A Path to Value: Strategies for Developing Care Pathways

December 13, 2018

National Council for Behavioral Health
Montefiore Medical Center
Northwell Health
New York State Office of Mental Health
Netsmart Technologies
Today’s Presenters

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Goals for Today

✓ Define care pathways and their key components;
✓ Explain how care pathways fit into population health management;
✓ Identify roles of care team members in operationalizing care pathways; and,
✓ Apply the care pathway development steps in their own provider setting.
✓ Discuss next steps
### CMS Change Package: Roadmap for Transformation

<table>
<thead>
<tr>
<th>Category</th>
<th>1.1 Patient &amp; family engagement</th>
<th>1.2 Team-based relationships</th>
<th>1.3 Population management</th>
<th>1.4 Practice as a community partner</th>
<th>1.5 Coordinated care delivery</th>
<th>1.6 Organized, evidence-based care</th>
<th>1.7 Enhanced access</th>
<th>2.1 Engaged and committed leadership</th>
<th>2.2 QI strategy supporting a culture of quality and safety</th>
<th>2.3 Transparent measurement and monitoring</th>
<th>2.4 Optimal use of HIT</th>
<th>3.1 Strategic use of practice revenue</th>
<th>3.2 Staff vitality and joy in work</th>
<th>3.3 Capability to analyze and document value</th>
<th>3.4 Efficiency of operation</th>
</tr>
</thead>
</table>
"The concept of value-based health care purchasing is that buyers should hold providers of health care accountable for both cost and quality of care. Value-based purchasing brings together information on the quality of health care, including patient outcomes and health status, with data on the dollar outlays going towards health. It focuses on managing the use of the health care system to reduce inappropriate care and to identify and reward the best-performing providers. This strategy can be contrasted with more limited efforts to negotiate price discounts, which reduce costs but do little to ensure that quality of care is improved."

The Value Equation

VALUE = Quality / Cost = Outcomes + Patient Experience

Direct Costs + Indirect Costs

Care Transitions Network
for People with Serious Mental Illness
Value Based Model Risk

Utilization Risk –

• The estimate of the amount of service that the covered population will use/require (e.g., average lengths of stay, average visits per case, & use of levels of care) is wrong.

• Utilization risk is the possibility that you and the provider organization you contract with will use/require significantly more care than you estimated.

• Right Care, At the Right Time, For the Right Consumer
<table>
<thead>
<tr>
<th>Screening &amp; Assessment</th>
<th>Level of Engagement</th>
<th>Level of Service Criteria/Cost</th>
<th>Service Bundle</th>
<th>Length of Care/Time to Tx</th>
<th>Target Parameters</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Male, 25 yrs old</td>
<td>Maintenance/Relapse Prevention</td>
<td>Low Intensity/$</td>
<td>Medication, Cog. Beh. Therapy</td>
<td>Low Intensity</td>
<td>Smoking Cessation or Reduction</td>
</tr>
<tr>
<td>Substance Addicted (nicotine)</td>
<td>Action</td>
<td>Moderate Intensity/$$</td>
<td>Smoking Cessation, Care Management</td>
<td>Moderate Intensity 9-18 Months</td>
<td>BP w/in Normal Range</td>
</tr>
<tr>
<td>Depressed</td>
<td>Preparation</td>
<td>Supported Employment Assistance</td>
<td>Supported Employment Assistance</td>
<td>High Intensity</td>
<td>PHQ-9 Score &lt;10</td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td>Precontemplation &amp; Contemplation</td>
<td>Housing Assistance</td>
<td>Housing Assistance</td>
<td>High Intensity 18-28 Months</td>
<td>Appt’s Kept</td>
</tr>
<tr>
<td>Unemployed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>No Hosp. &amp; ED Use</td>
</tr>
<tr>
<td>Homeless</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Employment</td>
</tr>
</tbody>
</table>

**Level of Service**
- Low Intensity/
- Moderate Intensity/$$
- High Intensity/$$$

**Length of Care/Time to Tx**
- Low Intensity 0-9 Months
- Moderate Intensity 9-18 Months
- High Intensity 18-28 Months
Where do Care Transitions Occur in the Day-to-Day Work of the Clinic?
What is a Care Pathway?

