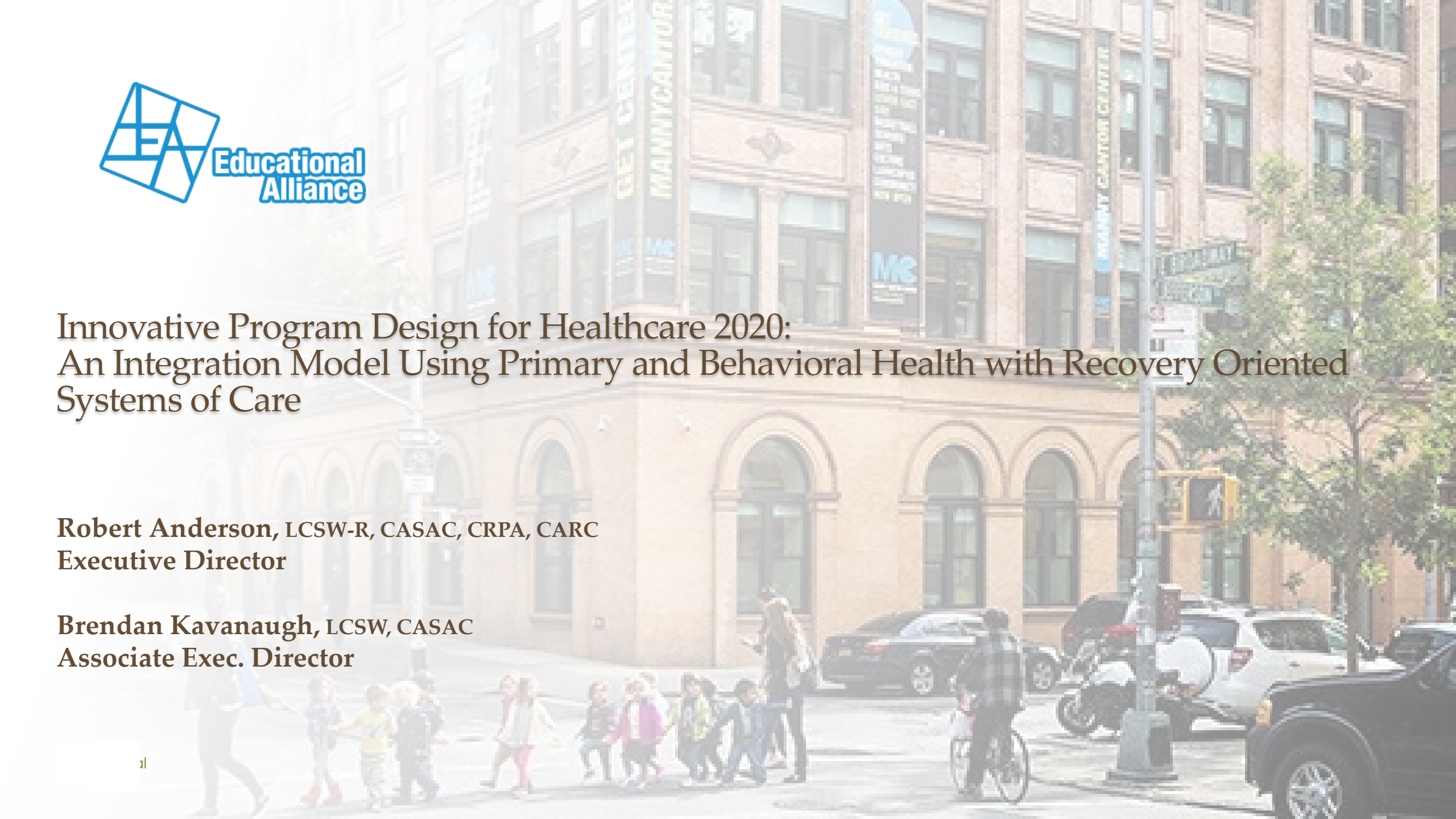

Innovative Program Design for Healthcare 2020: An Integration Model Using Primary and Behavioral Health with Recovery Oriented Systems of Care

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Executive Director

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Associate Exec. Director

Agenda

- Historical Overview
- Needs for 2020 Value based care
- How do I assess if my traditional treatment program needs to adapt to an integrated and sustainable model?
- Program Design case study- Center for Recovery and Wellness
  - Triple Aim; Community Assessment, Focus groups, Logic model
- Lessons learned
  - Culture
  - Trauma Informed Framework
  - Networks
  - Primary Integration with addiction and mental health
  - "Don't throw the baby out with the bath water"
- Outcomes and early success stories

How did we get here?

- Many of the larger traditional addiction agencies started as “grass roots” efforts.
- The 60’s and 70’s saw the need to develop models to address rising heroin and other narcotic use (Viet Nam, civil rights era)
  - rise of the TC model
  - 12 step programs began to focus more on narcotics rather than just traditional “AA”
  - Methadone introduced as harm reduction and social control

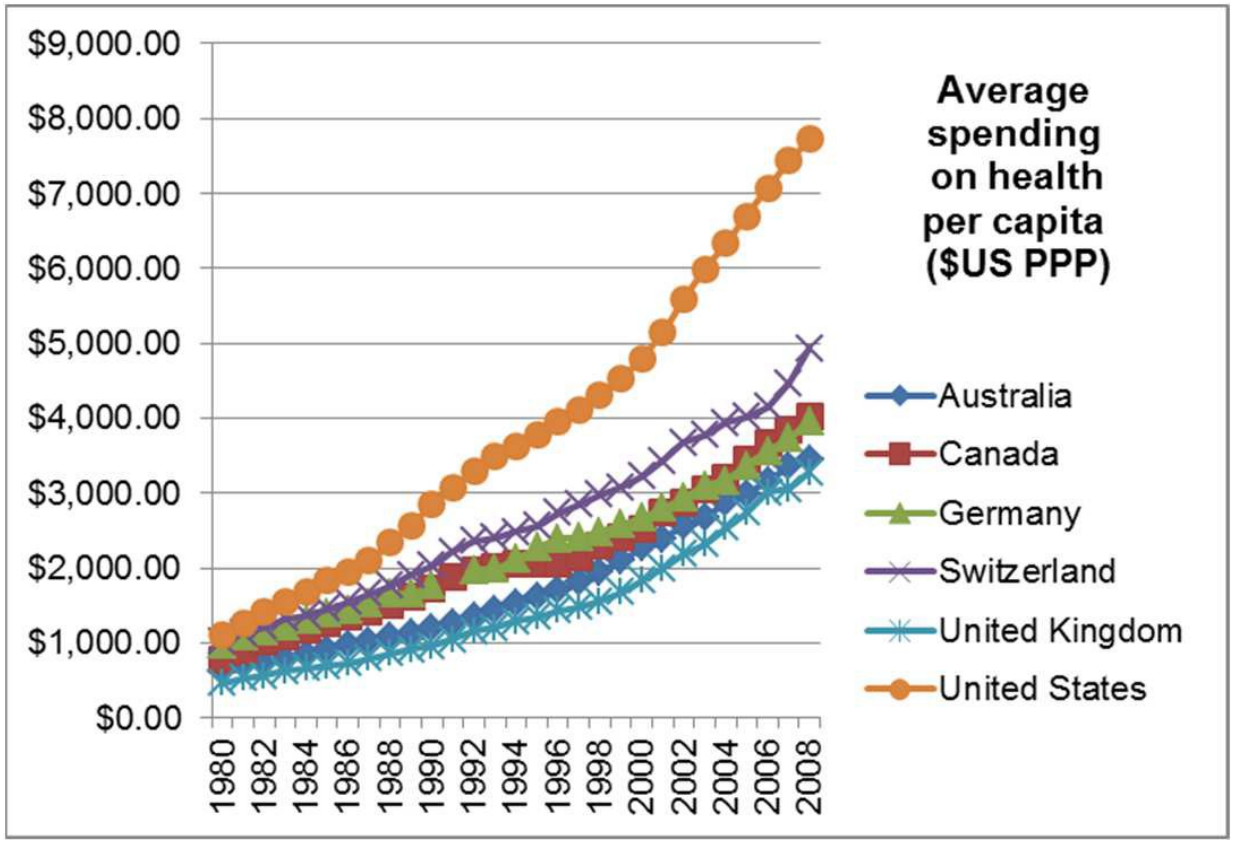
Historical Perspective

- As government got involved and began to regulate and fund treatment, there was a definite dichotomy for private versus public programs
- NYS to its credit has developed the largest system of public funded treatment programs
- With the AIDs epidemic, “Crack”, and today the Opiate epidemic, NYS OASAS based programs have become a venue to treat and manage the public populations affected.
- There has been a recent shift from a “public safety” lens to addiction to more of a “public health” model- less incarceration, more treatment

Healthcare in Flux

- With this greater “public health” focus comes a change in funding
- Previously, traditional publicly funded agencies relied mainly on state contracts and donations for funding, Medicaid limited to clinic based outpatient.
- Residential re-design has led to the 820 model of care, including Medicaid as a payor for residential medical and clinical services.
- Outpatient as well has been drawn into a value based paradigm.
- 2020 remains a target date we all need to be aware of and plan for.

WHY VBP? U.S. Healthcare Spending



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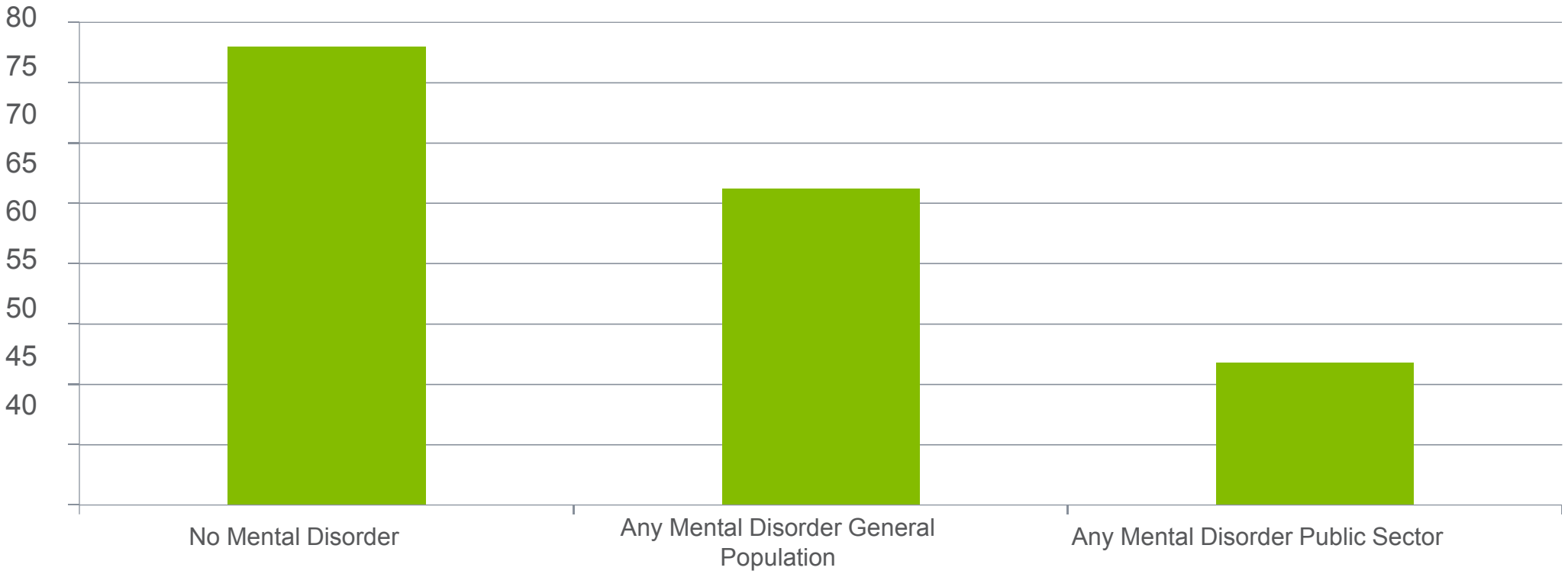
Life Expectancy



