Leveraging Technology to Capture Outcomes and Demonstrate Value: Practical Approaches to Move to Value Based Care

Dennis Morrison, PhD
Chief Clinical Advisor
Netsmart Technologies

Standardized Processes and Workflows: It all Starts With Measurement
MEASUREMENT

Knowledge Without Data is Opinion

Measurement isn’t new...
Improvement in Therapy
Client Self Report

\[ y = 10.825 \ln(x) + 26.459 \]

\[ R^2 = 0.8934 \]


DESCRIPTIVE ANALYTICS

BENCHMARKING
Why Benchmark?
Performance is measured in all organizations
Clinical, operational and financial
How helpful is performance data?
Manage by data rather than by opinion

The Limitations of Your Performance Data
Your internal data system tells you:
“**Our no-show rate is 17%**”
Your next question should be?
Compared to what?

Context Is Critical

Practice Based Evidence Clinical Improvement
High-Low-Average

Based on work done by Brent James at Intermountain Health Care
Consider these data

<table>
<thead>
<tr>
<th>Sample 1</th>
<th>Sample 2</th>
<th>Sample 3</th>
<th>Sample 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 4.26</td>
<td>1 3.7</td>
<td>1 5.39</td>
<td>16 12.5</td>
</tr>
<tr>
<td>2 5.68</td>
<td>2 4.74</td>
<td>2 6.89</td>
<td>5 6.69</td>
</tr>
<tr>
<td>3 7.24</td>
<td>3 6.13</td>
<td>3 6.08</td>
<td>5 5.25</td>
</tr>
<tr>
<td>4 4.82</td>
<td>4 7.26</td>
<td>4 6.42</td>
<td>5 7.91</td>
</tr>
<tr>
<td>5 6.95</td>
<td>5 8.14</td>
<td>5 6.77</td>
<td>5 5.76</td>
</tr>
<tr>
<td>6 8.81</td>
<td>6 8.77</td>
<td>6 7.11</td>
<td>5 8.84</td>
</tr>
<tr>
<td>7 8.04</td>
<td>7 9.14</td>
<td>7 7.46</td>
<td>5 6.58</td>
</tr>
<tr>
<td>8 8.33</td>
<td>8 9.26</td>
<td>8 7.81</td>
<td>5 6.47</td>
</tr>
<tr>
<td>9 10.84</td>
<td>9 9.13</td>
<td>9 8.15</td>
<td>5 5.56</td>
</tr>
<tr>
<td>10 7.58</td>
<td>10 8.74</td>
<td>10 12.74</td>
<td>5 7.71</td>
</tr>
<tr>
<td>11 9.96</td>
<td>11 8.1</td>
<td>11 8.84</td>
<td>5 7.04</td>
</tr>
</tbody>
</table>

Adapted from E.Tufte The Visual Display of Quantitative Information. Graphics Press, Cheshire, CT 1983

Consider how your end user absorbs information
Foundations of Value-based Care

Healthcare Costs

If other prices had followed the same trend as healthcare...

One dozen eggs would cost $55
A gallon of milk would cost $48
A dozen oranges would cost $134

Source: The Healthcare Imperative, Institute of Medicine

Disproportionate Cost

5% of people account for ~80% of the cost
25% of people account for ~98% of the cost
5%/50% is more typical
Annual Per Capita Costs of Behavioral Health Comorbidities Medicaid Beneficiaries

<table>
<thead>
<tr>
<th>Comorbidity</th>
<th>No BH/No SUD</th>
<th>BH/No SUD</th>
<th>SUD/No BH</th>
<th>BH and SUD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma/COPD</td>
<td>$5,600</td>
<td>$5,167</td>
<td>$6,563</td>
<td>$6,660</td>
</tr>
<tr>
<td>Congestive Heart Failure</td>
<td>$8,302</td>
<td>$9,427</td>
<td>$7,698</td>
<td>$7,268</td>
</tr>
<tr>
<td>Coronary Heart Disease</td>
<td>$10,607</td>
<td>$11,863</td>
<td>$9,425</td>
<td>$9,516</td>
</tr>
<tr>
<td>Diabetes</td>
<td>$16,738</td>
<td>$17,256</td>
<td>$16,230</td>
<td>$16,247</td>
</tr>
<tr>
<td>Hypertension</td>
<td>$23,693</td>
<td>$25,209</td>
<td>$24,845</td>
<td>$23,685</td>
</tr>
</tbody>
</table>