A protocol based/standardized set of clinical & administrative work flow process steps that staff engage in to assist a consumer with a social determinant, physical and/or behavioral health need.

A care pathway operationalizes care management components into replicable, measurable work flow steps.
What is a Care Pathway?

A defined path to health comprised of both clinical & administrative steps/workflows, including:

• Consumer engagement

• Screening, assessment & stepped evidence-based treatment with clearly defined treat-to-target parameters

• Interdisciplinary team-based care which employs population health management techniques

• Ongoing quality improvement to assess effectiveness & efficiency of the pathway
The Care Pathway in Context

Two critical components of care pathway development and execution are:

• Team-based Care
• Population Health Management
5 Components of Effective Interdisciplinary Teams

1. Defining appropriate team goals.
2. Clear role expectations for team members.
3. A flexible decision-making process.
4. The establishment of open, safe, communication patterns.
5. The ability of the team to “treat” itself.

What Makes a Google Team Effective?

The 5 key dynamics that set successful teams apart according to research.

1. **Psychological Safety**
   Team members feel safe to take risks and be vulnerable in front of each other.

2. **Dependability**
   Team members get things done on time and meet Google’s high bar for excellence.

3. **Structure & Clarity**
   Team members have clear roles, plans, and goals.

4. **Meaning**
   Work is personally important to team members.

5. **Impact**
   Team members think their work matters and creates change.

Research by: Google
Illustrated by: Larry Kim (@larrykim)
HUDDLE & TEAM MEETING: WHERE PHM & RS GET DONE!

Huddles & Team Meetings are an important practice change tool!

Although there are elements of successful and effective meetings, each clinic needs to determine, the form, shape, and process for their meetings.

EXAMPLE OF A HUDDLE AGENDA
✓ Review unfinished follow-ups from previous day
✓ Review status of clinic operations—staffing today, equipment or computer problems, any special events or meetings happening, any cancellations and open appointments
✓ Review schedule for the day and highlight any new cases in which BH needs to be involved
✓ Review any updates on patients with recent emergency or inpatient care and transition needs
✓ Identify patients for BHP intervention or rescreening with PHQ-9 or other tool.
✓ Discuss workflow challenges that need to be addressed.
✓ Review of registry for patients on the schedule and identification of follow-up needed that day
✓ Diagnostic or clinical updates for patients scheduled that day
✓ Celebrate!

EXAMPLE OF A TEAM AGENDA
✓ Celebrate!
✓ Review Population Level Data for all SDOH & clinical Conditions
✓ Case presentations
✓ Identify team process concerns that need to be discussed in team meeting.
✓ Review Care Pathway Elements/Processes that need Improvement/Change

CORE ELEMENTS
▶ Set agenda
▶ All members of the team attend
▶ Regular schedule
▶ Data Driven
Population Health Management Requires

1. Knowing what to ask about your consumer/population
2. Data registry with dashboards to describe/risk stratify your consumer/populations
3. Teams able (e.g., huddles/team meetings, supervision, analytically capable, etc.) to respond to the findings for a consumers/populations
4. Continuous quality improvement policies/procedures to change the care pathway when populations are not improving or cost/time is not on target/within specification
Care Pathway Assessment

The Successful Care Pathway:

• Standardized with protocols/procedures based in policy
• Supervisors are responsible for monitoring pathway fidelity
• For each step in the path the data collected, the time required to complete the step and the cost/billing source is identified
• Risk stratification determinations are clearly described in protocols to allow for stepping consumers up to more intensive services
• Clinical and administrative data dashboards are used to aggregate and easily convey risk, progress/lack of progress toward targets...lack of efficiency and effectiveness.
What are the steps to create a care pathway?