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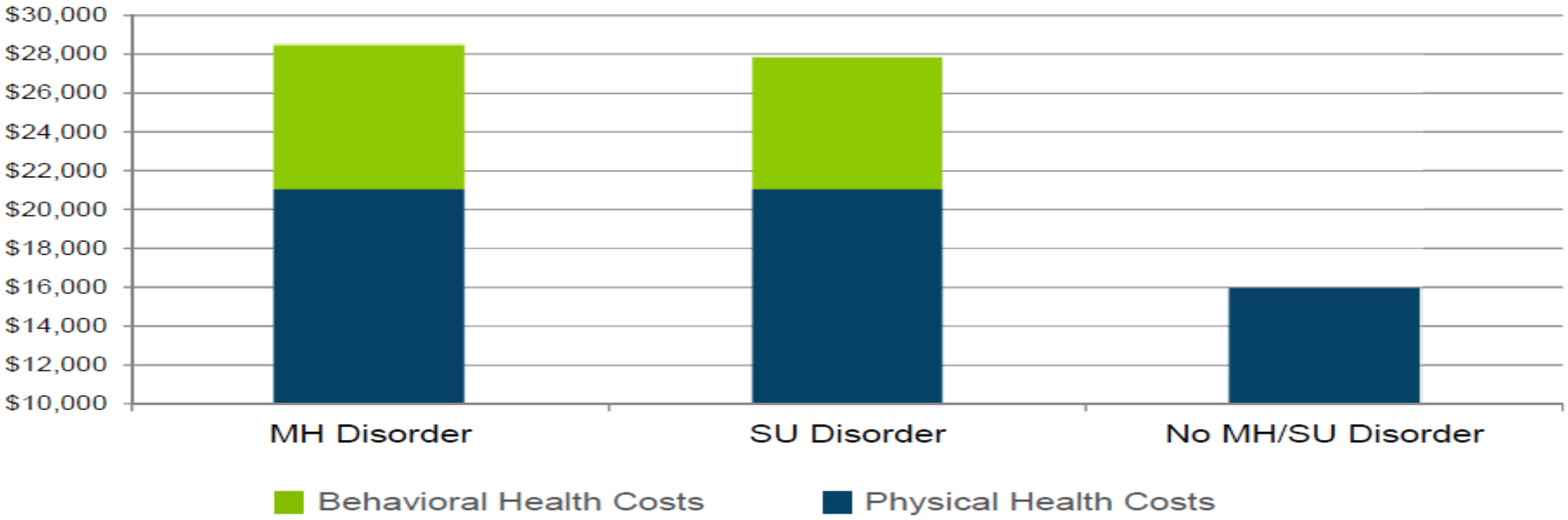
MH/SU costs in NY State's Medicaid Program



Target date-2020

- VBC or “value based care” payments and delivery systems are creating anxiety in many healthcare arenas
- Provider organizations, especially in the not-for-profit addiction and mental health systems are especially sensitive to potential missteps or poor planning.
- Given the infrastructure and budget gaps, many providers feel vulnerable or unsure of where they will land once Pay for Performance contracting is here.
- Currently: Organizations that are not large enough to stand alone are at risk- network and partnerships are necessary moving forward.

Target date-2020

- BHCCs, IPAs, ACOs and other fond acronyms
- Network groups are preparing for the transition to full managed and potentially capitated care, with performance based incentives.
- The Value Based Payment paradigm will impact our addiction/mental health system-one cannot just wish it goes away, or stay in “denial” with our heads in the sand

Value Based Preparation

- Person centered practices and the forces of Value Based Payment will change the way you deliver services.
- They will:
  - Promote Innovation
  - Impact Finances
  - Change the nature and roles of accountability
  - Foster/enhance collaboration

- Source McTAC and CASA Value Based bootcamp

Healthcare Reform: Volume vs. Value

Fee-for-Service/Volume: Payment is based on the number of services provided, regardless of quality or impact on health. Does not incentivize prevention, coordination, or integration.

Value Based Payments/Value: Some or all of payment is based on outcomes of services provided (achieving the Triple Aim!).

Inability to achieve the required outcomes will result in financial penalties and lower reimbursement and create a significant financial burden for providers.

Focus of Healthcare Reform: Achieving the Triple Aim

- Improving the patient experience of care (including quality and satisfaction)
- Improving the health of populations
- Reducing the per capita cost of health care

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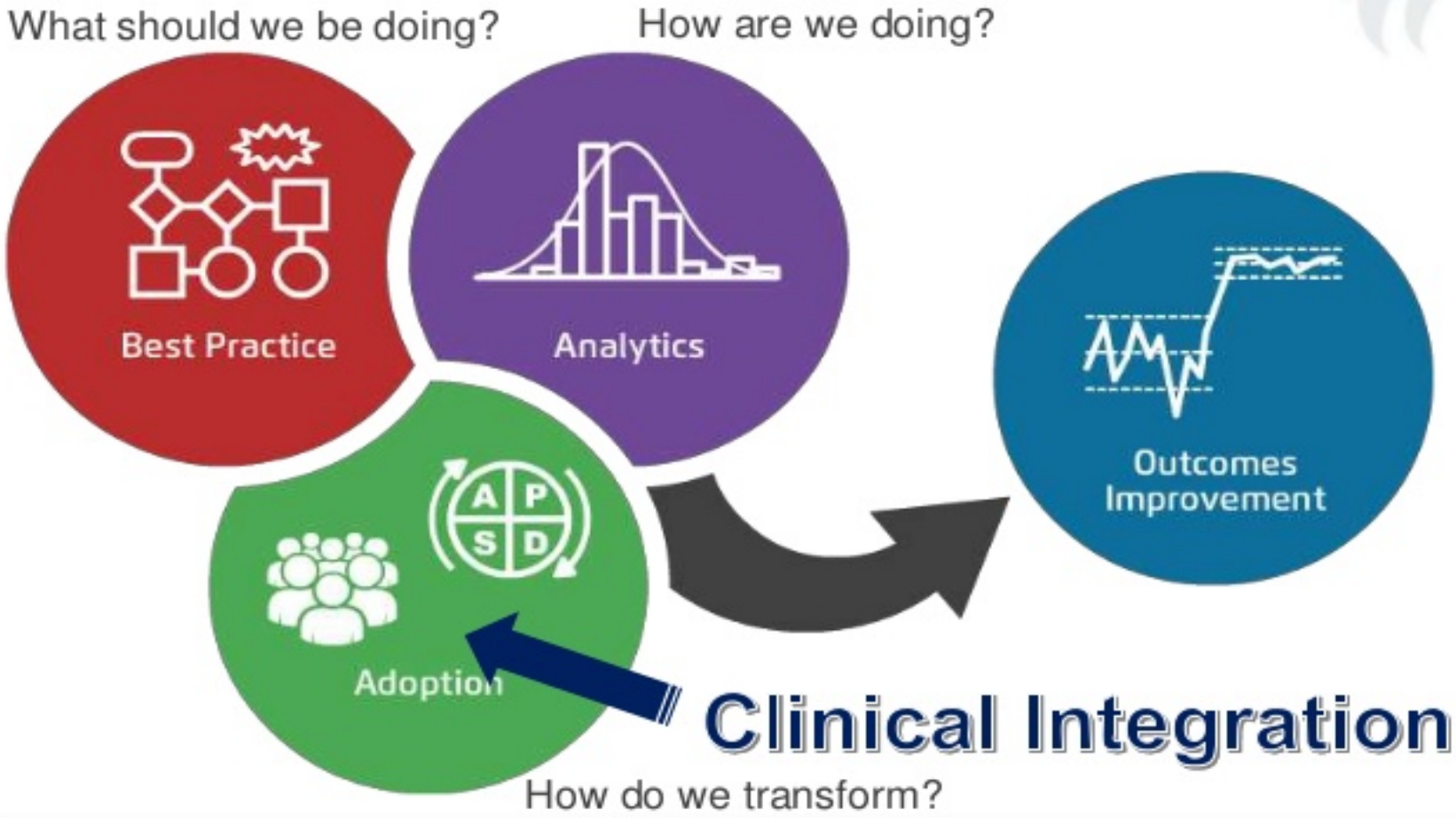
Three Systems for Improvement



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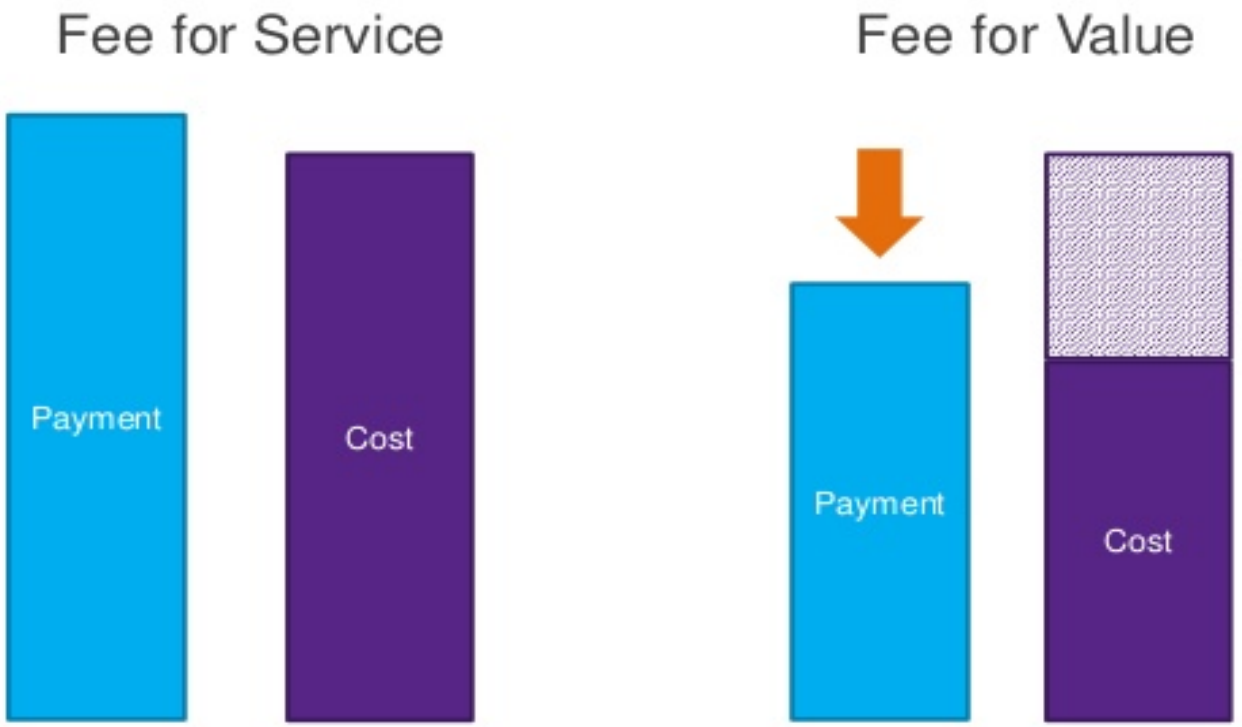
The Common Denominator: Reduce Costs, Improve Quality