Source: Center for Health Care Strategies

Life Expectancy

<table>
<thead>
<tr>
<th>Mental Disorder</th>
<th>General Population</th>
<th>Public Sector</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Mental Disorder</td>
<td>77.97</td>
<td>51.8</td>
</tr>
<tr>
<td>Any Mental Disorder</td>
<td>66.2</td>
<td>51.8</td>
</tr>
</tbody>
</table>

From Silos to Whole Person Care

The Evolution
Nearly 60 percent of people being treated for depression in the United States receive treatment in the primary care sector.\(^1\)

Patients with depression constitute 5 percent to 10 percent of patients seen in primary care clinics.\(^2\)

50% - 75% of patients with depressive disorders were inaccurately diagnosed by primary care physicians.\(^3\)

Of the 10 most common complaints in primary care, less than 16% had a diagnosable physical etiology.\(^4\)

Of individuals who die by suicide, 40% had visited their primary care physician within the month before their suicide.\(^5\)

85% of physician visits are for problems that have a significant psychological and/or behavioral component, such as chronic illnesses.\(^6\)

51% of behavioral health care services are delivered by non-psychiatric physicians.\(^7\)

Primary care practitioners prescribe about 70% of all psychiatric medications and 80% of antidepressants while psychiatrists write less than 16%.\(^8\)

70% of all primary care physician visits are for psychosocial problems.\(^9\)

Psychological treatments for depression and anxiety are on par or better than most medications, often with better and longer-lasting outcomes.\(^10,11\)

Psychologically distressed patients use 2 to 3 times more health care services than non-distressed patients.\(^12\)

Non-Psychiatric Physician Visits in Panic Disorder

How to Coordinate Care

---

Minimal Coordination

---

Virtual Integration

---
Incentive Evolution

<table>
<thead>
<tr>
<th>Reimbursement Model</th>
<th>Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fee for Service</td>
<td>Do More, Make More</td>
</tr>
<tr>
<td>Managed Care</td>
<td>Do Less, Make More</td>
</tr>
<tr>
<td>Value Based Purchasing</td>
<td>Do Better, Make More</td>
</tr>
</tbody>
</table>

Value = Quality/Cost

Integrated or Value Based Care = Reform of some flavor

- Reduce institutional/inpatient care
- Lower Emergency Room usage
- Ensure appropriate Level of Care
- Drive consumer satisfaction
- Deliver health services within an integrated and connected delivery system
- Identify and manage “high risk/cost” individuals
- Improve “value”
Value Based Care Considerations

- Early models stratify and attribute the population for you
- Emerging VBC models require you to create and analyze at a deeper level those cohorts
- Cohorts can be developed by utilization patterns, disease states, medications, etc.
- Attributed populations are just the start...you own the population on daily rate PPS model

Value Based Purchasing and Care Coordination
Excellence in Mental Health Act – A Transformational Shift

**Expansion of Services**

**Care Coordination**

**New Payment Model**

**Quality Measures & Reporting**

---

Health Care Payment Learning and Action Network (LAN) Alternative Payment Model (APM) Framework

- **Category 1:** FFS payments not linked to quality.
- **Category 2:** FFS payments linked to quality and value.
- **Category 3:** Alternative payment models based on FFS.
  - Shared savings/shared risk.
  - Bundled or episode-based payments.
- **Category 4:** Population-based payments.

