Preparing for Value-Based Payment in Behavioral Health and Primary Care 2018 Innovation Community Summer Cohort | Webinar 3

Presented by: Mindy Klowden, MNM, Director, Technical Assistance and Training,
National Council for Behavioral Health,
SAMHSA-HRSA Center for Integrated Health Solutions

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Setting the Stage: Today's Moderator

Roara Michael
Senior Associate
SAMHSA-HRSA Center for Integrated Health Solutions

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SAMHSA-HRSA Center for Integrated Health Solutions

WHO WE ARE

The **SAMHSA-HRSA Center for Integrated Health Solutions (CIHS)** is a national training and technical assistance center dedicated to the planning and development of **integration of primary and behavioral health care** for those with mental illness and/or substance use disorders and physical health conditions, whether seen in specialty mental health or primary care safety-net provider Settings across the country.

CIHS is jointly funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources Services Administration (HRSA), and is run by the National Council for Behavioral Health, the unifying voice of America's healthcare organizations that deliver mental health and addictions treatment and services.

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Slides for today's webinar will be available on the CIHS website:

www.integration.samhsa.gov

Under About Us/Innovation Communities 2018

https://www.integration.samhsa.gov/about-us/innovation-communities-2018/summer-cohort#value_based_payment_IC_summer

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Listserv

- Look for updates from: value_based_care_ic_2@nationalcouncilcommunities.org
- Add this email to your contacts to prevent emails from going to your spam
- Email us any team members that should be added to the listserv
- Just email the listserv link to engage with fellow participants outside of webinars

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To participate

Use the chat box to communicate with other attendees

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Disclaimer

The views, opinions, and content expressed in this presentation do not necessarily reflect the views, opinions, or policies of the Center for Mental Health Services (CMHS), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Resources and Services Administration (HRSA), or the U.S. Department of Health and Human Services (HHS).

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About the Presenter: Mindy Klowden, MNM

- Mindy is the Director of Training and Technical Assistance for CIHS and provides individualized consultation and training to community mental health centers, primary care clinics and other health care systems and providers working to integrate primary care, mental health and substance use disorder treatment. Ms. Klowden also works on health care payment and delivery system reform, and co-chairs the Colorado State Innovation Model Practice Transformation committee.
- Prior to joining the National Council, Mindy served as the Director of the Office of Healthcare Transformation at Jefferson Center for Mental Health in CO. In this role, she was an advisor to executive and senior management on health care policy and trends, developed key health reform initiatives, and worked to cultivate and sustain inter-agency partnerships that support the integration of behavioral health with primary care.
- Mindy has 25 years of experience in the nonprofit sector. Previous roles include working with the Colorado primary care association and with affordable housing and homeless service provider and advocacy groups.
- Mindy earned her Master's degree in Nonprofit Management from Regis University and her Bachelor's of Arts in Sociology from The Colorado College. She is also a graduate of the Bighorn Healthcare Policy Leadership Fellowship Program.

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Learning Objectives for Today

- ✓Prepare participants for webinar 4- 5x5 presentations
- ✓Share best practices and lessons learned in negotiating with payers
- ✓Provide overview of population health management and its importance to success under value-based payment

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Next steps

- ✓August 8th 3pm eastern- Final group webinar- 5x5 presentations!
- ✓Coaching calls- contact Diandreac@thenationalcouncil.org
- ✓Use list-serv value_based_care_ic_2@nationalcouncilcommunities.org

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5X5 Presentations

- ✓Looking for 6-9 volunteers
- ✓5 minutes, 5 slides
- ✓Keep it simple
- ✓Make it fun and get creative! This is an opportunity to share what you are proud of and/or what you have learned

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Recommended 5X5 content

- ✓What you set out to do (agency goals)
- ✓How you did it
- ✓What went well (achievements) and how participating in the Innovation Community helped
- ✓Challenges encountered and how you overcame them
- ✓Impact
- ✓Next steps

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What do payers want?