1. Choose a clinical condition or social determinant need
2. Define the patient population
3. Convene an inter-disciplinary team
4. Define the target outcome(s)
5. Review the evidence base
6. Map the care pathway
7. Develop clinical & administrative protocols
8. Pilot the care pathway
9. Evaluate the efficiency & effectiveness of the care pathway
10. Ongoing monitoring of the care pathway metric specifications

Care Pathway Development Example

1. Choose a clinical condition or social determinant need
   Let’s look at Depression

2. Convene an inter-disciplinary team
   You are here today w/ your team!

3. Define the target outcome(s)
   Clinically significant PHQ 9 Score dropping 10 pts w/in 3 months; No suicidal ideation

4. Define the patient population
   Adults with Serious Mental Illness

5. Review the evidence base
   PHQ9 & Columbia Guidelines; Depression Medication Algorithm; Individual & Group CBT; Case Management; Peer Coaching; Primary Care Coordination; Family Psychoeducation (as indicated)
Step 5. Review the Evidence Base/Depression Treat to Target Metrics

**Number of Clients Screened:** Screen all patients (some agencies will exclude people with bipolar disorder but must make sure have replacement screener) at least quarterly if not at every visit using PHQ 2 or 4.

<table>
<thead>
<tr>
<th>Numerator:</th>
<th># clients screened</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator:</td>
<td>all clients served – excluded clients</td>
</tr>
</tbody>
</table>

**Clients that Screen Positive Receive Follow-up Care:** Those that screen positive (e.g., PHQ 9 score ≥ 10) receive treatment.

<table>
<thead>
<tr>
<th>Numerator:</th>
<th>Number of clients with depression treatment plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator:</td>
<td># clients screening positive</td>
</tr>
</tbody>
</table>

**Clients with Positive Score on PHQ-9 Improve:** For those that screen positive, have they improved over a three-month period?

<table>
<thead>
<tr>
<th>Numerator:</th>
<th># clients with score improvement after three months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator:</td>
<td># clients screening positive w/ a treatment plan</td>
</tr>
</tbody>
</table>
## Depression Dashboard

### TRACKING PROGRESS AND ADJUSTING TREATMENT APPROACH

<table>
<thead>
<tr>
<th>View</th>
<th>Treatment Status</th>
<th>Name</th>
<th>Date of Initial Assessment</th>
<th>Date of Most Recent Contact</th>
<th>Number of Follow-up Contacts</th>
<th>Weeks in Treatment</th>
<th>Initial PHQ-9 Score</th>
<th>Last Available PHQ-9 Score</th>
<th>% Change in PHQ-9 Score</th>
<th>Date of Last PHQ-9 Score</th>
<th>Initial GAD-7 Score</th>
<th>Last Available GAD-7 Score</th>
<th>% Change in GAD-7 Score</th>
<th>Date of Last GAD-7 Score</th>
<th>Psychiatric Consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td>View</td>
<td>Active</td>
<td>Albert Smith</td>
<td>8/13/2015</td>
<td>12/1/2015</td>
<td>7</td>
<td>29</td>
<td>18</td>
<td>17</td>
<td>-6%</td>
<td>12/1/2015</td>
<td>14</td>
<td>10</td>
<td>-29%</td>
<td>12/1/2015</td>
<td>1/27/2016</td>
</tr>
</tbody>
</table>

*FREE UW AIMS Excel® Registry ([https://aims.uw.edu/resource-library/patient-tracking-spreadsheet-example-data](https://aims.uw.edu/resource-library/patient-tracking-spreadsheet-example-data))*
Metrics that are used in all Care Pathways

• Care Coordination
• Services use
• Risk Score
• Treatment Plan Goal Progress or Completion
• Cost
• Others?
What is meant by “Transitions of Care”?

The movement of patients between health care locations, providers, or different levels of care within the same location, as their conditions and care needs change.

- **Across health states**: e.g., palliative care to hospice, or personal residence to assisted living.
- **Between providers**: e.g., PCP to a psychiatrist, or acute care provider to a palliative care specialist.
- **Within settings**: e.g., primary care to specialty care team, or intensive care unit (ICU) to ward/department.
- **Between settings**: e.g., inpatient hospital to outpatient care, or ambulatory clinic to senior center.