---

**Strategies**

- **Carve-in.**
  - MCOs receive a payment to manage both behavioral and physical health services, among other services as relevant.
  - 16 states e.g. TN

- **Carve-out.**
  - Some or all behavioral health benefits are separately managed by a specialized behavioral health organization or by the Medicaid state agency on a FFS basis. Meeting these requirements often entails greater coordination of providers on the ground
  - e.g. PA

- **Specialty managed care model.**
  - Specialty behavioral health organizations manage all benefits, including physical health benefits, which are carved into the program
  - e.g. AZ

Source: Center for Health Care Strategies
Provider-based Delivery System Reforms

Health Homes
- Created by Affordable Care Act
- Comprehensive care management services
- Focus of 24/7 for individuals with serious mental illness
- Usually based in a behavioral health provider’s office
- Must offer comprehensive care management, transitional care and follow-up, and referrals to community and social support services

Accountable Care Organizations (ACOs)
- Hold providers financially accountable for health outcomes and costs of their patient population
- Usually shared savings or shared savings/shared risk payment models

Certified Community Behavioral Health Centers (CCBHCs)
- Created through Protecting Access to Medicare Act
- Demonstration program to expand access to behavioral health services in community-based settings
- Eight states selected
- Must provide a comprehensive range of behavioral health services
- Staffing, access, care coordination, data collection and quality requirements
- PPS - quality bonus payments or payment linked to quality outcomes

D. Hasselman and D. Bachrach, Implementing Health Homes in a Risk-Based Medicaid Managed Care Delivery System. Center for Health Care Strategies, June 2011. Available at: http://www.chcs.org/media/Final_Brief_HH_and_Managed_Care_FINAL.pdf


SUD Improvement Strategy: IAP

Medicaid Innovation Accelerator Program (IAP) CMS 2015
- Six states to improve states’ substance use disorder delivery systems via incentivizing better outcomes
- CMS to share “starting point” resources
- Episodes of care and payment bundles for (MAT) services

Pennsylvania:
- 45 Centers of Excellence to integrate behavioral health and primary care for Medicaid enrollees with an opioid use disorder

Expansion of Services

CCBHC Program/Service Requirements

1. Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization
2. Screening, assessment, and diagnosis, including risk management
3. Patient and treatment planning
4. Outpatient mental health and substance use services
5. Outpatient clinic primary care screening and monitoring
6. Targeted case management
7. Psychosocial rehabilitation services
8. Peer support, counseling services, and family connections
9. Connections with other providers and systems (oral health, foster care, child welfare, education, primary care, hospitals, etc.)
Care Coordination

Care coordination, including requirements to coordinate care across settings and providers to ensure seamless transitions for patients across the full spectrum of health services, including acute, chronic, and behavioral health needs.

- Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization
- Screening, assessment, and diagnosis, including risk management
- Patient-centered treatment planning
- Outpatient mental health and substance use services
- Primary care screening and monitoring
- Targeted case management
- Psychiatric rehabilitation services
- Peer support, counseling services, and family support services
- Services for members of the armed services and veterans
- Connections with other providers and systems (criminal justice, foster care, child welfare, education, primary care, hospitals, etc.)

CCBHC

CCBHC Acute Care Hospital(s) Social Services, School, Justice, Child Welfare Inpatient MH Facilities, Denus, Residential YA, RHC Acute Care Hospital(s)

New Payment Model

Prospective Payment System

One Selected by State

PPS-1: Daily Rate

- Total annual allowable CCBHC costs
- Total number of CCBHC Medicare daily visits per year

PPS-2: Monthly Rate

- Total annual allowable CCBHC costs excluding costs for services to clinic users with certain conditions and outlier payments
- Total number of CCBHC Medicare unduplicated monthly visits per year excluding clinic users with certain conditions

Quality Measures and Reporting

CCBHC Quality Measures (11)

- Number/percent of new clients with initial evaluation provided within 10 business days, unless number of days with clinical condition indicates otherwise
- Patient experience of care survey and family experience of care survey
- Preventive Care and Screening: Adult Body Mass Index (BMI) Screening and Follow-Up
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WAC) (see Medicaid Child Core Set)
- Preventive Care and Screening: Tobacco User Screening & Cessation Intervention
- Preventive Care and Screening: Unhealthy Alcohol Use Screening and Brief Intervention
- 1-year prior drug use assessment/ultra简体无故的
- Mental Health/Medicaid Adult Core Set
- Adult major depression disorder (MDD): Suicide Risk Assessment (see Medicaid Adult Core Set)
- Adult major depression disorder (MDD): Suicide Risk Assessment (see Medicaid Adult Core Set)
- Adult major depression disorder (MDD): Suicide Risk Assessment (see Medicaid Adult Core Set)
- Adult major depression disorder (MDD): Suicide Risk Assessment (see Medicaid Adult Core Set)
- Depression Remission at 12 months

Note the heavy reliance on process measures.
Collaborative Care Model (CCM) Primary Care: University of Washington

- Team-based approach include a primary care physician, care manager, and a consulting psychiatrist.