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What do payers want? continued

- ✓Market share
- ✓Lower costs (appropriate utilization)
- ✓Better care (demonstrated outcomes)
- ✓Patient satisfaction
- ✓Predictability
- ✓Integration of behavioral health and primary care
- ✓Social determinants addressed
- ✓Shared risk

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Preparation

- ✓Know your market share
- ✓Know your unit costs
- ✓Know what is currently in your contracts
  - ✓Know when each of your contracts expires and how much notice you must give to make changes
  - ✓Know what changes have been made in the past
- ✓To the extent possible, know what value-based payment arrangements the payer is engaged in
- ✓Know what is important to the payer
- ✓Know as much about the payer's obligations and requirements as possible

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During negotiation

- ✓Listen
- ✓Bring your partners when applicable
- ✓Demonstrate your value proposition
  - ✓Come armed with data
- ✓Look for the win-win
- ✓Determine a bargaining range that includes an optimum, minimum, and target goal
- ✓Recognize its not just about rates; its about value

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Working with state Medicaid agencies

- ✓Participate in any and all public forums, hearings, stakeholder committees
- ✓Know what is important to the agency
- ✓Recognize the partnership and provide your ideas

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Building the business case in the larger community

- ✓Identify your most compelling outcomes
  - Health indicators (physical health and behavioral health)
  - Patient satisfaction
  - Cost savings (particularly reductions in ER utilization, hospital admissions/readmissions)
- ✓Develop fact sheets or other collateral materials with strong visuals
- ✓Collect patient/client testimonials (give a human face to your data!)
- ✓Identify opportunities to share your data
  - Earned media
  - Open houses
  - Meetings with key stakeholders

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What will the payer do to help you succeed?

- ✓Provide data?
  - ✓Claims
  - ✓Notification of admission/ER visit
- ✓Provide training/practice transformation support?
- ✓Help communicate with patients?
- ✓Facilitate communication with other providers?
- ✓Work with you to address barriers such as prior authorizations?

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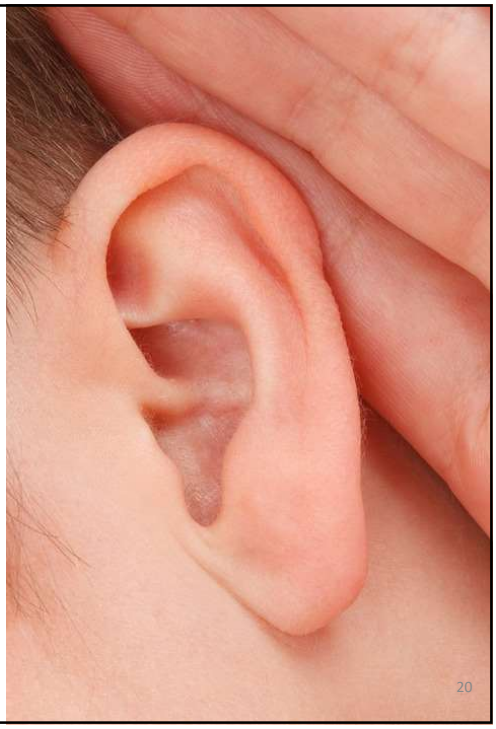
Concerns I've heard from participants

- ✓Attribution methodologies
- ✓Bifurcated systems on the payer side
- ✓Not knowing who to talk to
- ✓Lack of alignment among payers
- ✓Rates too low
- ✓Incentives earned in value based payment models do not cover costs
- ✓Upfront expenses



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Discussion- part 1

Defining "Population Health Management"

- ✓ A set of interventions designed to maintain and improve a patient's health across the full continuum of care—from low-risk, healthy individuals to high-risk individuals with one or more chronic condition (Felt-Lisk & Higgins, 2011).
- ✓ Population medicine is the design, delivery, coordination, and payment of high-quality health care services to manage the Triple Aim for a population using the best resources we have available to us (Institute for Healthcare Improvement (IHI), 2017).
- ✓ Population health management focuses on high-risk individuals, who generate most of the health care costs. At the same time, it addresses comprehensively the preventive and chronic care needs of every patient. The goal is to keep individuals as healthy as possible—thereby minimizing expensive interventions—by modifying the risk factors that make them sick or worsen their conditions (Institute for Health Technology Transformation, 2012).