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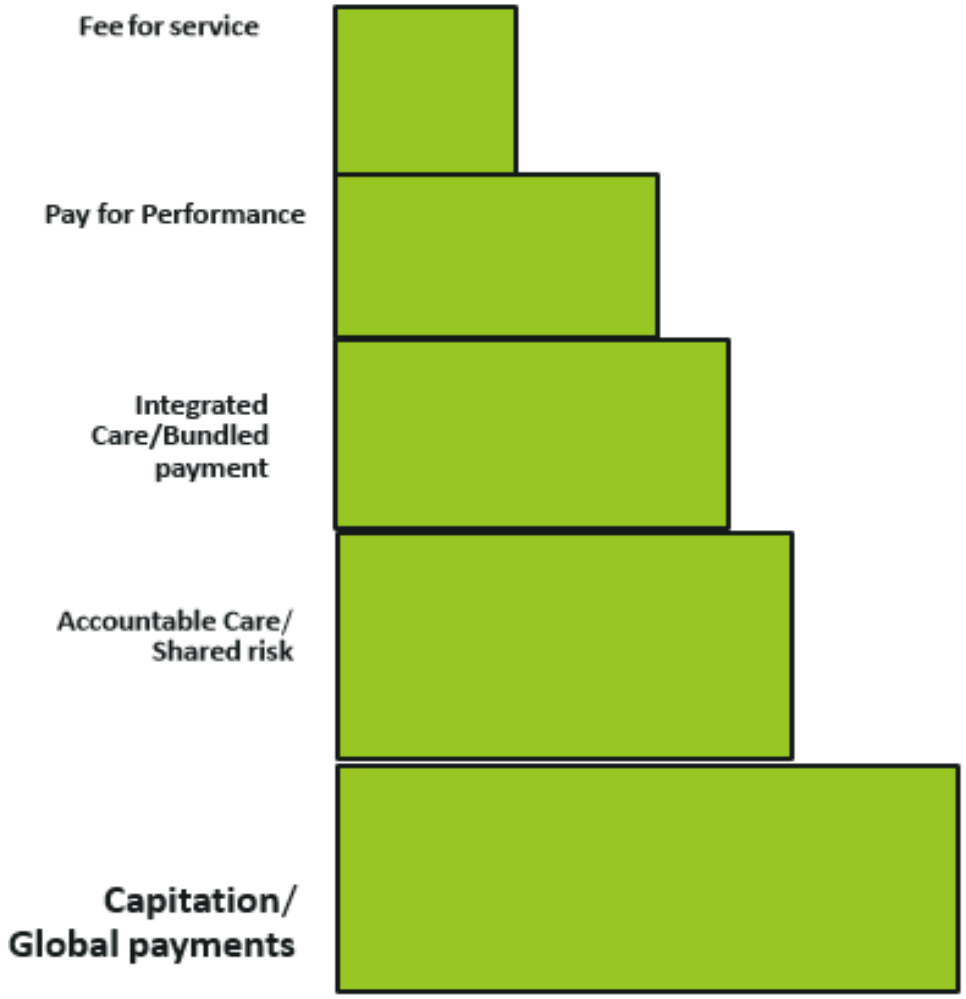
Setting the Context of Healthcare reform



Healthcare payment reform:
This directly shows the flow of where we are headed in regards to payment for your services

Payment paradigm

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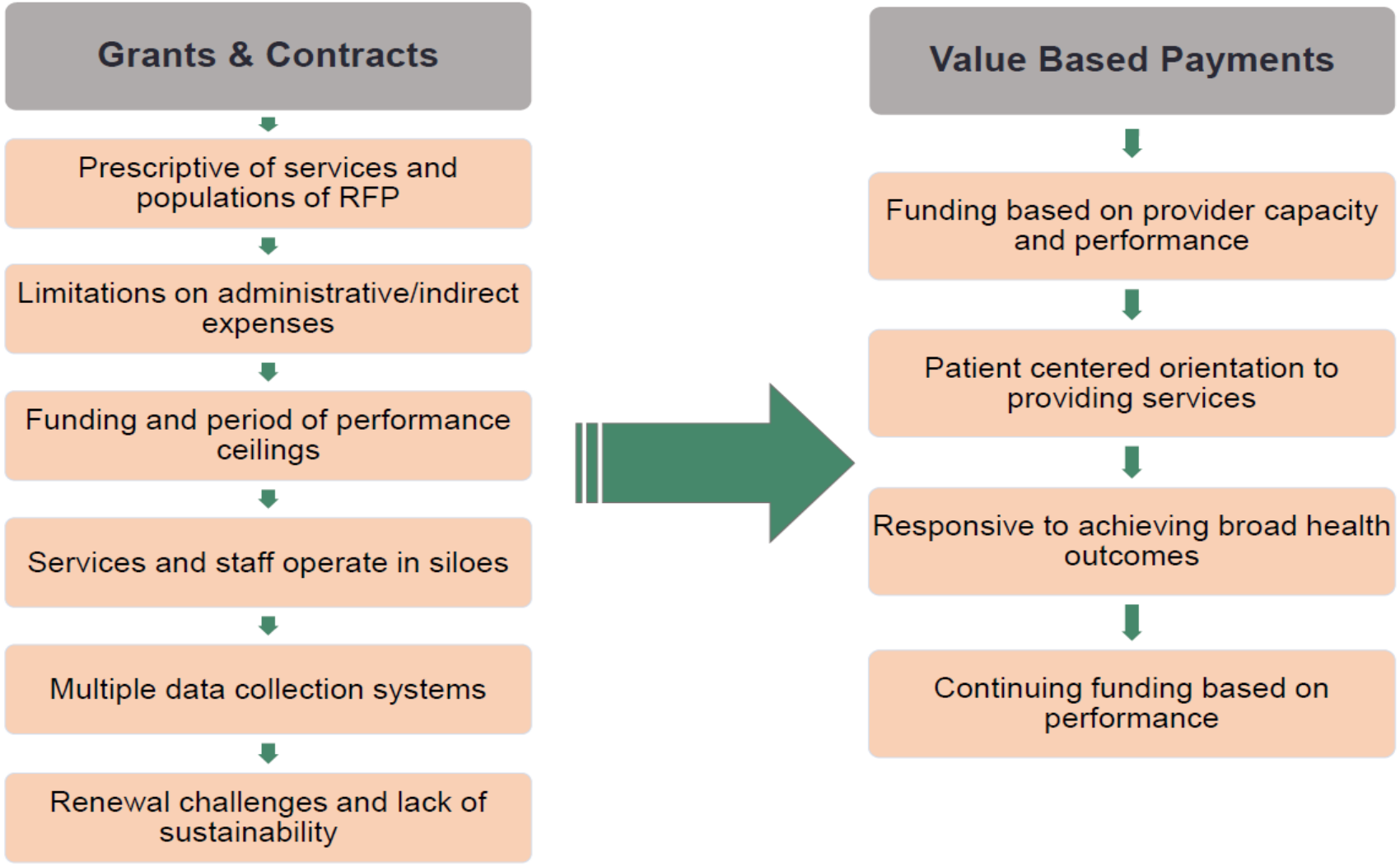
Grants & Contracts
Prescriptive of services and populations of RFP
Limitations on administrative/indirect expenses
Funding and period of performance ceilings
Services and staff operate in siloes
Multiple data collection systems
Renewal challenges and lack of sustainability
Value Based Payments
Funding based on provider capacity and performance
Patient centered orientation to providing services
Responsive to achieving broad health outcomes
Continuing funding based on performance

Does my agency need a new model?

- Factors and data to look at:
  - The number of hospital beds per 1,000 people has declined in the U.S. from **7.9** in 1970 to **2.9** in 2012.
  - Residential addiction beds have followed this same pattern-yet Outpatient options are growing (even in an Opiate epidemic)
  - Physician and Program income has remained static over the past decade
  - National retailers like Walmart, CVS, and Walgreens are going after the primary care market on a large scale, by offering in-store clinics that provide basic services at prices as much as 40% below what physicians' offices charge.
  - In the past, providers would cover losses from Medicare and Medicaid and from uninsured populations by demanding higher payment rates from commercial insurance plans—often winning increases of 8% to 10% per year. **THOSE DAYS ARE LONG GONE! Now commercial and M/C have managed care oversight.**

➡ Performance will ultimately dictate payment !!

How do we prepare or if needed-change?

- Organizations that fail to improve “value”, no matter how prestigious and powerful they seem today, are likely to encounter growing pressure.
- Even health insurers that are slow to embrace and support the value agenda—by failing, for example, to favor high-value providers—will lose subscribers to those that do.
- Providers that cling to today’s broken system will become “dinosaurs” (unless prepared public system giants could need to merge or become acquired- we have evidence of this already) Reputations that are based on perception, not actual outcomes, will fade. DATA, DATA, and the ability to transmit DATA
- Those organizations—be they large or small, community based or academic—that can master the value agenda (performance based outcomes) will be rewarded with financial viability and the only kind of reputation that should matter in health care—excellence in outcomes and pride in the value they deliver

How do we prepare or if needed-change?

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Treatment Gaps

So now that we are subject to this general philosophical shift, **HOW DO WE APPLY THIS MODEL TO OUR ORGANIZATION**?

- Which services do we keep? Move away from?
- Is clinical care based on the bottom line or what is clinically necessary? Or both?
- Like all data driven organizational strategies-we must first look at the overall needs…of the community, our clientele, our referents, and society itself
- Mission and Vision must still be matched with model

Treatment Gaps

- SAMHSA offers the **NBHQF** as a guiding document for the identification and implementation of key behavioral health quality measures for use in agency or system funding decisions, monitoring behavioral health of the nation, and the delivery of behavioral health care.