- The five core principles of the model:
  - Patient-centered team care
  - Population-based care
  - Measurement-based treatment
  - Evidence-based care
  - Accountable care

- 25 percent of total provider payments in CCM models:
  - Improved provider fidelity to key elements of CCM
  - Improved patient depression outcomes.

Certified Community Behavioral Health (CCBHC) Programs

Remember This?

Disproportionate Cost

- 5% of people account for 80% of the cost
- 25% of people account for 95% of the cost
- TANF is more typical
Start with Population Risk Stratification

Target a small number of population health management use cases that will produce immediate results.

- Use data from a variety of sources
- Stratification can be as simple as:
  - Top 1% based upon chronic conditions
  - Top 1% based upon client cost

- Meeting clients where they are: Home | School | Work | Community | Clinic
- Connecting with clients in the way that suits best for them: Email | Text | Phone | Face-to-face | Telehealth

DEFINCE ASSESS STRATIFY ENGAGE MANAGE

- Differential Management
  - Tailored Interventions
  - Care Coordination
  - Clinical Case Management
  - Population Health
  - Risk Management
  - Clinical Recovery

- Tailored Interventions
- Care Coordination
- Clinical Case Management
- Population Health
- Risk Management
- Clinical Recovery

- Meeting clients where they are: Home | School | Work | Community | Clinic
- Connecting with clients in the way that suits best for them: Email | Text | Phone | Face-to-face | Telehealth
Focusing on Interventions

Hemoglobin A1c Control for Diabetes

<table>
<thead>
<tr>
<th>Managed</th>
<th>Identified</th>
<th>Intervene</th>
</tr>
</thead>
<tbody>
<tr>
<td>215</td>
<td>301</td>
<td>Goal: 60%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ID</th>
<th>Name</th>
<th>Gender</th>
<th>Age</th>
<th>Case Manager</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>234</td>
<td>Arencia,</td>
<td>M</td>
<td>57</td>
<td>Gibson, Janet</td>
<td></td>
</tr>
<tr>
<td>256</td>
<td>Brown, Todd</td>
<td>M</td>
<td>64</td>
<td>Gibson, Janet</td>
<td></td>
</tr>
<tr>
<td>456</td>
<td>Walken, Tony</td>
<td>F</td>
<td>19</td>
<td>Green, Sue</td>
<td></td>
</tr>
<tr>
<td>6576</td>
<td>Jones, Betty</td>
<td>F</td>
<td>65</td>
<td>Gibson, Janet</td>
<td></td>
</tr>
</tbody>
</table>

Quality Measures & Reporting – Population Health

Adult Body Mass Index (BMI) Screening and Follow-Up

<table>
<thead>
<tr>
<th>Managed</th>
<th>Identified</th>
<th>Intervene</th>
</tr>
</thead>
<tbody>
<tr>
<td>268</td>
<td>1292</td>
<td>Goal: 70%</td>
</tr>
</tbody>
</table>

Suicide Risk Assessment

<table>
<thead>
<tr>
<th>Managed</th>
<th>Identified</th>
<th>Intervene</th>
</tr>
</thead>
<tbody>
<tr>
<td>697</td>
<td>1297</td>
<td>Goal: 60%</td>
</tr>
</tbody>
</table>

Screening for Clinical Depression and Follow-Up Plan

<table>
<thead>
<tr>
<th>Managed</th>
<th>Identified</th>
<th>Intervene</th>
</tr>
</thead>
<tbody>
<tr>
<td>594</td>
<td>1295</td>
<td>Goal: 37%</td>
</tr>
</tbody>
</table>