Source: NTOCC
Elements of Transitions of Care

Seven Essential Elements:

1. Medication Management
2. Transition Planning
3. Client and Family Engagement
4. Information Transfer
5. Follow-Up Care
6. Healthcare Provider Engagement
7. Shared Accountability Across Providers and Organizations

Source: NTOCC's Seven Essential Elements of Transitions of Care
Care Transition (CT) Elements and Associated Metrics

**Elements**

1. Medication Management
2. Transition Planning
3. Client and Family Engagement
4. Information Transfer
5. Follow-Up Care
6. Healthcare Provider Engagement
7. Shared Accountability across Providers and Organizations

**Metric Examples**

1. Prescriptions filled by client
2. Number of CT meetings between CMH/hospital
3. Number of CT meetings with client/family/CMH/Hospital staff
4. CCD shared between providers
5. Appt scheduled within 7 days of hospitalization
6. Number of no-shows
7. Metrics defined in BAA
Care Transition Target Metrics

**Follow-up within 7 days of hospital discharge:** All clients admitted to the hospital will be seen by a BH professional within seven days of discharge from the hospital

Numerator: # clients seen within 7 days
Denominator: all clients admitted to the hospital

**Clients admitted to the hospital will have at least one care transition meeting:** All clients admitted to the hospital will have at least one Care Transitions meeting attended by ABC Hospital and XYZ staff

Numerator: # clients admitted to hospital how at least one CT meeting
Denominator: all clients admitted to the hospital

**Other metrics could be created based on what you and your transition of care partner decide!**
# Depression Dashboard with Care Transition Data

**TRACKING PROGRESS AND ADJUSTING TREATMENT APPROACH**

<table>
<thead>
<tr>
<th>View</th>
<th>Treatment Status</th>
<th>Name</th>
<th>Date of Initial Assessment</th>
<th>Date of Most Recent Contact</th>
<th>Number of Follow-up Contacts</th>
<th>Weeks in Treatment</th>
<th>Date of Admit to PCC Hospital</th>
<th>Date of Discharge from PCC</th>
<th>CT Meeting</th>
<th>IJ/Ha</th>
<th>TAY/Ha</th>
<th>Initial PHQ-9 Score</th>
<th>Last Available PHQ-9 Score</th>
<th>% Change in PHQ-9 Score</th>
<th>Initial GAD-7 Score</th>
<th>Last Available GAD-7 Score</th>
<th>% Change in GAD-7 Score</th>
<th>Flag</th>
<th>Most Recent Psychiatric Case Review Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rho</td>
<td>Active</td>
<td>Beverly</td>
<td>11/1/2016</td>
<td>11/12/2017</td>
<td>0</td>
<td>3</td>
<td>No Soon</td>
<td></td>
<td></td>
<td>10</td>
<td>0</td>
<td>-100%</td>
<td>11/20/2018</td>
<td></td>
<td>14</td>
<td>1</td>
<td>-95%</td>
<td></td>
<td>19/10/2018</td>
</tr>
<tr>
<td>Mr</td>
<td>RP</td>
<td>John Doe</td>
<td>1/18/2016</td>
<td>11/16/2016</td>
<td>12</td>
<td>13</td>
<td></td>
<td></td>
<td></td>
<td>20</td>
<td>0</td>
<td>-20%</td>
<td>19/10/2018</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>19/10/2018</td>
</tr>
<tr>
<td>Mr</td>
<td>Active</td>
<td>Susan</td>
<td>5/20/2016</td>
<td>1/2/2017</td>
<td>10</td>
<td>15</td>
<td></td>
<td></td>
<td></td>
<td>22</td>
<td>15</td>
<td>-3%</td>
<td>19/10/2018</td>
<td>1%</td>
<td>14</td>
<td>-2%</td>
<td>19/10/2018</td>
<td></td>
<td>19/10/2018</td>
</tr>
<tr>
<td>Mr</td>
<td>Active</td>
<td>Joe Smith</td>
<td>11/1/2016</td>
<td>1/18/2017</td>
<td>5</td>
<td>11</td>
<td></td>
<td></td>
<td></td>
<td>15</td>
<td>0</td>
<td>-40%</td>
<td>11/20/2018</td>
<td></td>
<td>14</td>
<td>7</td>
<td>-8%</td>
<td></td>
<td>19/10/2018</td>
</tr>
</tbody>
</table>

**FREE UW AIMS Excel® Registry** ([https://aims.uw.edu/resource-library/patient-tracking-spreadsheet-example-data](https://aims.uw.edu/resource-library/patient-tracking-spreadsheet-example-data))
Step 6. Map the Care Pathway

A. A care pathway workflow is a sequence of connected clinical and administrative process steps diagramed/flowcharted to explain the movement of materials, information, or people through a process that has clearly defined start and stop points.