- How are these measures determined? And how can we drill down to make them relevant to our own agencies and communities?

- Most are **process measures**, focusing primarily on mental health conditions such as depression and with the push for integration-many primary health outcomes are being considered.

Treatment Gaps

- SAMHSA also recognizes there are BH activities and practices for which the evidence base is not mature or areas in which data collection is still evolving (AKA “a politically correct way of saying Addiction Treatment”). The field of behavioral health quality measurement is relatively young in its development.

- We have moved to a mindset of “Integration”, so when planning-
  - are you capable of providing true integrated care?
  - Who do you need to partner with?
  - If we know what type of outcomes are being touted, and that integrated care is the model; can we back in to designing clinical programs that connect these areas?

- There are think tank nationally and at our state level that are looking at metrics and outcome measures. These will help define what managed care and our regulators are looking for-but clinical design is still in your ballpark!

Treatment Gaps

- These are the guiding goals that one must consider when designing (or re-designing) clinical models of care:
  - evidence-based practices,
  - person-centered care,
  - coordinated care,
  - healthy living for communities,
  - reduction of adverse events,
  - and cost reductions.

Disclaimer: The proposed measures are not intended to be the complete or total set of measures a payer, system, practitioner, or program may want to use to monitor quality of its overall system or the care or activities it provides.

Treatment Gaps

- The impact of each of these areas will be tracked via these core behavioral health quality measures and metrics across three targets or domains.

- The targets are:
  - payers (Medicaid, SAMHSA, other federal agency, state/county, or private payers);
  - providers/practitioners;
  - and general populations (individuals, families, and communities). DO NOT be afraid to go to the source and elicit information-they are the experts in their own situations. They know what they need!

Bridging Treatment Gaps: Community Needs Assessment

- In order to make the case that we're having an impact on the community, we first need to demonstrate that we understand the level of need currently existing in the community
- Our Community Needs Assessment model includes:
  - Rapid surveying of CRW clients and non-clients in the community, obtaining a sample of responses that are **representative** of the community
  - Root cause analysis linking social determinants of health to outcomes experienced by community members
  - Geo-mapping to identify the source of each issue on a hyper-local level

Bridging Treatment Gaps: Community Needs Assessment

- Phase 1: Community Surveys
- Phase 2: Vetting and Validation of Systemic Causes
- Phase 3: Baseline Establishment and Recommendation of Indicators
- Phase 4: Analysis, Link Community Needs and Social Determinants of Health
- Phase 5: Ongoing Tracking of Client Outcomes (SDH) Relative to Community Needs

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Case Study in Change Management- From Inception

- Let's look at how Educational Alliance literally changed the entire location, clinical structure, culture, payment design, physical plant and models of care within a 2 year period.
- Collaborative planning:
  - Work with OASAS and our Board to identify an exciting, first of a kind, community based model
- Look back at traditional strength and needs of the agency
    - Community center model based on Recovery and Wellness principles
    - Diverse full continuum of OASAS care
    - Need to break down siloes, create a culture of excellence
    - Opportunities- 820, recovery support services, 1115i waiver

Case study in change management

- Gather data to inform decision making
  - Surveys
  - Pilot groups
  - Community assessment
- Agree and get buy in for the model: Recovery and Wellness based paradigm which fits directly into healthcare reform
- One simple fact about “Change Management”- Organizations do not change; People do!!
  - Culture shift
  - Planned team building
  - Revisit mission and vision

WHAT IS CHANGE MANAGEMENT? A TREATMENT PLAN FOR OUR ORGANIZATION

- Change management is the discipline that guides how we prepare, equip and support individuals to successfully adopt change in order to drive organizational success and outcomes.

- While all changes are unique and all individuals are unique, decades of research shows there are actions we can take to influence people in their individual transitions. Change management provides a structured approach for supporting the individuals in your organization to move from their own current states to their own future states.

THREE LEVELS OF CHANGE MANAGEMENT

Individual Change Management

- It is natural for humans to resist change, yet we are actually quite resilient creatures. When supported through times of change, we can be wonderfully adaptive and successful.

- Individual change management requires understanding how people experience change and what they need to change successfully.

- It also requires knowing what will help people make a successful transition: what messages do people need to hear when and from whom, when the optimal time to teach someone a new skill is, how to coach people to demonstrate new behaviors, and what makes changes “stick” in someone’s work.

THREE LEVELS OF CHANGE MANAGEMENT

Organizational/Initiative Change Management

- While change happens at the individual level, it would be impossible to manage change on a person-by-person basis in a large organization.

- Organizational change management provides us with the steps and actions to take at the project level to support the hundreds or thousands of individuals who are impacted by a project.
  - first identifying the groups and people who will need to change as the result of the project,
  - in what ways they will need to change?
  - Create a customized plan for ensuring impacted employees receive the awareness, leadership, coaching, and training they need in order to change successfully.
  - Driving successful individual transitions should be the central focus of the activities in organizational change management.

- Organizational change management is complementary to your project management. Project management ensures your project's solution is designed, developed and delivered, while change management ensures your project's solution is effectively embraced, adopted and used.

THREE LEVELS OF CHANGE MANAGEMENT

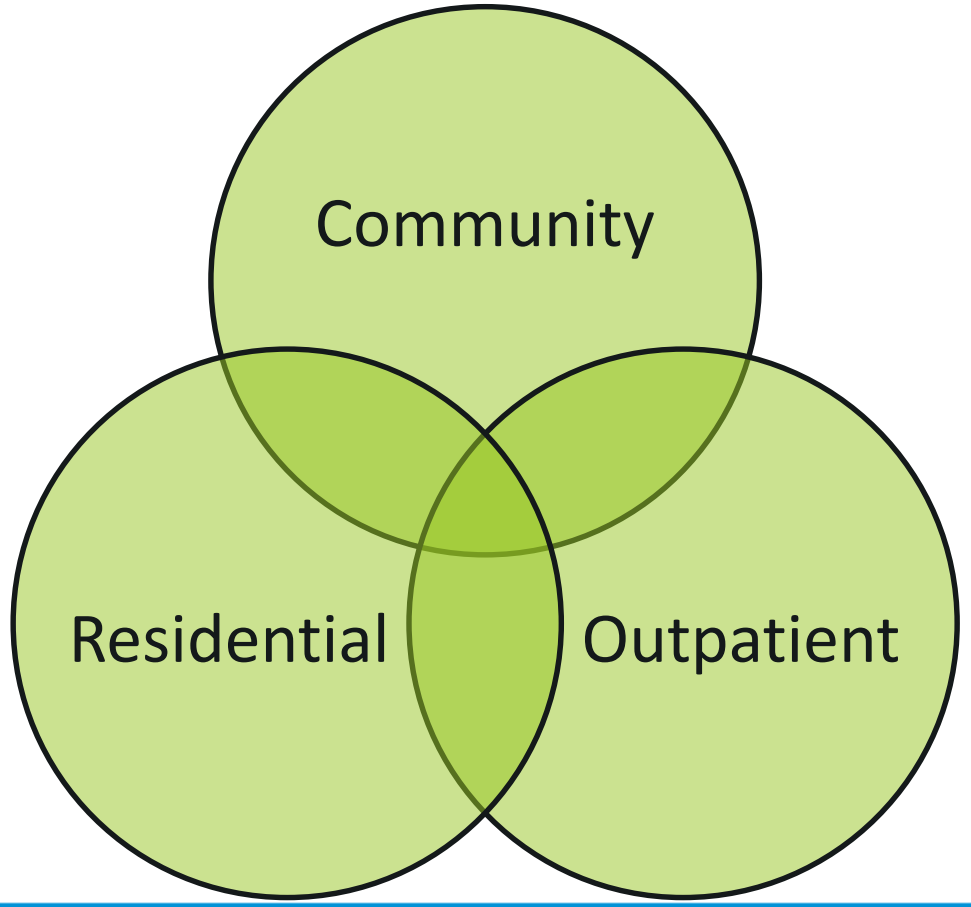
Enterprise Change Management Capability

- Enterprise change management is an organizational core competency that provides competitive differentiation and the ability to effectively adapt to the ever-changing world.
- Enterprise change management allows for effective change management to be embedded into your organization's roles, structures, processes, projects and leadership competencies.
- Change management processes are consistently and effectively applied to initiatives, leaders have the skills to guide their teams through change, and employees know what to ask for in order to be successful.
- The end result of an enterprise change management capability is that individuals embrace change more quickly and effectively, and organizations are able to respond quickly to market changes, embrace strategic initiatives, and adopt new technology more quickly and with less productivity impact.
- This capability does not happen by chance, however, and requires a strategic approach to embed change management across an organization.

Why change to a Community Center model?

- With collaborative planning with OASAS; we took the strengths of our overall agency and applied it to our addiction and co-occurring disorder programs.
- Borrowed a community intervention idea from the HIV world
- Redesign physical plant and model to reflect a true community center.
  - Community Centers are public locations where members of a community tend to gather for group activities, social support, public information, and other purposes. They may sometimes be open for the whole community or for a specialized group within the greater community.
  - If the HIV world could use a community center model to bring down the viral load of a neighborhood, why couldn't we do the same thing with substance use disorder?

How do we get to the sweet spot of wellness?



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Intervention Levels

- Individual – who is the person, why did they come into the Center, how can we be part of uplifting this life?
- Group – usually a peer but could be family, friends, neighbor? What is the goal of the meeting or gathering?
- Community – if the community does not focus on wellness, can the individual stay healthy?
- Structural – is their a change need in the laws or policies in order to accomplish goals?

How to develop a Community Center model?

- Learn the neighborhood and it's needs.
- ID the risk factors in the neighborhood?
- Do you have expertise in that area?
- Do you know your neighbors?
- When was the last time you invited your neighbors in to your "home"?
- Are you really welcoming? (Culture shift)
- Develop programming that integrates internal clients with community based efforts, as well as traditional and emerging practices.
- Recovery center is a key piece!
    - What did we learn?

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Community

Educational Alliance
Center for Recovery and Wellness

Now that we decided to build it - what next?