Unhealthy Alcohol Use: Screening and Brief Counseling

<table>
<thead>
<tr>
<th>Managed</th>
<th>Identified</th>
<th>Intervene</th>
</tr>
</thead>
<tbody>
<tr>
<td>215</td>
<td>301</td>
<td>Goal: 60%</td>
</tr>
</tbody>
</table>

CCBHCs Require Us to Think in NEW AND INNOVATIVE WAYS

- Reduction in cost and improved care for the ENTIRE population
- Data exchange and coordination of care across a broader network
- Alter process and technology to support reporting & service delivery requirements
State Strategic Initiative Examples

North Carolina CCBHC Overview

The populations of focus are children and youth with serious emotional disturbances, adults with serious mental illness, individuals with long-term and serious substance use disorders and those with mental illness and substance use disorders.

<table>
<thead>
<tr>
<th>Name</th>
<th>North Carolina</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motivational Interviewing/Motivational Enhancement Therapy</td>
<td>MI/MET</td>
<td>8</td>
</tr>
<tr>
<td>Cognitive Behavioral Therapy</td>
<td>CBT</td>
<td>6</td>
</tr>
<tr>
<td>Assertive Community Treatment</td>
<td>ACT</td>
<td>5</td>
</tr>
<tr>
<td>Early/1st Interventions for Psychosis</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>Motivational Interviewing/Motivational Enhancement Therapy</td>
<td>MI/MET</td>
<td>8</td>
</tr>
<tr>
<td>Cognitive Behavioral Therapy</td>
<td>CBT</td>
<td>6</td>
</tr>
<tr>
<td>Early/1st Interventions for Psychosis</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>Trauma Focused/CBT</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>Dialectical Behavior Therapy</td>
<td>DBT</td>
<td>4</td>
</tr>
<tr>
<td>Wellness Recovery Action Plan</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Wrap Around</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Family Psychoeducation</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Medication Assisted Treatment</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Multi-systemic Therapy</td>
<td>MST</td>
<td>3</td>
</tr>
<tr>
<td>Peer Recovery Supports</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Forensic ACT</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Functional Family Therapy</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Other Trauma Informed Care</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Supported Employment</td>
<td></td>
<td>2</td>
</tr>
</tbody>
</table>

North Carolina CCBHC Outcomes Measures

- Motivational Interviewing/Motivational Enhancement Therapy
- Cognitive Behavioral Therapy
- Trauma Focused/CBT
- Dialectical Behavior Therapy
- Community Wrap-around
- Evidence-based Medication Evaluation and Management
- Assertive Community Treatment
- Multi-systemic Therapy
Florida Care Coordination Framework

“The organization of care activities between two or more participants including the person served and family (with consent) involved in an individual’s care to facilitate the effective delivery of health care services.”

Florida High Level Recommendations

Add Care Coordination as a billable, covered service
Contract with network service providers that are qualified based on core competencies outlined in framework
Standardize Level of Care assessments and fund implementation
Implement data sharing agreements across providers and funders to ensure effective flow of information
Managing Entities to link with stakeholders that provide services and supports (primary care, housing, employment, criminal justice) that ensures holistic approach and addresses social determinants of health.
Monitor implementation and outcomes.
Implement consistent discharge protocols for individuals returning to community from state mental health treatment facilities.

Priority Named Populations

Persons with a Serious Mental Illness awaiting placement in a civil state mental health treatment facility (SMHTF) or awaiting discharge from a SMHTF back to the community

Individuals with a SMI and/or Substance Use Disorder who account for a disproportionate amount of BH expenditures

Over time the ME’s will have flexibility to add priority populations based on needs identified in their respective regions. The above first two groups were chosen to “pilot” this approach.
California Whole Person Care

The overarching goal of the Whole Person Care (WPC) Pilots is the coordination of health, behavioral health, and social services, as applicable, in a patient-centered manner with the goals of improved beneficiary health and wellbeing through more efficient and effective use of resources.

Program Design

• Targeting homeless individuals with avoidable ED visits

• Created due to rise of ED utilization by homeless recipients

• Funded by local hospitals and HHS

• Managed by county coalition

County Example

Key Elements of County VBC Program

Target Population

• Medi-Cal insured adults with...