   Did you get all the clinical & administrative steps diagramed?

B. Promotes understanding of each team member’s role(s).

   Did you identify what members of the team do what in the workflow?

C. Clarifies the process and outcome measures being used to collect data and report findings as part of a population health management and risk stratification approach?

   Did you define the measurement tools and data to be collected? Did you explain how it will be collected, analyzed, and shared?

D. Estimates the cost associated with providing the service.

   Does the workflow indicated what is billable and what is not so a cost estimate can be obtained?
For each Step Write Down What Data is Collected and Where it is Entered

For each Step Write Down the costs (Salary/Supplies/Overhead) and How it is Paid for (Grant, Billing Code)

For each Step Write Down the Time it Takes on Average to be Completed
Critical for Effective Billing

4.0 REGISTRATION FOR PRIMARY CARE: Train consumer on getting

- Demographics
- HIPAA Release
- Patient Rights
- Insurance/Income
- Consent to Treatment
- Medical History

Makes an appointment for the next day if PAR not in or takes paperwork to PAR who makes appointment

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Diagnosis Code</th>
<th>Credential</th>
<th>Who/Rate/Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPST – 51% in community</td>
<td>Behavioral Health Diagnosis</td>
<td>LMHP, MD, APRN CNS</td>
<td>$20.28/15 minutes</td>
</tr>
<tr>
<td>Community Support Service Under</td>
<td>Behavioral Health Diagnosis</td>
<td>LMHP, MHP or MHS under</td>
<td></td>
</tr>
<tr>
<td>Rehab Option – PSR – Skill</td>
<td></td>
<td>supervision of</td>
<td></td>
</tr>
<tr>
<td>Building</td>
<td></td>
<td>LMHP</td>
<td>$12.50/15 minutes</td>
</tr>
</tbody>
</table>

TIME NEEDED: 20 minutes
DOCUMENTED IN: MH/MR Clinical Record – Note must show rehab
XYZ CMHC & ABC Hosp: Transitions of Care Pathway

**Work Flow Metrics**

1. For each Step Write Down What Data is Collected and Where it is Entered
2. For each Step Write Down the costs (Salary/Supplies/Overhead) and How it is Paid for (Grant, Billing Code)
3. For each Step Write Down the Time it Takes on Average to be Completed

---

**ABC Social Worker (SW)**

1.0 SW registers clt. onto psychiatric unit; checks EMR to is if XYZ clt.

   1.1 XYZ clt.?

   **NO** → End

   **YES** →

   1.2 Discuss crisis plan w/ clt.; schedule CT meeting(s) w/ natural supports if indicated; schedule contacts w/ CT

   **Start/Stop**

   **Decision**

   1.3 Facilitate CT meeting/D/C meeting as indicated

   1.4 Coor. d/c plan to include outpt appt; meds through to psych rx appt;

   1.5 Conduct d/c meeting w/ natural supports and CM as indicated

---

**XYZ Care Manager (CM)**

2.0 Share clt’s CCD w/ ABC CM which includes crisis plan; Alerts team clt. in hosp; Schedules to attend hosp CT meeting

2.1 Review clt’s crisis plan follow steps (e.g., contacting natural supports; assit. w/ pets, housing needs, contact w/ employer, etc.)

2.2: Provide updates to clt. & ABC SW; attend CT meetings in person or via ph/video

2.3 Sched. CM/Rx’er appt w/in 7 days d/c

2.4 See clt. At CM/Rx’er appt
Managing Depression: Clinical Pathways in Primary and Behavioral Health Care

Foundational Performance Metrics:

- Screening Rate

90 Days following first PHQ-9 Administration:

- Percent of Patients with at least two PHQ-9s in Initial 90 Days Following First Out of Patients with at least one PHQ-9
- Percent of Standard Met in Initial 90 Days Out of Patients with at least two PHQ-9 Scores 90 Days preceding Last Administration of the PHQ-9
- Percent of Patients with at least two PHQ-9s in 90 Days Prior to Last Out of Patients with at least one PHQ-9
- Percent of Standard Met in 90 Days Prior to Last Out of Patients with at least two PHQ-9 Scores

