated person who can analyze the data so decision making can occur in real time.
- Implementing a stretch project in one program area before populating across all program areas in the agency allows for a more efficient PDSA process.
- Creation and use of a template that standardizes the documentation of a stretch project for future projects.

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Sustainability Plan

- Analyze the results and implement changes on a permanent basis with the Stretch Leader monitoring if future changes and the reconvening of the team is needed
- Solidify strategies for partnering with physical healthcare partners via Partnering Provider Plans.
- Select data analytics vendor and begin to build out capability to utilize, including performance and outcome dashboards and notifications; preliminary work toward development of patient registries.
- Complete development of costing model for various service areas.
- Initiate discussions with MCOs/BH-ASO regarding integrated care efforts and future VBP models

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Greater Lakes Mental Healthcare

Accomplishments

- Through our participation in the VBP academy, we have increased our knowledge regarding value based contracts and the associated requirements/considerations.
- We have shifted our thinking from quantity of service to quality of service and outcomes.

Accomplishments (cont'd)

- In our first project, we developed a value based clinical protocol with associated metrics. This involved a protocol to deliver more intensive clinical and prescriptive services to individual adult with higher PHQ9 scores. The desired outcome was that by providing more intensive services and psychotropic meds that the level of depression would be reduced. Due to a misunderstanding on our part, we believed the project timeline to be shorter than it was, and concluded the project at an earlier juncture. The client scores did in fact improve, although we might have achieved an even better result had we allowed the project to go on longer.

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Lessons Learned

- Don't jump into an incomplete or poorly designed proposal due to pressure to establish a contract.
- A thorough business assessment is important to ensure that the proposal is of equal benefit to the client, the MCO and the provider.
- A sufficient population size is necessary to make a business case for any downside risk to the provider.
- Also required prior to accepting downside risk is a more complete picture of the client population to be served, i.e., demographics, utilization rates, etc.

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Lessons Learned (cont'd)

- VBP contracts have the potential to be exceedingly complex, with multiple partners (pharmacy, clinical and MCO), and may involve jargon, terms and concepts that are less well known to behavioral health providers.
- Caution and consultation are advised when considering a VBP contract, especially one with downside risk, with a huge, nation-wide MCO who is expert in the business models, has all the data and holds all the cards.

Sustainability Plan

- Our next steps will be to begin to have these sorts of value-based conversations with the MCOs.
- We fully expect that since they are required to have VBP contracts with providers, that we will be partnering with them to develop these contract designs.
- We also recognize that we have a great deal to learn, and that we absolutely need to be in a position to have utilization data, along with population health data available to us.
- We believe that with our upcoming affiliation with MultiCare Health system, we will be in a better position to develop the data flows and skill sets required for successful VBP contracts.

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Kitsap Mental Health Services

Stretch Project November 2017

Goal: Reduce the number of avoidable ED visits and unnecessary (general) hospitalizations by 5%.	1. Reduced emergency department visits 2. Reduced hospitalization rates	Medicaid Data	Early intervention and managed disease results in health improvements
Objectives/Outcomes: 100% of patients will be referred for a primary care wellness visit; 75% of client population will receive an annual PCP wellness visit.	1. Increased number of persons completing PCP wellness visit	EHR	Preventative wellness visits favorably impact health outcomes
100% of patient charts note patient has been provided information regarding alternatives to the emergency room for non emergent visits			
Outputs: To increase care coordination clients will be encouraged to complete an ROI with their PCP for bidirectional care. 100% of clients will be referred to chornic disease self management programs and/or education.	1. 100% of patients have established a PCP and have completed annual visit	EHR	Regular PCP visits help prevent and manage chronic disease care coordination is improved with provider to provider communication
Activities: Create patient registry that can identify, track over time, and treat to target each of the following chronic diseases: a) prediabetes, b) diabetes, c) hypertension, d) obesity. Identify operational workflows to support risk stratification processes	1. Registries created 2. Staff implementing workflows	EHR Organizational protocols	Patient registries are an evidence based practice that allows targeted interventions according to risk and improve care management

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Accomplishments Specific to Selected Project: Pediatric Asthma among children with SED

- FOCUS: Reduce ED visits through shared care coordination with PCMH and CBHA to include community based patient education/environmental controls to result in decreased avoidable ED visits for pediatric asthma

- ACHIEVEMENTS:
  - 3 formal MOAs for practice collaboration;
  - improved provider capacity for referral and information sharing, including warm hand offs for behavioral medication management
  - Developing shared registry

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Lessons Learned

- Projects focused on integration between practices are valuable in building relationships that go beyond scope of project, ie problem solving how to share information for coordination of care, how to ease warm hand-offs from specialty BH care to primary care and for referrals from primary care to specialty BH care
- Bridging the primary care system and BH system takes leadership, shared understanding of constraints, time to build out project details
- Measures exist on primary care side for physical health, still need to determine measures for behavioral health ie, anxiety, depression or other

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Sustainability Plan

- This response described a specific stretch project focus to reduce ED visits.
- **To move the agency overall toward VBP we have:**
  Hosted 3 VBP education sessions with Leadership Team, and with Management Team, instituted an agency-wide VBP design team as of March.
- **Next step is to focus on population health strategies** including risk stratification, selecting measures to be included in EHR so as to assure treat to target capacity, monitoring, and ability to move patient through recovery process, demonstrate improved patient outcomes, registries to be in place, staff trained to function in VBP environment.

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MultiCare Behavioral Health

Accomplishments

- Pilot group for depression care pathway has volunteers and energy (access, intake med services, treatment teams through discharge)
- We have data on PHQ-9 and CSSR-S
- Current operational process is understood & team is willing to adjust and improve
- The term VBP is part of our vocabulary
- Several disagreements which is healthy and allowed for shared accountability
- We have selected EPIC as our new future health record.