• Highest medical utilization, repeated avoidable ED visits

• 2 serious chronic conditions (one is MH or SUD)

• High risk for homelessness

Program Tenets

• Assertive community outreach and ongoing service engagement

• Comprehensive behavioral and medical evaluations and comprehensive multi-modal assessments

• Personalized holistic care plan

• Assignment and referral to the principal agencies

Missouri Health Home

…develop Missouri’s CMHC Healthcare Home and Primary Care Health Home models
Why CMHC Healthcare Homes?

Because addressing behavioral health needs requires addressing other healthcare issues

- Individuals with SMI, on average, die 25 years earlier than the general population.
- 60% of premature deaths in persons with schizophrenia are due to medical conditions such as cardiovascular, pulmonary and infectious diseases.
- Second generation anti-psychotic medications are highly associated with weight gain, diabetes, dyslipidemia (abnormal cholesterol) and metabolic syndrome.

CMHC as Health Care Home

Case management coordination and facilitation of healthcare
Primary Care Nurse Care Managers
Medical disease management for persons with SMI
Preventive healthcare screening and monitoring by MH providers
Integrated/consolidated CMHC/CHC Services

Missouri CCBHC Example

Care Coordination
Interoperability
Analytics
Quality Measures and Reporting
Missouri Coalition
Missouri CCBHC Example

CMS/EHRs
Patient Care Data
Risk Mitigation
Population Health Data View
Interoperability
Analytics
Care Coordination
The Power of Whole Person Care

18 Month Cost Savings

- Health Homes: $23.1M
- Disease Management: 3,560 lives $22.3M

Community Hospital Acceleration, Revitalization, and Transformation (CHART) Investment Program

...$120 million reinvestment program funded by an assessment on large health systems and commercial insurers that will make phased investments for certain Massachusetts community hospitals to enhance their delivery of efficient, effective care.


CHART Hospitals

The CHART Investment Program
Theory of Change

- Foster **executive commitment** to change and prioritize investments where such commitment is present;
- Provide **meaningful infrastructure investments** to build a foundation for change;
- Incentivize **innovative** delivery models;
- Build a model for **sustainability**.


---

Strategic Areas of Investment for CHART Hospitals

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Coordination</td>
<td>75%</td>
</tr>
<tr>
<td>ED/Acute Care</td>
<td>75%</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>65%</td>
</tr>
<tr>
<td>Workforce Training &amp; Development</td>
<td>20%</td>
</tr>
<tr>
<td>Data Management &amp; Use</td>
<td>10%</td>
</tr>
<tr>
<td>Service Line Efficiency</td>
<td>5%</td>
</tr>
<tr>
<td>Patient Safety</td>
<td>5%</td>
</tr>
</tbody>
</table>


---

Priority Domains

- Reducing readmissions and improving transfers to post-acute care
- Reducing unnecessary ED utilization
- Enhancing behavioral health care
- Building the technological foundation necessary for patient safety, quality and efficiency

One significant driver of visits to the ED is lack of sufficient and easily accessible behavioral health care for patients with mental illness and substance use disorder.

Delivery System Reform Incentive Payment Program (DSRIP)

DSRIP waivers are not grant programs – they are performance-based incentive programs.

DSRIP Project Example

- Implementing Patient Activation Activities to Engage, Educate and Integrate the Uninsured and Low/non-utilizing Medicaid Populations into Community based care
  - Core Components and Deliverables:
    - Patient Engagement: Develop activities that promote community activation and engagement
    - Linkages to financially accessible health care resources: Provide community bridges that allow access to health coverage resources
    - Linkages to Health Systems and PPS: Build linkages to community based primary and preventative services and community based health education to grow community and patient activation across the region
  - Leveraging HH Care Managers to perform the Patient Activation Measure tool
Patient Activation: Four Stages

- Believing the patient role is important
- Having the confidence and knowledge necessary to take action
- Actually taking action to maintain and improve one’s health,
- Staying the course even under stress.