Icon Key:

1. Indicates that Clinical Decision Support is in place to support movement along pathway.

Notes:

1. Negative on PHQ-2 is defined as a score of 0; Positive on PHQ-2 is defined as a score of 1-2.
2. Negative Response to PHQ-9 is defined as a score of 0-9; Positive Response to PHQ-9 is defined as a score of 10-27.
3. Active or File to History/Resolved is determined in accordance with guidelines included in Appendix A: Problem List Entry Guidance.
Conducting a Data Tracer to Help Map Your Care Pathway

Purpose of the Data Tracer exercise is to trace data from granular level/first collection through to aggregation/use.

1. What data point is collected?
2. Why is it collected?
3. When is it collected?
4. When is it reviewed, how & by whom?
5. How is it used by the consumer, consumer’s natural supports, care provider(s), administrator(s), funder(s) & accrediting bodies?
Data Tracer Example

• What is collected?: PHQ-9
• Why is it collected?: To screen & assess for depression & suicide; Required by state; Evidence-based practice/treatment
• When is collected?: Collected at intake & every visit thereafter if consumer scores positive otherwise given annually
• When is it reviewed, how & by whom?: Each session the clinician shows the consumer their score; At least wkly clinicians review scores to identify outliers; Supervisor reviews scores for caseloads at least monthly; Quarterly chart audits, Team huddles, Quarterly as part of team report to utilization review team & for upload to the state. Data are accessed by EMR data dashboard report
• Where is it collected?: Consumer fills out paper form in waiting room & form is reviewed by therapist. The score is entered into EMR
• Who uses the data?: Consumer uses it along with therapist & prescriber to chart progress in reduction of depression symptoms; Administration uses data to monitor strategic plan goal to achieve 80% of tx targets; State uses data to monitor CCBHC progress/effectiveness
Step 7. Develop Clinical & Amin. Protocols

<table>
<thead>
<tr>
<th>Clinical</th>
<th>Administrative</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Screening &amp; Assessment</td>
<td>• PHQ &amp; Columbia Data Entry</td>
</tr>
<tr>
<td>(PHQ-9 &amp; Columbia Suicide Screen; Clinical Interview)</td>
<td></td>
</tr>
<tr>
<td>• Level of Care Determination</td>
<td>• Biopsychosocial Documentation &amp;/or Progress Note</td>
</tr>
<tr>
<td>• Person-center Plan w/ Treatment Targets (includes family involvement &amp; crisis plan)</td>
<td></td>
</tr>
<tr>
<td>• Clinical Practices:</td>
<td>• Care Coordination Data Entry (e.g., referral, scheduling, data sharing)</td>
</tr>
<tr>
<td>• Cognitive Beh. Therapy</td>
<td>• Team Huddle</td>
</tr>
<tr>
<td>• Motivational Interviewing</td>
<td>• Individual &amp; Group Supervision</td>
</tr>
<tr>
<td>• Trauma Informed Care</td>
<td>• Billing &amp; Revenue Cycle</td>
</tr>
<tr>
<td>• Case Management</td>
<td></td>
</tr>
<tr>
<td>• Medication Therapy</td>
<td></td>
</tr>
<tr>
<td>• Family Psychoeducation</td>
<td></td>
</tr>
</tbody>
</table>
Next steps:

8. Pilot the care pathway:

Develop a plan for piloting the Care Pathway

• Identify a small group (team/patients) who will try it out
• For how long?
• Who will lead?
Finally:

9. Evaluate the efficiency & effectiveness of the care pathway
   • How will you know if the pathway is effective?
   • Have you built in your data points for reporting and for evaluating whether what you are doing is working?
   • What other services/community supports etc. do you need to make this plan effective (e.g., care coordination)?

10. Ongoing monitoring of the care pathway metric specifications
    • Once the Care Pathway is standard operating procedure make sure to use CQI tools to monitor it and insure it stays within specification.
This is all well & good…but now what...
How do we start?

You can’t know where you’re going unless you first know where you stand and where you want to go!