- Meeting the community where they are at!
- How does your agency want to be viewed?
  - The outsider “do-gooder”
  - Or the “valuable partner” and member
- Think **MI**…avoid the expert trap!
- When in doubt- just ask???
  - Engage the community
  - Identify community based needs, and professional field and internal agency systems
  - DATA, DATA, DATA

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Community

Educational Alliance
Center for Recovery and Wellness

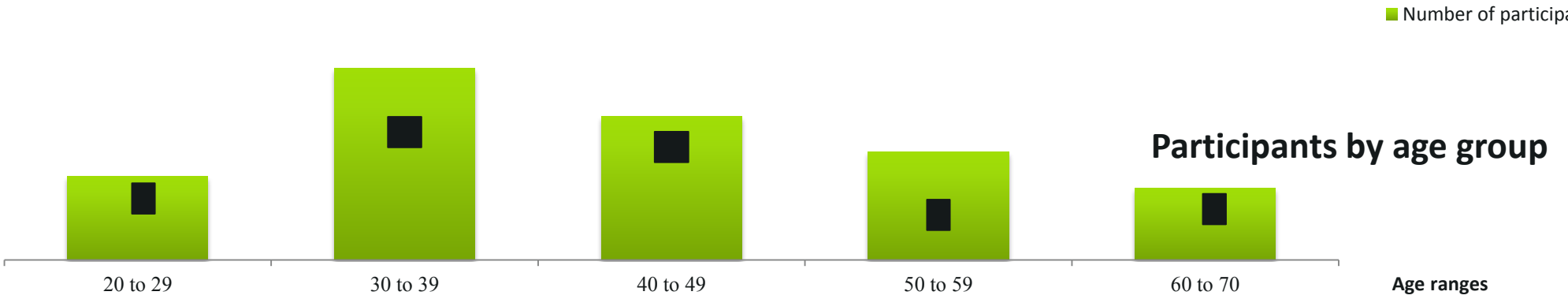
Focus group process:

- Introduction to EA and their services
- Discussion of the proposed Center for Recovery
- Respondents were also asked about their future interest in recovery services
- Trained facilitators discussed:
    - familiarity with addiction
    - recovery and treatment
    - the community need for additional resources

Participant Characteristics

Sample: There was a total of 54 participants in 5 different groups.
Age: Participants ranged in age from 23 to 68 years old, with an average age of 42. Most of the participants were between 30 and 49 years in age.

Group 1 Staff -EA	Group 2	Group 3	Group 4	Group 5 Addiction Division
8	8	12	19	7



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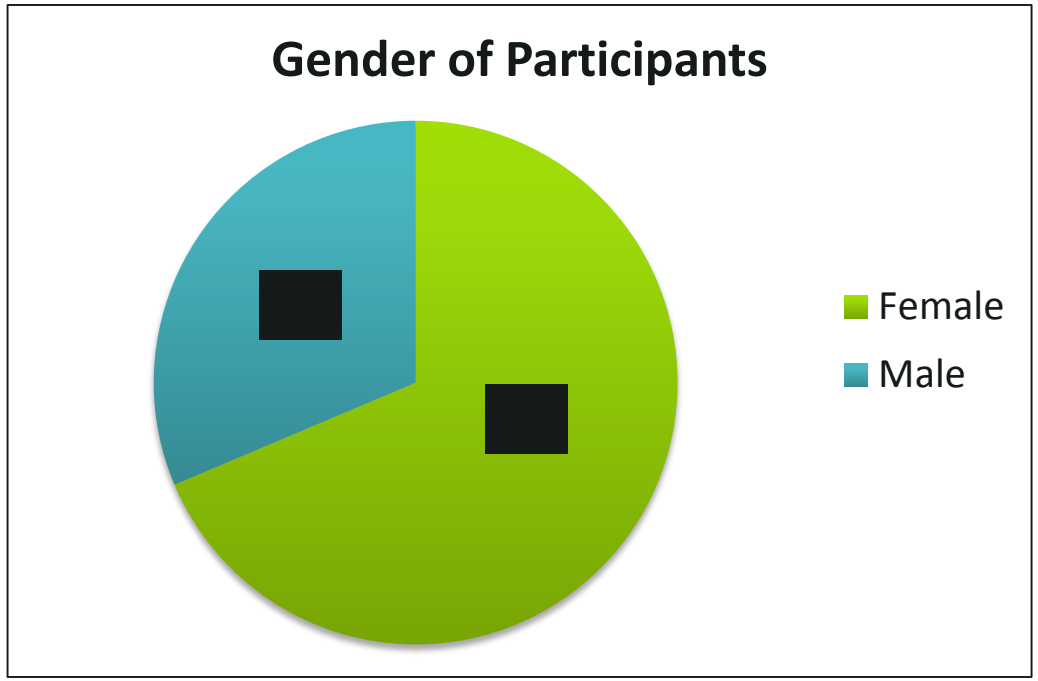
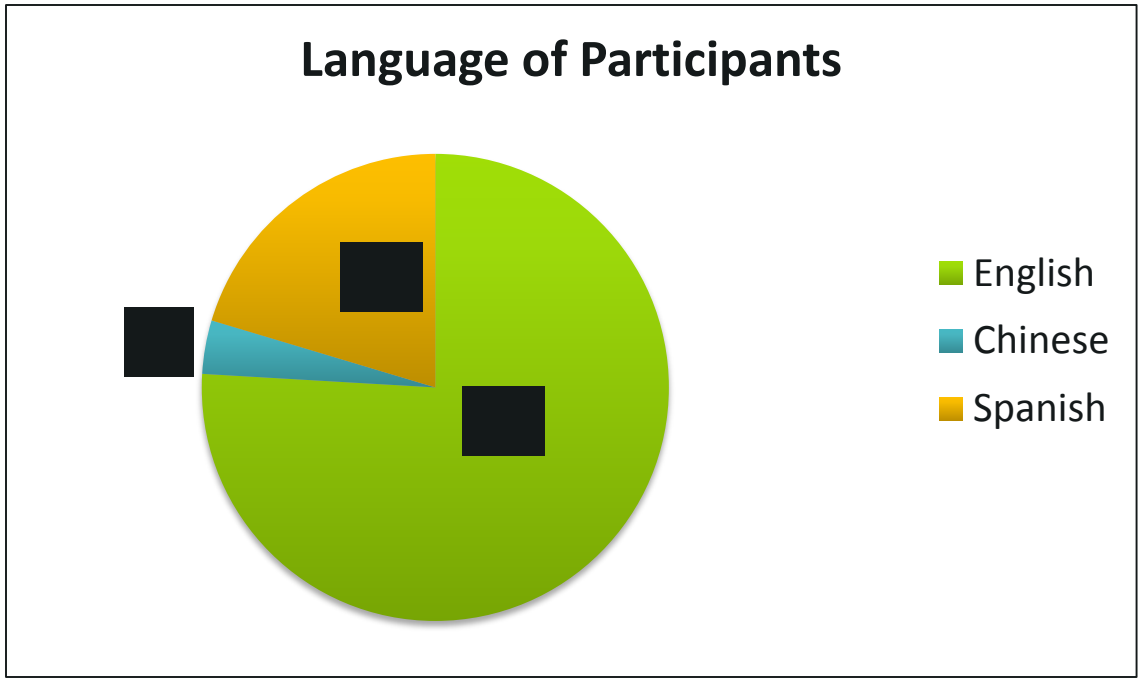
Participant Characteristics

Gender: The majority (69%) of the participants were female

Language: English was spoken by a majority (76%), followed by Spanish (20%) and Chinese (4%)





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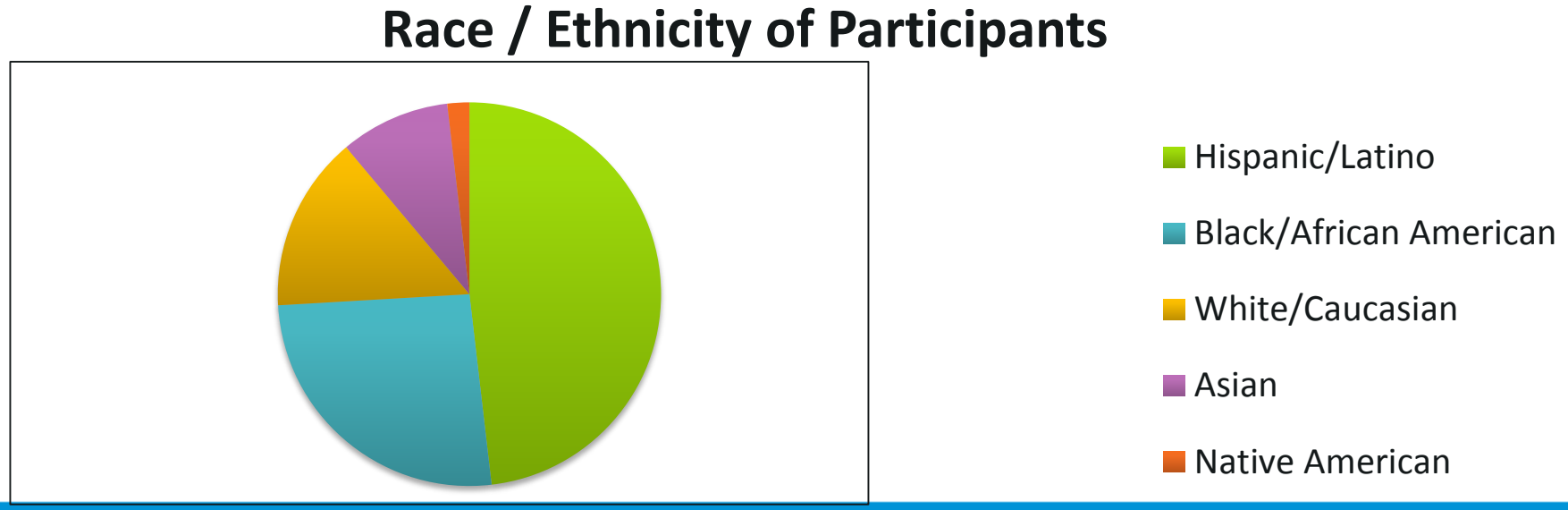
Participant Characteristics

- Almost half of all participants self-identified as Hispanic / Latino (48%)
- Approximately one quarter of the sample identified as Black/African American (26%)
- Only one person identified as Native American



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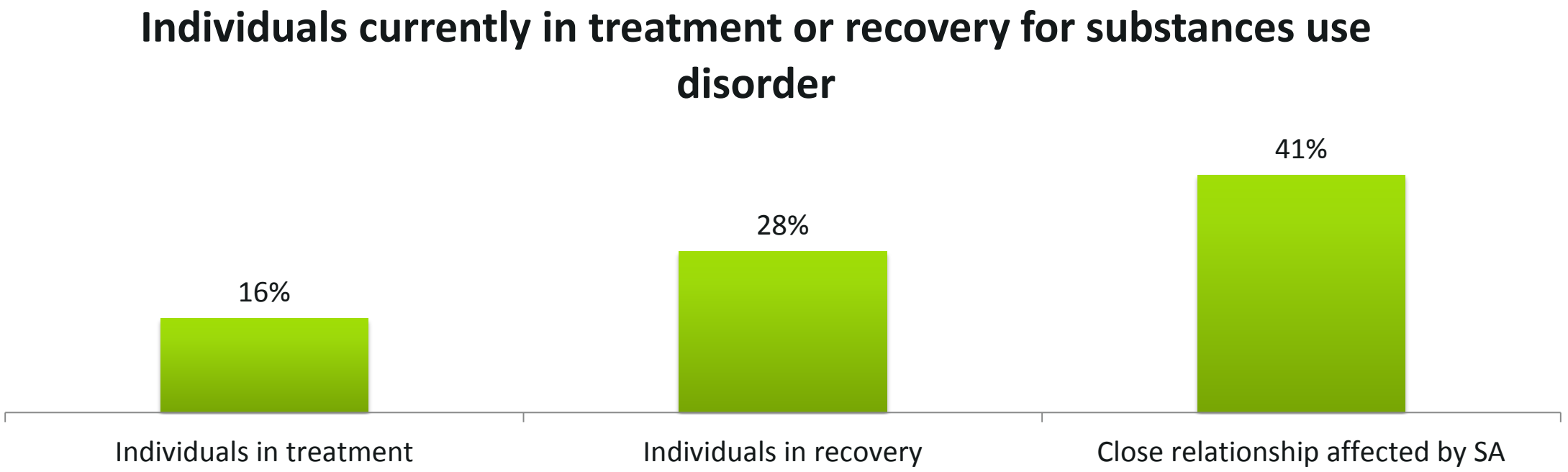
Participant Characteristics

More individuals reported they were having close relationships affected by substance abuse than were in treatment or recovery.



