A Care Pathway in Action: Lessons from the Field

Thursday, May 9th
12:00-1:30pm

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

Jeff Capobianco, PhD
Senior Consultant
National Council for Behavioral Health

Jane Mullin, LCSW-R
Chief Strategic Integration Officer
Jawonio, Inc.
## CMS Change Package: Roadmap for Transformation

| Patient and Family-Centered Care Design | 1.1 Patient & family engagement  
1.2 **Team-based relationships**  
1.3 Population management  
1.4 Practice as a community partner  
1.5 **Coordinated care delivery**  
1.6 Organized, evidence-based care  
1.7 Enhanced access |
| Continuous, Data-Driven Quality Improvement | 2.1 Engaged and committed leadership  
2.2 QI strategy supporting a culture of quality and safety  
2.3 Transparent measurement and monitoring  
2.4 Optimal use of HIT |
| Sustainable Business Operations | 3.1 Strategic use of practice revenue  
3.2 Staff vitality and joy in work  
3.3 Capability to analyze and document value  
3.4 Efficiency of operation |
Goals for Today

Understand how to:
✓ Use care pathways to address social determinants of health.
✓ Identify roles of care team members in operationalizing care pathways.
✓ Measure and track client outcomes.
✓ Use quality improvement strategies to refine care pathways in their own provider setting.
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.
Why are Care Pathways Important?

- Allows providers to be both efficient & effective in care provision.
- Focus on not just engaging clients in care, but activating them toward health behavioral change through trauma informed care, motivational interviewing, family involvement approaches all of which lead to health literacy, skills creation, and competence.
- Clearly maps how care is to be coordinated within and across team members, outside/referral providers, the client, and their natural supports.
Why are Care Pathways Important?

• Reduces variation in care provision, data collection, communication, and billing, and therefore waste, through standardized protocols.
• Uses evidence-based practices and treatment guidelines.
• Utilizes team-based care and continuous quality improvement framework.
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 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

Poll Question

What areas of care pathway implementation are you experiencing the most opportunities? (select all that apply)

1. Selecting a physical, behavioral health or social determinant of health need
2. Choosing target outcomes and reviewing the evidence-base
3. Mapping the current state process
4. Developing or refining or piloting a care pathway
5. Other (or provide more detailed information on one of the above)
Jawonio is dedicated to advancing the independence, well-being and equality of people with disabilities and special needs.
Choosing a Care Pathways Project

- Where is our challenge in attaining services for individuals with a high need of social determinants of health?
- What can we do to get things done?
- What can be done to insure a reasonable chance of success in order to engage, motivate and support staff?
Clients eligible for HCBS services identified through HARP eligibility or enrollment became our target population.

Metrics were established/our outcome targets identified.

A team of HH Care Managers, supervisors and service provider(s) was created to determine the most efficient, expedient and appropriate pathway.

Review protocols were established ahead of time and at set intervals.
<table>
<thead>
<tr>
<th>Health Home</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Member is referred for Care Management</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>CMA</td>
<td></td>
</tr>
<tr>
<td>CMA checks member HARP eligibility status</td>
<td>Is member eligible for HARP/HCBS?</td>
</tr>
<tr>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Care Manager proceeds with HH CM activity</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>H9 Status</td>
<td>CM works with member to convert to H1 and then refers to HARP Assessor</td>
</tr>
<tr>
<td>Assessor and member, supported by CM, complete assessment and identify needs and services</td>
<td></td>
</tr>
<tr>
<td>Assessor completes Level of Service determination and preliminary and submits to MCO and CM</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HCBS Providers/IDT</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessor and member, supported by CM, complete assessment and identify needs and services</td>
<td></td>
</tr>
<tr>
<td>CM and assessor schedule appointment</td>
<td></td>
</tr>
<tr>
<td>CM begins referrals to providers of member’s choice</td>
<td></td>
</tr>
<tr>
<td>CM monitors member’s progress and satisfaction</td>
<td></td>
</tr>
<tr>
<td>Upon receipt of MCO approval, providers enroll members in desired services and complete care plan</td>
<td></td>
</tr>
<tr>
<td>CM and IDT meet on a regular schedule</td>
<td></td>
</tr>
</tbody>
</table>
Mapping our Care Pathway

The care pathway, just like the treatment plan, is individualized based on the needs identified and desired.

If an individual opts out of assessment or service, a safety plan is created with the client, care manager and team and monitored closely.