CIHS value-based payment organizational readiness assessment key domain #4

Population health management: how prepared is the organization to improve the health outcomes of a group by monitoring and identifying individual patients within that group?

Population health management requires providers to develop the capacity to utilize data to risk stratify patients into groups and then respond to the needs of individuals in those groups efficiently and effectively.

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Why do population health management?

- ✓Essential to impactful care coordination and care management
- ✓Risk stratification helps direct care appropriately while maximizing limited resources
- ✓Increases likelihood of success under value-based payment contracts
- ✓Provides key data points to use both towards utilization management and outcome tracking

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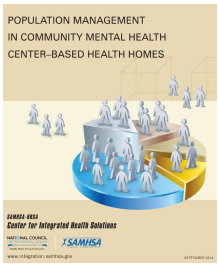
Principles of population health management (CIHS, 2014)

1. Population-based care: focuses on the health of an entire patient population by systematically assessing, tracking, and managing the group's health conditions and treatment response across the entire target group, rather than just the patients who actively seek care.
2. Data-driven: utilize data and analytics in order to make informed decisions to serve those in your population who most need care.
3. Evidence-based care: using the best available evidence to guide treatment decisions and delivery of care.
4. Care Management: provide care coordination for all patients, but more targeted care management services for high utilizers or high risk patients.



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Key components

- Define the population
- Identify gaps in care
- Stratify risk
- Engage patients
- Manage care
- Measure outcomes

Advocates for Human Potential, 2015
http://www.ahpnet.com/AHPNet/media/AHPNetMediaLibrary/White%20Papers/AHP-Whitepaper.pdf

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Keys to successful population health management:

1. Knowing what to ask about your population
2. Appropriate technology (e.g., data registry) to describe/risk stratify your populations
3. Proficiency with quality improvement tools to respond to the findings and treat to target
4. Continuous quality improvement to sustain impact

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Let's look at depression as an example

1. Know what to ask about your population

How are we doing with the treatment of our consumers who have a depression diagnosis?

2. Using your registry Risk Stratify the population of consumers with depression

Pull & Aggregate Consumer PHQ-9 Scores by Team and Clinician.

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Continued…

3. Proficiency with quality improvement tools to respond to the findings

Develop/review work flows to see what process steps need to be changed/improved to bring the PHQ-9 scores to the benchmark target.

4. Continuous quality improvement policies/procedures to sustain data specification targets

Put the changes/improvements into policy/procedure (e.g., supervision, huddles, administration meetings, etc.).

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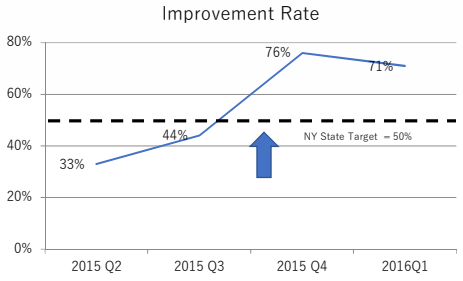
Sample dashboard for monitoring depression care population outcomes

Metric	Definition
Improvement Rate:	Number (#) and proportion (%) of patients in treatment for 70 days (10 weeks) or greater who demonstrated clinically significant improvement either by: a 50% reduction from baseline PHQ-9 or a drop from baseline PHQ-9 of at least 5 points and to less than 10.

Year	Quarter	Improvement Rate
2015	Q2	33%
2015	Q3	44%
2015	Q4	76%
2016	Q1	71%



Source: Institute for Family Health

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AIMS Center Free Dashboard Template

https://aims.uw.edu/resource-library/patient-tracking-spreadsheet-example-data

	Treatment Status					PHQ-9				GAD-7				Psychiatric Case Review	
	! Indicates that the most recent contact was over 1 month (30 days) ago ⚑ Indicates that the next follow-up contact is past due					✓ Indicates that the last available PHQ-9 score is at target (less than 5 or 50% decrease from initial score) ! Indicates that the last available PHQ-9 score is more than 30 days old				✓ Indicates that the last available GAD-7 score is at target (less than 10 or 50% decrease from initial score) ! Indicates that the last available GAD-7 score is more than 30 days old					
Name	Date of Initial Assessment	Date of Most Recent Contact	Date Next Follow-up Due	Number of Follow-up Contacts	Weeks in Treatment	Initial PHQ-9 Score	Last Available PHQ-9 Score	% Change in PHQ-9 Score	Date of Last PHQ-9 Score	Initial GAD-7 Score	Last Available GAD-7 Score	% Change in GAD-7 Score	Date of Last GAD-7 Score	Flag	Most Recent Psychiatric Case Review Note
Bob Dolittle	3/2/2016	! 4/28/2016	⚑ 5/12/2016	3	26	22	19	-14%	! 4/28/2016	12	10	-17%	! 4/28/2016	Flag as safety risk	2/18/2016
Betty Test	12/15/2015	! 6/15/2016	⚑ 7/15/2016	10	37	12	✓ 1	✓ -92%	! 6/15/2016	9	✓ 3	✓ -67%	! 6/15/2016		
Susan Test	11/20/2015	! 7/30/2016	⚑ 8/13/2016	10	41	22	15	-32%	! 7/30/2016	18	14	-22%	! 7/30/2016	Flag for discussion & safety risk	4/17/2016
John Doe	9/15/2015	! 7/16/2016	⚑ 8/15/2016	12	50	20	✓ 0	✓ -100%	! 7/16/2016	14	✓ 1	✓ -93%	! 7/16/2016		6/15/2016
Albert Smith	5/5/2016	! 7/22/2016	⚑ 8/19/2016	5	17	18	18	0%	! 7/22/2016	14	10	-29%	! 7/22/2016	Flag for discussion	
Nancy Fake	8/5/2016	! 8/5/2016	⚑ 8/19/2016	0	4	No Score	No Score			No Score	No Score				
Joe Smith	6/1/2016	! 8/8/2016	⚑ 8/22/2016	5	13	15	9	-40%	! 8/8/2016	11	✓ 7	-36%	! 8/8/2016		7/24/2016

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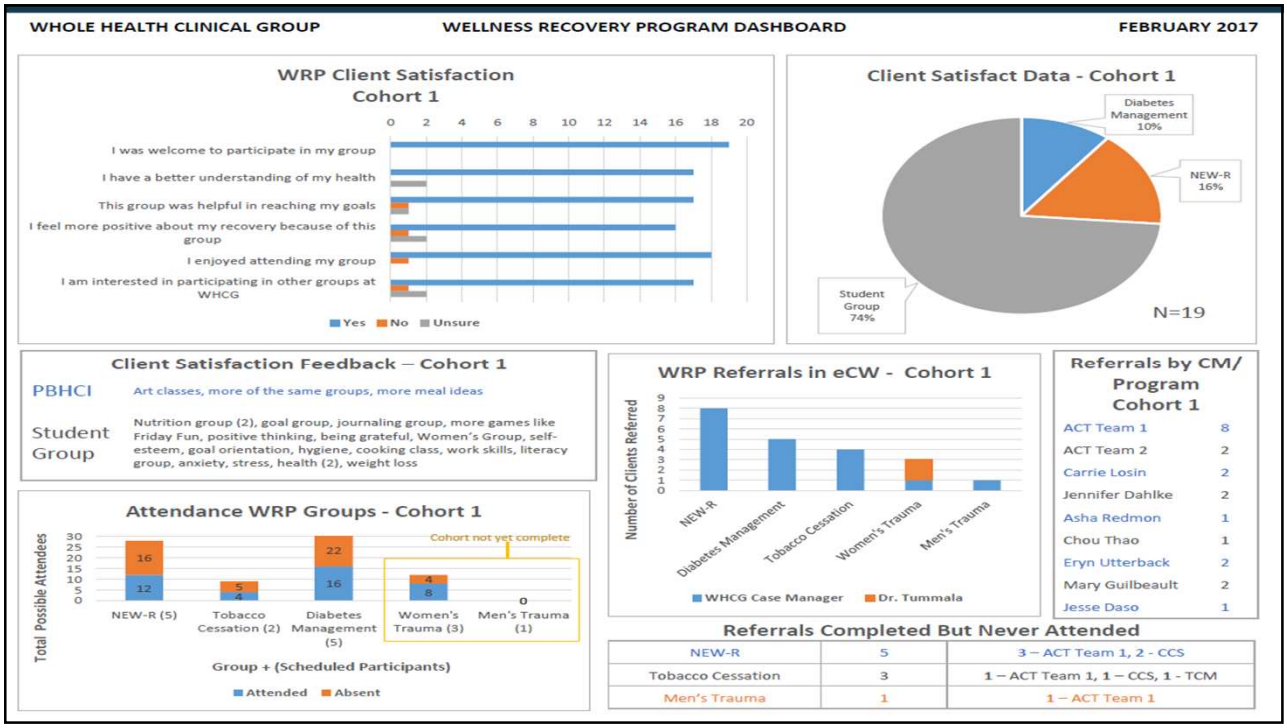