1. Conduct a baseline assessment for care pathway development to know where you stand!
2. Take inventory of your resources:
   a. Who are you (i.e., CEO, Middle Manager, Frontline Staff Champion)?
   b. How many resources do you have (i.e., staff, time, etc.)?
   c. What is realistic to be accomplished knowing a & b?
3. Define the SMART goal(s) (i.e., by XX date we will have accomplished X)
4. Develop your work plan and get to work!
**Care Pathway Worksheet/Assessment**

<table>
<thead>
<tr>
<th>Instructions: Each member of your team should fill out this worksheet on their own. Once all team members have completed the worksheet meet as a team and discuss your findings. Averaging the scores across team member can help target areas of Care Pathway strength and opportunity.</th>
<th>Agree</th>
<th>Mixed</th>
<th>Disagree</th>
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<tbody>
<tr>
<td>1.) Our organization has care pathway protocols describing the steps for how clinical conditions and social determinants of health needs are addressed through our services.</td>
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<td>2.) Our care pathway protocols include the collection, analysis, and monitoring of process and outcome measures specific to the clinical condition or social determinant need.</td>
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<td>3.) Our job descriptions describe the specific scope of practice for each member of the interdisciplinary team (i.e., clinical and administrative staff).</td>
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<td>4.) Our mental health, substance use disorder, and physical health care clinical pathway protocols are based on the latest evidence-based practice guidelines.</td>
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<td>5.) Our social determinants of health care pathway protocols are based on latest evidence-based practice guidelines.</td>
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<td>6.) Teams have access to service cost estimates for clients being served.</td>
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<td>7.) Teams have access to timeframe estimates for achieving clinical and social determinant need outcome metrics.</td>
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<td>8.) Our care pathways clarify the process and outcome measures being used to collect data and report findings as part of a population health management and risk stratification approach.</td>
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<td>9.) Teams have access to the process and outcome data collected in the care pathways.</td>
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<td>10.) A risk stratification process is clearly described in our care pathway protocol to help with decisions about stepping consumers up to more intensive services or down to less intensive services.</td>
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<td>11.) We are using clinical and administrative data dashboards to aggregate and easily convey data findings for individual clients and populations served.</td>
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<td>12.) Group and individual supervision include the monitoring of staff/team fidelity to the pathway protocols.</td>
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<td>13.) Our teams have regular huddle meetings to discuss clients who were just seen and about to be seen.</td>
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<td>14.) Our team has established open, safe, communication patterns.</td>
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<td>CMS Change Package: Roadmap for Transformation</td>
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<td>Patient and Family-Centered Care Design</td>
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<tr>
<td>1.1 Patient &amp; family engagement</td>
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<td><strong>1.2 Team-based relationships</strong></td>
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<td>1.3 Population management</td>
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<td>1.4 Practice as a community partner</td>
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<td><strong>1.5 Coordinated care delivery</strong></td>
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<td>1.6 Organized, evidence-based care</td>
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<td>1.7 Enhanced access</td>
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<td>Continuous, Data-Driven Quality Improvement</td>
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<td>2.1 Engaged and committed leadership</td>
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<td>2.2 QI strategy supporting a culture of quality and safety</td>
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<td>2.3 Transparent measurement and monitoring</td>
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<td>2.4 Optimal use of HIT</td>
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<td>Sustainable Business Operations</td>
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<td>3.1 Strategic use of practice revenue</td>
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<td>3.2 Staff vitality and joy in work</td>
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<td>3.3 Capability to analyze and document value</td>
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<td>3.4 Efficiency of operation</td>
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Tying it Together

• Care Pathways Workshops
  • Identify the need
  • Mapping a care pathway
  • Discuss challenges to creation of care pathways

• Behavioral and Physical Health Co-Management Webinar Series
  • 1st Webinar: Reducing Fragmentation Through Coordinated Care – Thursday, January 17, 12-1 p.m. ET (CEUs available)
NATCON 19
MARCH 25-27, 2019
GAYLORD OPRYLAND, NASHVILLE, TN

NATCON19.THENATIONALCOUNCIL.ORG

Don’t forget to enter “NATCON200” to get $200 off your registration!
The project described was supported by Funding Opportunity Number CMS-1L1-15-003 from the U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services.

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