Focus Group Discussion

- **Outcomes/Impact of addiction:**
  - expressed need for addiction services to include families in the treatment process
  - help people communicate better
  - Provide resources for the community where none currently exist

Focus Group Discussion

Services that participants identified as needed:

- Having informative and educational workshops, skill building groups, and wellness-related fun activities (such as gardening, open mic poetry)
  - Some participants wanted treatment programs to include non-denominational spiritual components, grief counseling and services that cater to LGBT populations
  - Many community members wanted friends to be included in the family support groups and have AA/NA available on site

Focus Group Discussion

Seminars such as:

- Life skills training (for children and adults), housing support, financial counseling, prevention related topics, nutrition and cooking classes, exercise classes were some of the most frequently mentioned topics
- There was considerable interest in adding *social activities* for building community support

Meeting the Community Where They Are At

Strategic Planning

- Community input and data obtained-next steps
- Choice of programming-fiscally viable yet cutting edge
- Build to existing strengths
- Plan for and train for robust treatment with multifaceted modalities
- Recovery Oriented focus
- Combine existing models with emerging best practice
- Overarching paradigm of “Community Center”

Building Essential Elements of CRW

- Staffing – Agency Employees and Mentor mix
- Full Continuum of Care with 820 licensure incorporated
- Individual Treatment Plans and Services-in practice not just in print
- Peer Support “wrap around” of every program
- Community Outreach and EA In-reach
    - Use of existing agency resources and other community centers in the Educational Alliance portfolio
    - Break down silos
- “Family” as a therapeutic concept; Community as a tool enhances client centered approaches
- Community as Healer!

CRW Client Focus

Make sure our members:

- Connectedness to the Recovery Community
- Physical Health
- Emotional Health
- Spiritual Health
- Living Accommodations
- School/Job/Education
- Personal Daily Living Management
- Rehabilitation-Learn to live again!

The Continuum

- **NYS OASAS certified programs**
  - Prevention and Outpatient
  - Residential 820
    - 3 elements: Stabilization, Rehabilitation, Re-Integration
- **OASAS collaborative development**
  - Innovation: First of its kind; overarching “Community Center” paradigm dedicated to addiction and holistic wellness
  - Formal Recovery Center and ROSC Supports/coaching
- **EA driven**
  - Community outreach and navigation
  - Heavy emphasis on Peer Services
  - Offsite service development with community partners: NYCHA; Housing programs; Schools and Family Groups

Meeting the Community Where They Are At

Clinical Strategic plan

- Implement a full continuum of care
  - Focus on community outreach and education
  - Leverage agency partnerships to bridge gaps and break down silos
  - Community level workshops on primary health, substance use disorder, obesity, high risk behavior reduction and holistic wellness; NARCAN distribution and training
  - Incorporate the 820 residential re-design model
  - 822 Outpatient with an Offsite and Onsite service mix
  - Wrap around peer support at all levels
  - Access to community center for all!!
  - Long term goal: DEVELOP AN INSITITUTE!

Community-Based Approach to Recovery

- Educational Alliance's newly opened Center for Recovery and Wellness is proudly pioneering an **innovative approach to substance abuse and community health.**

- Utilizing Educational Alliance's **community-based approach**, this progressive center has **extended the continuum of care** to include programming for the whole community.

- This new model recognizes that complex factors including trauma, lack of connectedness, and inability to self-regulate can prevent individuals from accessing the critical resources—including recovery services—that are needed to live healthy, whole, and productive lives.

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Community-Based Approach to Recovery

Four pillars that all of Educational Alliance's community centers are based on:

- Education
- Health and Wellness
- Arts and Culture
- Civic education and Community engagement

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What prevents community members from accessing services?

- **Complex factors**
  - Trauma
  - Lack of social connectedness
  - Inability to self-regulate
  - Stigma
  - Uninformed
  - Poverty

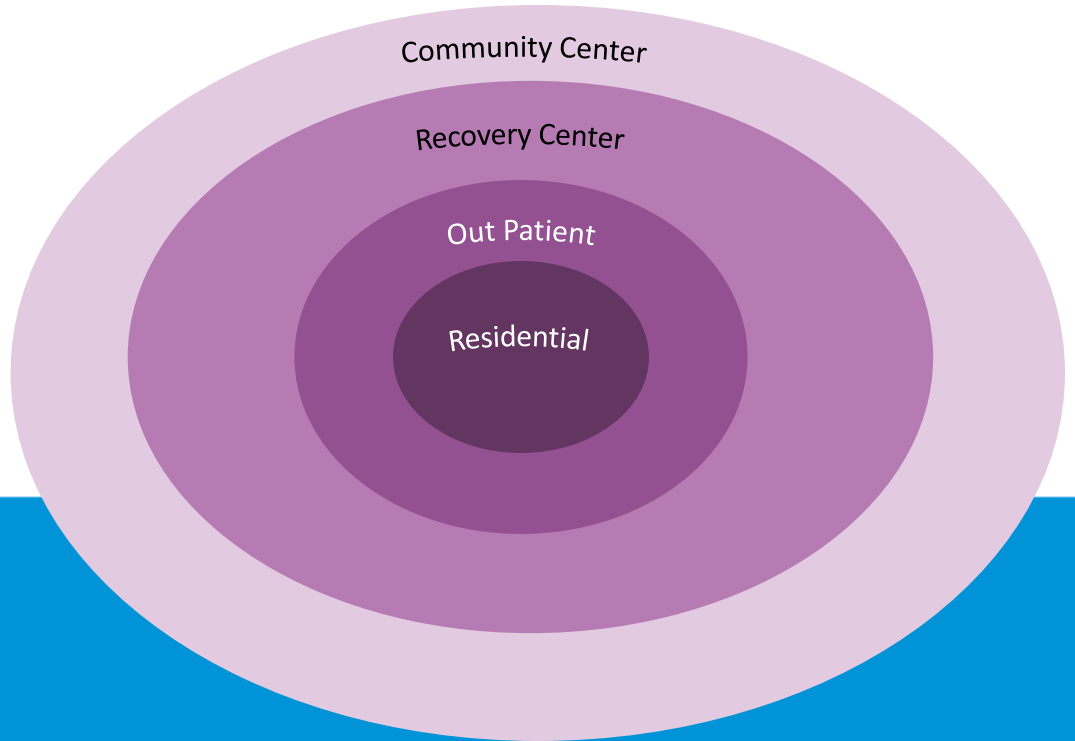
= treatment gaps that perhaps a focus on Social Determinants of Health could address!

Our Innovative Approach to Substance Abuse & Community Health

Community-Based Approach

Extending the continuum of care

Outreach → Prevention → Out Patient → Residential 820→ Out Patient → Recovery Center → **Community Center (does not have to be linear)**



Outreach

Prevention

Our Innovative Approach to Substance Abuse & Community Health

By addressing the community, we can:

- Connect community members to internal and external resources, including addiction services
- Utilize the community and its strengths as tools for prevention, treatment and recovery
- Address underlying factors that contribute to substance use, mental health symptoms, and other negative impacts on social determinants of health

Overarching goal: Bring down substance use disorder rates in the community

Healthcare 2020: Educational Alliance CRW "Triple Aim" Logic Model

Inputs

Needs Assessment

Focus on Social Determinants of Health

Community Center Approach

Community Partners

Federally Qualified Health Center (FQHC) Partner

Contracted Providers

Funding
- Managed Care
- OASAS Contracts
- Federal Probation Contract
- Self-pay
- Grants/Donations

Research Partners

Activities/Outputs

Community Needs Assessment
- **Identify needs present throughout community**
- **Identify needs of specific subgroups**
  - **Homeless**
  - **Co-occurring**
  - **Court Mandated**

Data-Driven Services
- **Ongoing monitoring of treatment gaps, needs, client progress**

Community Center Approach: "One Stop Shop" for Clients
- **Outreach Services**
- **Wellness Programming**
- **Outpatient Care**
- **Family Services**
- **Self-help groups**
- **Life Skills Programming**
- **Engage Alumni as Mentors**

Residential Care
- **<u>Evidence-based services</u> delivered by individual need**
  - **Stabilization**
  - **Rehabilitation**
  - **Reintegration**
- **Housing and vocational counseling**
- **Medication-assisted treatment**

Short-Term Outcomes

Residential + Outpatient Care
- **Stabilizing physical/mental health conditions, substance use**
- **Foundational level of safety**
- **Establish baseline primary health needs**
- **Engage positive relationships with counselors, group members**
- **Awareness of life challenges**
- **Develop non-crisis support systems**
- **Identify internal strengths and competencies**
- **Explore areas for clinical attention**
- **Job readiness, housing and legal referrals**

Social Determinants of Health / Recovery Supports
- **Peer support networks**
- **Learn to navigate systems**
- **Awareness of key recovery concepts (behavioral health)**
- **Exposure to support systems**
- **Reduction in social isolation**

Prevention
- **Life skills training**
- **Initiate parenting skills work**
- **Exposure to health and wellness materials**

Mid-Term Outcomes

Improved Behavioral Health:
- ER Visit reduction
- Reduced hospitalizations
- Link to PCP
- Smoking cessation
- Medication adherence
- Appointment adherence
- Continuity of service
- Reduced Medicaid use
- Housing stability

Community Health
- Reduction in stigma toward substance use disorder
- Networked community of supports
- Reduction in depth and breadth of community needs

Long-Term Outcomes

Improved Health Outcomes…

…Improved Patient Experience…

…at a Reduced Cost

Lessons Learned- Transforming Culture

- Starting point: a silo'd system of 819, 822 and prevention programs embedded in a system of traditional settlement homes
- Collaborate, re-org, re-design
- Change don't come easy!