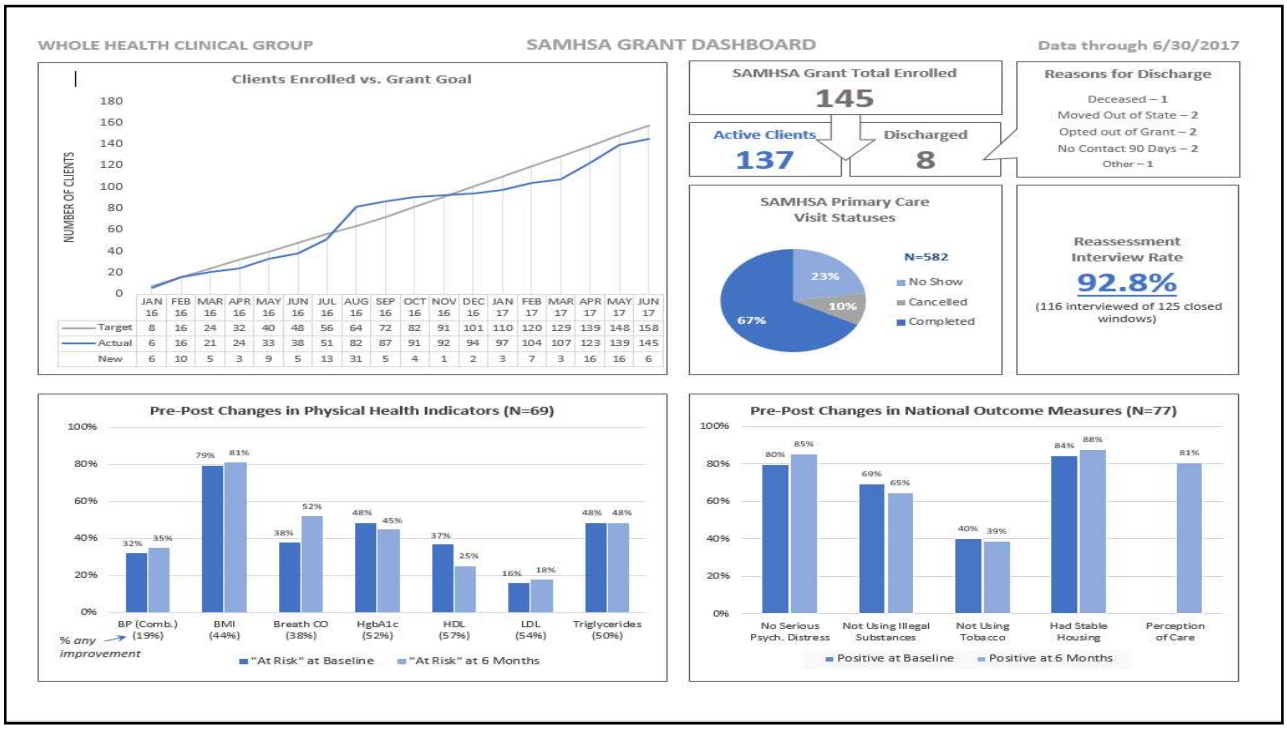

Discussion- part 2

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Free consultation on any integration-related topic!

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Thank You

SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

The mission of HRSA is to improve health and achieve health equity through access to quality services, a skilled health workforce, and innovative programs.

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