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Lessons Learned

- Identifying metrics (Financial, clinical, patient experience & employee engagement)
- Identifying stakeholders & constantly communicating
- Resistance to standardization exists
- Bringing all of the stakeholders together will require intentional process for implementation

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Sustainability Plan

- Formal presentation to providers on July 11
- Stakeholder meeting shortly thereafter
- Formal pilot planning & implementation team process of 4 working meetings
- Project management as we begin pilot in TBD go live date
- Comparing care pathway to general care approach
- Building reports to measure performance
- Plan, do, adjust rapid change model necessary

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Peninsula Behavioral Health

Accomplishments

- Quickly Determined what success would look like
- Got buy-ins from Administration, Leadership, and Providers
- Started with a manageable goal
- Utilized an easily measurable metric that is already being captured
- We were able to maintain our tracking tool over the course of the year
- Ended up with about 25 people we followed from IPE onward with about 9 of them successfully dropping PHQ 9 scores by at least 5 points (36%)
- Provider team was able to better understand the process of Value Based Care

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Lessons Learned

- We took the approach that understanding value-based care and imparting the idea that individual providers can impact improved patient care as well as improved reimbursement was far more important than the actual goal of the stretch project
- Meeting with Provider and Nursing Teams to review the HCA purchasing goals through 2021and discuss value-based principles was very helpful
- Getting active participation in the Logframe for our stretch project set the stage for success
- Had to change selection criteria some to better define our study population
- It is very hard to maintain the trending sheet in a busy practice

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Sustainability Plan

- We will continue to utilize this current trending data and look for other opportunities to expand into other measures
- Assessing new EHR to help trend metrics for us
- We need to include value based metrics in our protocols moving forward

Sea Mar Community Health Centers

Accomplishments

- Trained on utilization management skills (referrals to higher level of care, brief treatment)
- Organization-wide training for Integrated Mental Health Therapists on integrated workflow
- Standardized tools in primary care and behavioral health (PHQ2, PHQ9)

**At this time, we cannot report PHQ9 scores for clients at all sites.

  - From January through June 2018, of the clients referred to BH and that expressed interest in services, approximately 40% enrolled in services.
  - At the Des Moines clinic, 87.5% of clients improved after being referred and enrolling in services.

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Lessons Learned

- Creating and managing a client registry is essential to track client data and utilization management.
- Assessments and tools need to be adapted to and appropriate for the integrated care environment (i.e. shortened assessment).
- More communication is better than less communication in the implementation of changes.

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Sustainability Plan

- Sea Mar remodeled the integrated provider position and model.
  - The Integrated Mental Health therapist role can bill for services, conduct assessments, and do brief intervention
- Continue to seek funding sources that will sustain the integrated care model.

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Sound

Accomplishments

- Identified change opportunities
  - Generate usable data
  - Understand usability of data
  - Metric development
- Implemented change to address opportunities
  - Data analysis
  - Dashboards
  - Population and risk stratification
- Developed improved understanding of deliverables

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Lessons Learned

- Start small and scale with success
- Create manageable and realistic goals based on ability to deliver and or, meet project guidelines
- Develop alternative resources, or set limits on data challenges outside agency control
- Understand payers' needs and how our works meets those needs

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Sustainability Plan

- Implement what we have learned and developed in response to identified opportunities
- Reinitiate original project with a better defined and simplified population subgroup
- Build an improved value based proposition on data and outcomes that can now be generated

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Willapa Behavioral Health

Accomplishments

- Willapa Behavioral Health has achieved 25% reductions in MH hospitalizations and completion of 2 MeHAF agency assessments showing marked improvement across most dimensions toward the 5-9 end of the scale in preparation for primary care and behavioral health clinical integration along with VBP financial integration set for 1/1/2020 in GRBHO region.

Lessons Learned

- Lessons learned are to just really commit to using a Qualis coach and doing MeHAF and Billing and IT assessment to drive positive cultural and clinical delivery changes ahead fo the deadline for enough testing of new systems of care delivery. WBH intends to apply to future value-based payment practice transformation efforts to enlarge on our current practice improvements.

Sustainability Plan

- Willapa Behavioral Health's next steps for our stretch project are to re-evaluate all factors contributing to a 25% decrease in hospitalizations for MH clients. WBH is hiring more Admin/Billing/IT and Clinical staff to expand # of covered lives and have more bandwidth with operating Credible HER, billing daily and increasing clinical capacity and capability with covered lives to increase margin for our mission.

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Yakima Valley Farm Workers Clinic Behavioral Health Services

Accomplishments

- Clarified no show definition and established data collection
- Analyzed no show patterns
- Set up processes: immediate call back and streamlined rescheduling for no-shows
- Current no show rate for last three months of project is lower, averaged 14%

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Lessons Learned

- Benchmarks, data points and workflows all need to be established and documented
- Even with clearly defining no shows, reports may include unintended data and codes
- Changes in data entry undercut any meaningful comparisons across time periods
- Staff need lead time to change work processes
- Need dedicated time for data gathering and analysis

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Sustainability Plan

- Continue new work flow processes for on-going improvement
- Continue periodic analysis to track sustained improvement and identify problem areas
- Participate in all meetings with BHO, ACH, HCA, MCO, etc., etc., as part of the move to IMC
- Work with organization's managed care department incorporating value-based measures specific to behavioral health

Value proposition: Improving access to the continuum of whole-person healthcare at YVFWC

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Next Steps…

Next Steps

- Complete VBP Academy Evaluation
- Update logframes for stretch projects
- Continue coaching calls through August
- Implement your Sustainability Plan
- Continue progress on the VTA!

Questions? Email Joan Miller
JMiller@thewashingtoncouncil.org

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Thank you!

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