Culture: Initial steps towards “One Team, One Dream”

- Conscious effort to break down internal silos
- Utilize the data from community as well as staff satisfaction
- Increased standards of care
  - Review policy
  - Review protocols
  - Develop curriculum, structures, forms-
  - New Electronic Health Record
  - Integrated care model- Co-Occurring Primary and Mental Health with enhanced addiction services (820 model; wellness paradigm; trauma informed system development (not just a “Seeking Safety group”)

“One Team, One Dream”

- Establish basic metrics and create program dashboards
- Key performance indicators- data driven reports and responses
- Human Resources:
  - Centralize licensure standards for positions
  - Creatively re-allocate resources based on strengths
    - i.e. New design of “Individualized clinical teams” for every client
    - Opened up new budget lines
    - Peer positions; clinicians, behaviorists-all working together
  - Update and evolve Job Descriptions
  - Transform human resource actions and responses
  - Lessons learned:
    - Not everyone wants to see “progressive change”
    - Change must be incremental; yet structure and scheduled
    - Incorporate trauma and wellness practices for staff
    - Staff had distinct amounts of “organizational trauma” history and counter transferred frequently

“One Team, One Dream”

- Revamp committee work
  - CQI committee
  - Health and Safety Committee
  - Billing Committee
  - BHCC network affiliations (involve multiple leaders, not one liaison)
- Response to MCO/ Medicaid issues
  - Workflow re-design
  - Development of UR/QA and RCM teams
  - Break down silo with central fiscal department

Leadership Values

- **Leadership Team values data and information in ways such as:**
  - Routinely talking about agency performance
  - Willing to conduct authentic agency program and service assessments using internal and/or external resources
  - Always willing to take a “deeper dive” to better understand the meaning of the information
  - Performance is an acceptable topic to talk about at the staff and management levels of the organization
  - Agency performance is routinely reported out and discussed during board meetings
  - Accountability for improvement exists at all levels of the organization

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Internal Leadership Model; why rounding?

"Most employees do not leave an organization because of pay or benefits—or even because they want to leave the healthcare industry.

The number one reason they leave—39 percent of employees—is because they have a poor relationship with their supervisor."

All Employees desire:

- ❑ A leader who cares about and values them.
- ❑ Systems that work and the tools and equipment to do the job
- ❑ Opportunities for professional development.
- ❑ To be recognized and rewarded for doing a good job
- ❑ Not to work with low performers.

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Internal Leadership Model; rounding log

Topic/Discussion Points	Comments	
Personal Connection:		
What's working well:		
Staff or clinicians to recognize (who and why):	Who	Why
Tough questions/issues: **Specific to department or organization wide rumors**		
Systems needing improvement, barriers to care, safety, or efficiency		
Do you have the tools/equipment/training for you to do your best at work?		
What is one thing we can do to make this a better place for you to work?		
What can I do to be a better leader FOR YOU?	Thank you!	
FOR THE LEADER: What did I learn about the engagement of this person and what do I need to do with that information?		

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Develop a Trauma Informed Setting

SAMSHA; TRAUMA INFORMED CARE

According to SAMSHA's concept of a trauma-informed approach, 'A program, organization, or system that is trauma-informed'

- Realizes the widespread impact of trauma and understands potential paths for recovery
- Recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system
- Responds by fully integrating knowledge about trauma into policies, procedures, and practices.
- Seeks to actively resist re-traumatization

Develop a Trauma Informed Setting

SAMSHA- TRAUMA INFORMED CARE

'A trauma-informed approach reflects adherence to Six Key Principles rather than a prescribed set of practices or procedures. These principles may be generalizable across multiple types of settings'

- **Safety**
- **Trustworthiness and Transparency**
- **Peer support**
- **Collaboration and Mutuality**
- **Empowerment Voice and Choice**
- **Competency with Cultural, Historical, and Gender issues**

Continuous Learning

The Culture Shift Continues

- **Investment in learning/training is made for all levels of the organization**
  - Continuous transformation is encouraged during trainings
  - Ongoing research to identify evidence based practices is taking place
  - Investment in innovation

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What is a Culture?

- Culture is the way of thinking, behaving, or working that exists in a place or organization (such as a business).

- It is a belief system that impacts what is considered to be of "value" and how decisions are made.

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An Organization's Performance Driven Culture is found in its....

- Corporate Policy
- Leadership Values
- Performance Dashboard
- Human Resources
- Continuous Learning
- Communication
- Collaboration

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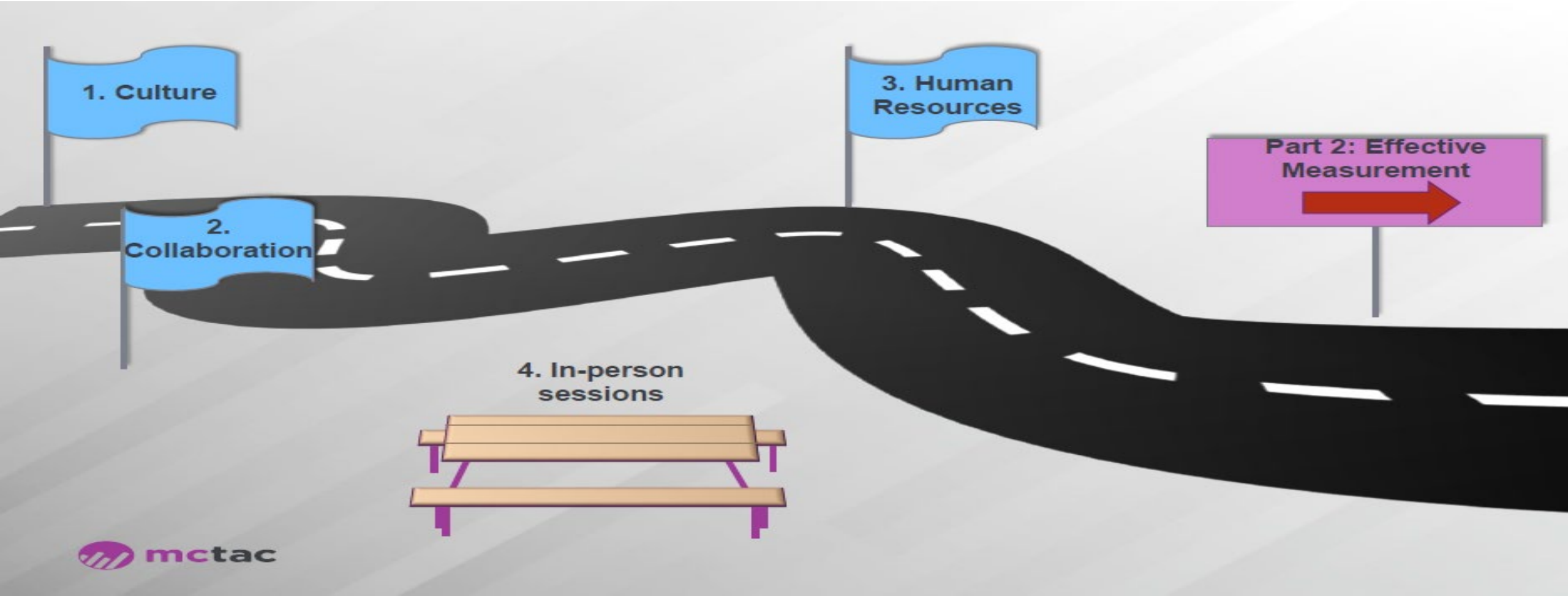
Setting the tone for Performance based culture



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Process

- Effective change management, coordination of efforts into designing a new clinical model, and building a culture of excellence requires certain initial steps;
  - Identify current culture and attitude towards data and CQI
  - Capture necessary data and use it to make decisions
  - Meet with formal and informal change leaders
  - Elicit input and buy-in
  - Collaboration!
  - Human Resources
  - Develop metrics to show how the new model defines progress
  - Meet with staff consistently: train, supervise, coach, monitor fidelity

Why is Data Important?

- Supports the wise use of limited resources
- Encourages informed decision making
- Heightens accountability to make a difference/impact
- Important in supporting a more certain future during uncertain times

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Why is Data Important?

- Encourages an organization to take on meaningful challenges
- Prepares an organization for greater accountability as new payers (MCOs, ACOs) emerge
- Positions an organization for the possibility of participating in Value Based Payment arrangements
- It's the right thing to do for the service recipients

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Why would you want a performance driven culture?

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Are you ready for some VBP?

- You may commit to re-design and getting ready for VBP but:
- If you build it , will they come! Will you get paid?
- How do we connect this great new model to “Value Based” methodology and develop sustainability?
- Alphabet Soup time:
  - BHCC - ACO
  - IPA - CCBHC

How to decide on systems changes or revisions for your agency?

- Realization: Non-profits traditionally rely on contracts or donations along with fee for service; these are shrinking.
- Health Homes and DSRIP were just the beginning of payment reform
- $60 billion dedicated to the “Triple Aim”

How to decide on systems changes or revisions for your agency?

- How does this tie in to how you re-design and deliver services for the community.
  - Realization that contracts are shrinking; Medicaid expansion (or is it now?)
  - Benefits of building an holistic model; referents prefer “one-stop” shops
  - Partner with other CBOs that offer what you don’t
  - Look at treatment gaps realistically

How to decide on systems changes or revisions for your agency?

- How does this tie in to how you re-design and deliver services for the community.
  - What does your budget allow as far as enhanced staffing and program design?
  - Do your clinical programs naturally flow towards desired value based metrics and outcomes?
  - Have you sought out and used input from community, clients and all stakeholders?
  - What will you retain from your model? Generally if you remove an element you need to replace it with something to fill the gap, or to meet the need!

Gaps and needs

Many CBOs are not "one stop shops"

- Relatively small geographic reach (scale)
- Small number of people being served (scale)
- Gaps in services for clients that required licensure to deliver
- Lack of electronic health records
- Multiple contractual reporting and data systems
- Lack of capacity for robust quality assurance and CQI
- Struggling billing departments in the face of ever-changing payment structures, payers and rules

- Get involved in a network collaboration-quickly! What else are your payers looking for???

Behavioral Health in Primary Care

- Mild to moderate behavioral health problems are common in primary care settings
  - Anxiety, depression, substance use in adults
  - Anxiety, ADHD, behavioral problems in children
    - Prevention and early intervention opportunity
- People with common medical disorders have high rates of behavioral health concerns
  - E.g., Diabetes, heart disease, asthma and depression
    - Worse outcomes and higher costs if both problems aren't addressed

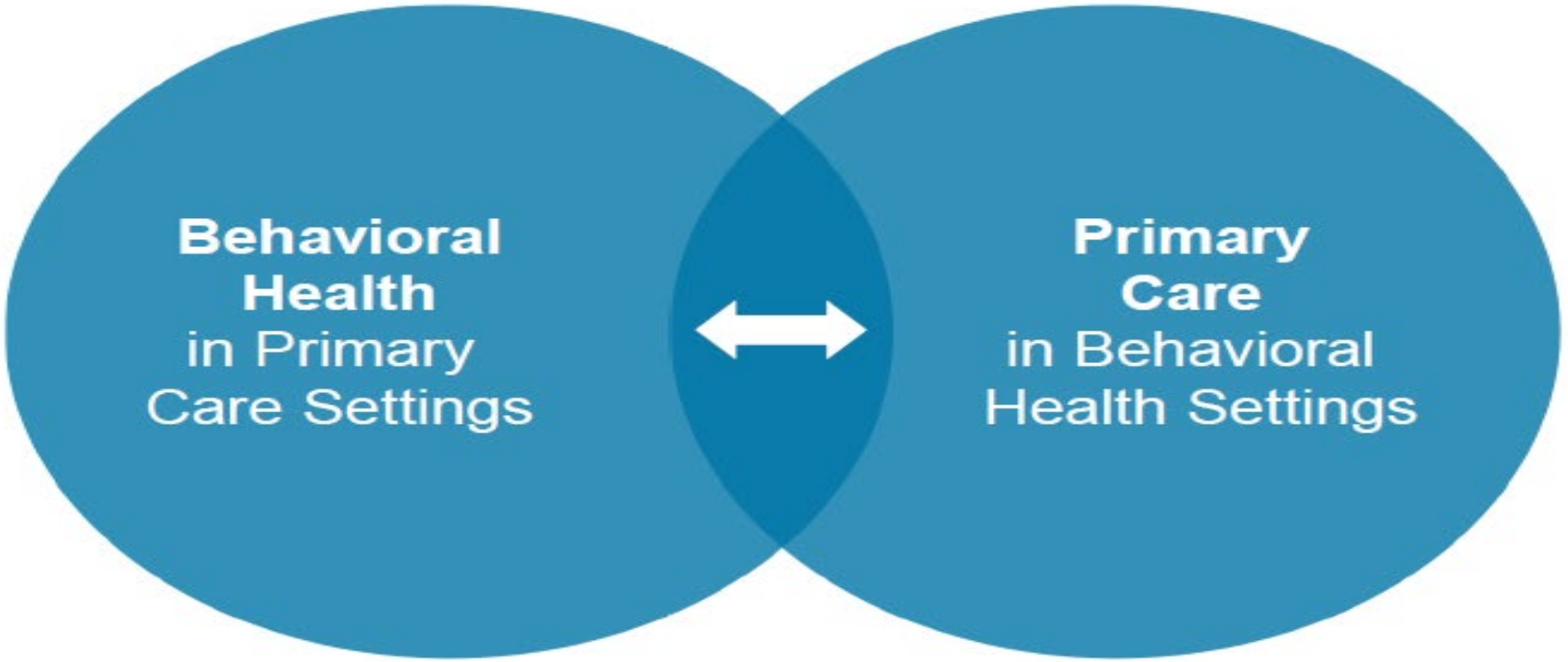
Why Primary Care Services in Mental Health?

- High rates of physical illness with mental illness
- Premature mortality
- People with mental illness receive a lower quality of care in primary care settings
- High cost of physical illness with mental illness
- Access problems

Without Integration

- Mental illnesses go undetected and untreated
- When primary care providers detect mental illnesses, they tend to under-treat them
- Populations of color, children and adolescents, older adults, uninsured, and low-income patients more often receive inadequate care for mental health problems
- Substance use care involves same issues, if not worse

Bidirectional Integration



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What else payers want

- Predictability
- Integration with BH (but don't know what that is)
- Social determinants addressed (but don't know how to)
- You (and everyone else) to share their risk

Building Blocks of a Value Based Payment Model

Key Elements of Value Base Payment Models

PATIENT ASSIGNMENT:

The number of patient assigned or attributed must be adequate to make the model financially sound.

STABLE MEDICAID ELIGIBILITY:

The patient eligibility must be relatively stable-12 months of continuous eligibility is preferred but a minimum of six month is required.

CLAIMS, ENCOUNTERS, & CLINICAL DATA:

There should be at least 12 to 24 months of cost, utilization, and health risk data to set payment rates.

RISK STRATISFICATION:

Patient should be group by level of risk and payment should be adjusted appropriately.

QUALITY OR OUTCOME MEASURES:

There should be a standard set of quality or outcome measures that can be validated and reported within the performance period.

EMBEDDED INCENTIVES:

The embedded financial incentive must align with the expected performance requirements to provide a ROI.

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Underlying Economic Drivers

- VBPs reward or penalize providers based on outcome and cost
- At its core, VBP is “demand side cost containment strategy”
- Key drivers
  - Shared risk (improve quality while managing cost and utilization)
  - Clinician accountability
  - Efficient resource use
  - Continuous Performance Improvement

BH Advantages

- Higher cost/utilization patients have more opportunities for improving and cost savings
- More comfortable working outside of clinic/in community
- Ability to maintain engagement with people others don't understand and can't tolerate
- Actually know what social determinates of health are and how to impact them
- Motivational interviewing
- Lower unit cost for personal interactions

What is a Population Health Management?

- Not just a healthcare benefit
- Not just a program or a team
- It's a system and an organizational transformation

Population-Based Care

- Don't rely solely on patients to know when they need care and what care to ask for and from whom - use data analytics for outreach to high need/utilizer patients
- Don't focus on fixing all care gaps one patient at a time - choose selected high prevalence and highly actionable individual care gaps for intervention across the whole population
- The population-based health care provider is the public health agency for their clinic population

Population Management

- Selects those from whole population:
  - Care for whole population
  - New interventions and programs
  - Early identification and prevention
  - Choosing and targeting health education
- Aids in planning:
  - Most immediate risk
  - Most actionable improvement opportunities

Data-driven Care

- Patient registries
- Risk stratification
- Predictive analytics
- Performance benchmarking
- Data sharing

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Data Uses

- Aggregate reporting – performance benchmarking
- Individual drill down – care coordination
- Disease registry – care management
  - Identify care gaps
  - Generate to-do lists for action
- Enrollment registry – deploying data and payments
- Understanding – planning and operations
- Telling your story – presentation like this

Six Population Health Management Services

- Care management
- Care coordination
- Managing transitions of care
- Health promotion
- Individual and family support
- Referral to community services

Comprehensive Care Management

- Identification and targeting of high-risk individuals
- Monitoring of health status and adherence
- Identification and targeting care gaps
- Individualized planning with the patient

Important Provider Competencies

Characteristics:

- Outcomes-oriented
- Enabled by technology
- Patient-centered
- Use of data and analytics
- Performance transparency
- Ability to partner across organizations

Putting It All Together

- Data identify treatment and prevention opportunities
- Training implements new evidence-based interventions
- Personal interaction is the true change agent
- Data analytics identify the dose response curve of personal interaction required
- Training allows use of a lower-cost FTE to produce an effective personal interaction

High Impact Performance Indicators

- Medication adherence
- Keeping PCP appointments
- Follow up after discharge
- Asthma
  - Being on inhaled corticosteroid
  - Adherence to inhaled corticosteroid
- Medication assisted treatment for suds

Change

When the winds of change blow hard enough, the most trivial of things can turn into deadly projectiles.

www.despair.com

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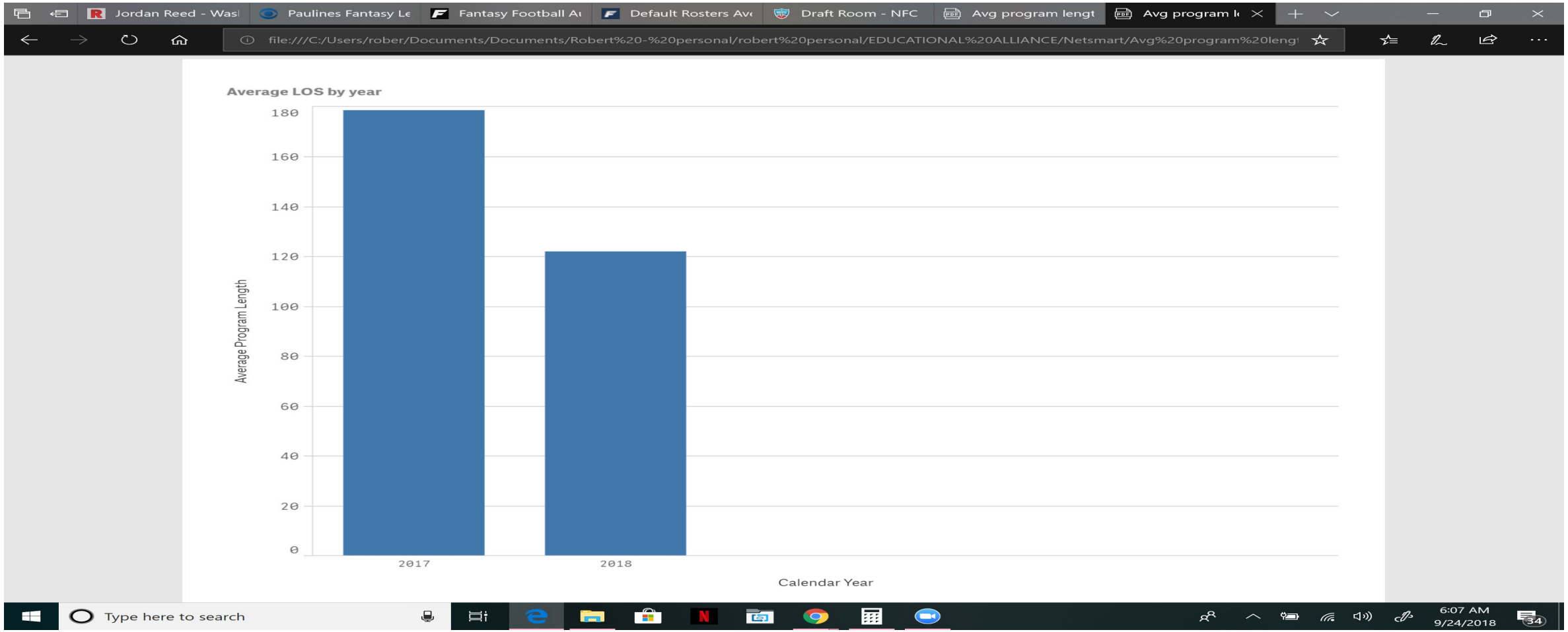
An interesting perspective



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Monitor Data

- Annual review and revision of:
  - Dashboards, even some metrics
  - Realign clinical goals
  - Fiscal Drivers (each Program Director reports out on output, goals and fiscal impact)
  - Policy and procedure
  - Satisfaction
  - Treatment gaps
  - Community input and needs

Conclusion/ Initial Outcomes

- Client perception - anonymous survey:
  - 86% would refer a family member or friend to CRW
- Fiscal viability
- Preparation for 2020 underway with solid integration and community networks
- CQI team and data are driving the Clinical improvements (not just the bottom line)
- The ability to reinvest in community (internal and external)
- We are meeting our mission and vision, have made significant improvements to the program with dedicated outcomes and overall client /staff satisfaction
- We have a solid plan for a future with VBPs. IPAs, ACOs and any other acronym you can find!!