The Journey to Integrated Care

Interoperability

<table>
<thead>
<tr>
<th>Interoperability</th>
<th>[image]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documentation Exchange</td>
<td>Standardizing data transfer with CCDs, labs, public health registries and health information exchanges</td>
</tr>
<tr>
<td>Secure, Direct Exchange</td>
<td>Direct Message internally as well as externally to the larger provider community, enabling coordinated care across the care continuum</td>
</tr>
<tr>
<td>Transitions of Care</td>
<td>Point-to-point referrals within a single workflow</td>
</tr>
<tr>
<td>Query-based Exchange</td>
<td>Find/request information from other providers, such as discharge summaries</td>
</tr>
<tr>
<td>Integrated, Whole-person Care</td>
<td>Single patient record across the entire continuum</td>
</tr>
</tbody>
</table>

Direct Secure Messaging Solution

A Look at Some Key Capabilities

- Quickly and securely exchange referrals with external provider organizations
- Send and receive clinical data, lab results and treatment plans as required for integrated care models
- Incorporate external data directly into the consumer’s chart utilizing the existing user workflow

<table>
<thead>
<tr>
<th>Direct Secure Messaging Solution</th>
<th>[image]</th>
</tr>
</thead>
<tbody>
<tr>
<td>[image]</td>
<td>[image]</td>
</tr>
</tbody>
</table>
TECHNOLOGY, LEADERSHIP AND CULTURE

Every system is perfectly designed to get the results it gets.

Source: Earl Conway or Paul Batalden or W. Edwards Deming or Don Berwick or…


Conway’s Law

Companies create products and services that are a reflection of themselves, the way they’re organized, communicate and work.

Sam Newman 30 JUN 2014 Demystifying Conway’s Law. ThoughtWorks
https://www.thoughtworks.com/insights/blog/demystifying-conways-law
“Culture is not the most important thing, it’s the only thing”.
Jim Sinegal, Costco co-founder

Leaders need to recognize that all experiences create culture, and their culture is either working for them or against them.

Roger Connors, CEO Partners in Leadership in Organizational Culture in The Digital Age

...if you asked most people to list the things that create and maintain a strong company culture...

...chances are they wouldn’t list technology.

https://hbr.org/2016/02/build-a-great-company-culture-with-help-from-technology
Leadership and Technology Lines Blurring

...CEO, CFOs and COOs are becoming more immersed in technology decisions, while CIOs and CTOs -- and their IT staff members as well -- are being asked to join in on high-level decision-making teams.


Keys to Successful HIT Implementation

Workflow
Data Flow
Leadership

Leadership and The “Why”

Technology = “what”
Purpose, goals, etc.
But why do we want the technology?

Why are we doing this and why aren’t we doing that?
The Unique Role of Senior Leadership (especially the CEO):
What Can Only You Do?

Send a clear and unequivocal message:
This change is going to happen
The organization will be better off because of it
All are invited to be part of the adventure, but it will happen
These are the things we will no longer be doing.

The Unique Role of Senior Leadership:
Develop Guiding Principles.
Example: EHR Implementation
- Single Source of Truth
- Data will be entered once and once only
- "Go Live" is the beginning, not the end
- We aren’t as different as we think we are
- 80% is good enough to start

Common Themes for Value Based Care Initiatives
- If you’ve seen one, you’ve seen one
- Targeted Population
- Care Coordination
  - Measurement and Analytics
  - Leadership
- Electronic Data Capture and Exchange
Key Challenges in Implementing Value Based Purchasing

- Quality Measurement
- Provider Capacity
- Oversight
- Privacy And Data-sharing Constraints.

Soper, MH, Matulis, R, and Menschner, C. Moving Toward Value-Based Payment for Medicaid Behavioral Health Services Center for Health Care Strategies June 2017

Too often we hold fast to the clichés of our forbearers. We subject all facts to a prefabricated set of interpretations. We enjoy the comfort of opinion without the discomfort of thought.

- John F. Kennedy

Thank You

Dennis Morrison, PhD
Chief Clinical Advisor
Netsmart
dmorrison@netsmart.com
Twitter: @DrDennyM

YouTube TEDxBloomington
http://www.youtube.com/watch?v=zQbtDaJCi0M