Target metrics are established.

Protocols established and reviewed and adapted or amended.

Protocols established and reviewed and adapted or amended.
Clinical Protocols

• We changed our clinical protocols to ensure clarity of the role of each team member, including the role of and need for cooperation of the individual and/or his/her advocate.

• Screenings for SDOH and clinical needs are completed at intake, and followed up on via the HARP/HCBS comprehensive assessment.

• After the first 3 months of this pilot, we determined that this pathway would be used in our entire Care Management department to lessen the burden on all CMs, and to ensure consistency across all domains, from intake to assessment, from referral to service delivery, and from documentation, tracking and revenue management.

• Using the resulting screening and assessment data, services are identified, referrals made and outcomes developed and monitored on a prescribed timeline.
Administrative Protocols

- HARP coordinator and division coordinator now work in tandem to track execution of the care pathway for each individual and communicate via email, telephone and in scheduled weekly meetings with each other, the CM, treatment providers and when indicated, the MCO.

- Data entry, which includes referrals, scheduling, and data sharing among CM and providers ensures accurate tracking is completed contemporaneously by the HARP and Division coordinators.

- The protocols are monitored by the department supervisor during both individual and group weekly supervision.

- Billing is monitored by department supervisor in conjunction with billing department. Revenue Cycle meetings are held with finance department.
Our Pilot Care Pathway

• This care pathway protocol has now been in place for 6 months for non-eligible care management staff, and 3 months for all care management staff.

• We completed training for all staff involved, including finance, compliance and QI. Training was structured for appropriateness to each department involved. Motivational interviewing was high on the list.

• We hold ongoing refresher training for the care management staff and have now worked with our Health Home to share our protocol with our colleagues in our Health Home cohort.
Our pilot is going strong and both staff and clients are reporting positive experiences.

This care pathway is monitored regularly and adjustments continue to be made when needed, whether at the request of the member, CM or providers.

Metrics are reviewed monthly and shared.
How do Care Pathways Create Value in a Value-based Payment Environment?

• Reduce staff workflow variability and therefore waste
• Standardization of service processes allow for the efficient use of CQI tools like PDSA cycles (i.e., allows for the testing of process steps to see what is and is not working)
• Time and cost can be measured to establish episode of care estimates
• Metrics make explicit whether process and outcome targets are achieved
• Promote team-based care by creating a common language, clear delineation of roles/scope of practice, and shared/team dashboard metrics
• Tie together administrative processes with clinical processes via the consumer’s treatment plan
Poll Question

What are your biggest takeaways from our discussion? (select all that apply)

a.) How to choose a care pathway  
b.) How to choose process and outcome metrics  
c.) How to develop administrative and clinical protocols  
d.) How to map the care pathway  
e.) How to engage staff in the development and implementation  
f.) Other (please type your takeaway into the chat box!)
Poll Question

What resources do you need to continue your care pathway implementation?
1. 1:1 consultation
2. Additional examples
3. Other (write in chat box)
Upcoming Webinars

<table>
<thead>
<tr>
<th>Event</th>
<th>Date and Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>What Non-Prescribers Need to Know About Simultaneous Use of Multiple Antipsychotics</td>
<td>Tuesday, May 21 from 12:00-1:00pm</td>
</tr>
<tr>
<td>Health Information Technology and Behavioral Health Performance Metrics</td>
<td>Wednesday, May 28 from 1:00-2:00pm</td>
</tr>
<tr>
<td>Practitioner Interventions: Assessing, Documenting and Addressing Medication Non-Adherence</td>
<td>Thursday, May 29 from 12:00-1:00pm</td>
</tr>
<tr>
<td>Organizational Practices and Policies to Support Medication Adherence</td>
<td>Tuesday, June 11 from 12:00-1:00pm</td>
</tr>
</tbody>
</table>
Upcoming In-Person Events

• **Payer Forums** hosted by MCTAC and the Care Transitions Network
  • New York City – Tuesday, June 4th
  • Plattsburgh – Thursday, June 6th
  • Buffalo – Wednesday, June 12th
  • Syracuse – Thursday, June 13th
  • Albany – Friday, June 14th

• **End of Project Celebration**
  • Tuesday, August 13th
Thank you!

www.CareTransitionsNetwork.org
CareTransitions@TheNationalCouncil.org

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.

Disclaimer: The contents provided are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies.