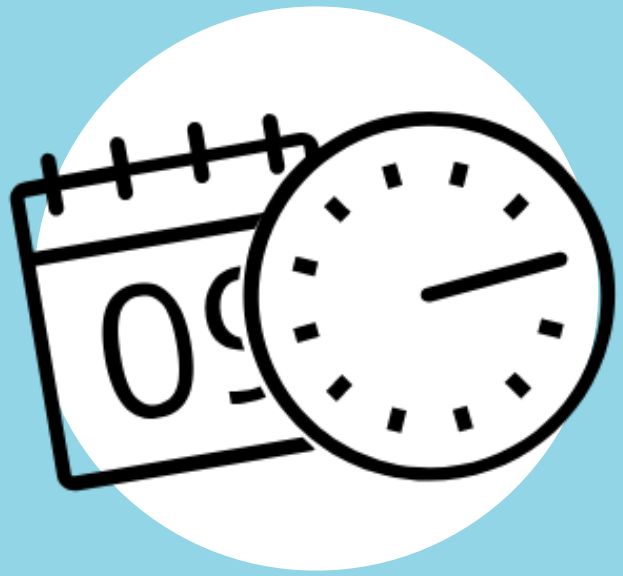
Delta Center Learning & Action Collaborative Convening #2- Day One

Seattle, WA

Rachel Tobey
Director, JSI California and
Delta Center for a Thriving
Safety Net


Drawing
wing.



What's Happened since June

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Press Release

Did you use it?

"Safety net providers—in both primary care and behavioral health—are acutely aware of what their communities want and need to be healthy," said Andrea Ducas, senior program officer at RWJF. "We want to position them as leaders in transforming the health care system so that it can best meet the needs of patients and their families."

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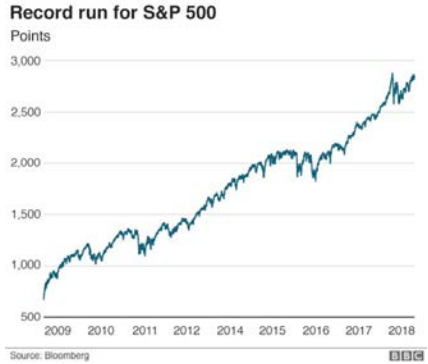
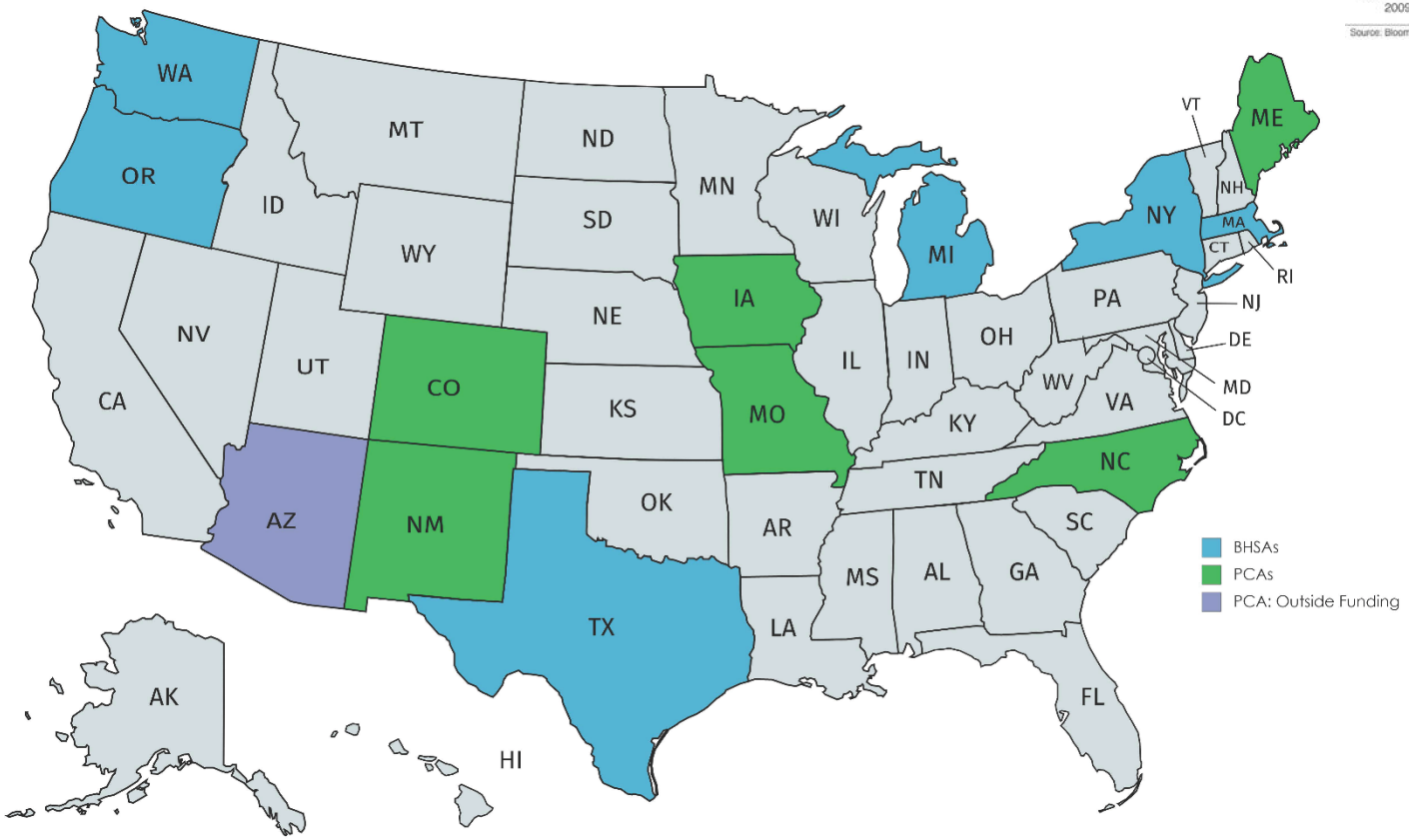
The Cohort has Grown





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T&TA Support: Coaching

Katie Coleman
MacColl

Colorado
Oregon

Kate Davidson,
NCBH

New York
Texas

Rachel Tobey
JSI California

Iowa
Missouri
Arizona

Juliane Tomlin
CCI

Michigan
Maine
North Carolina

Andrew Philip,
NCBH

Massachusetts
Washington
New Mexico

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Delta Center Goals

Build internal capacity of state associations

- *VBP/C Vision & Strategy Development*
- *Board & Staff Engagement*
- *Learning Organization Practices*
- *Sustainability Planning*

Build policy and advocacy capacity to advance value-based payment & care at state level

Foster collaboration between primary care and behavioral health at state level

Build capacity to provide TA and training to advance value-based payment & care at provider level

For more information and resources please visit our website:

deltacenter.jsi.com

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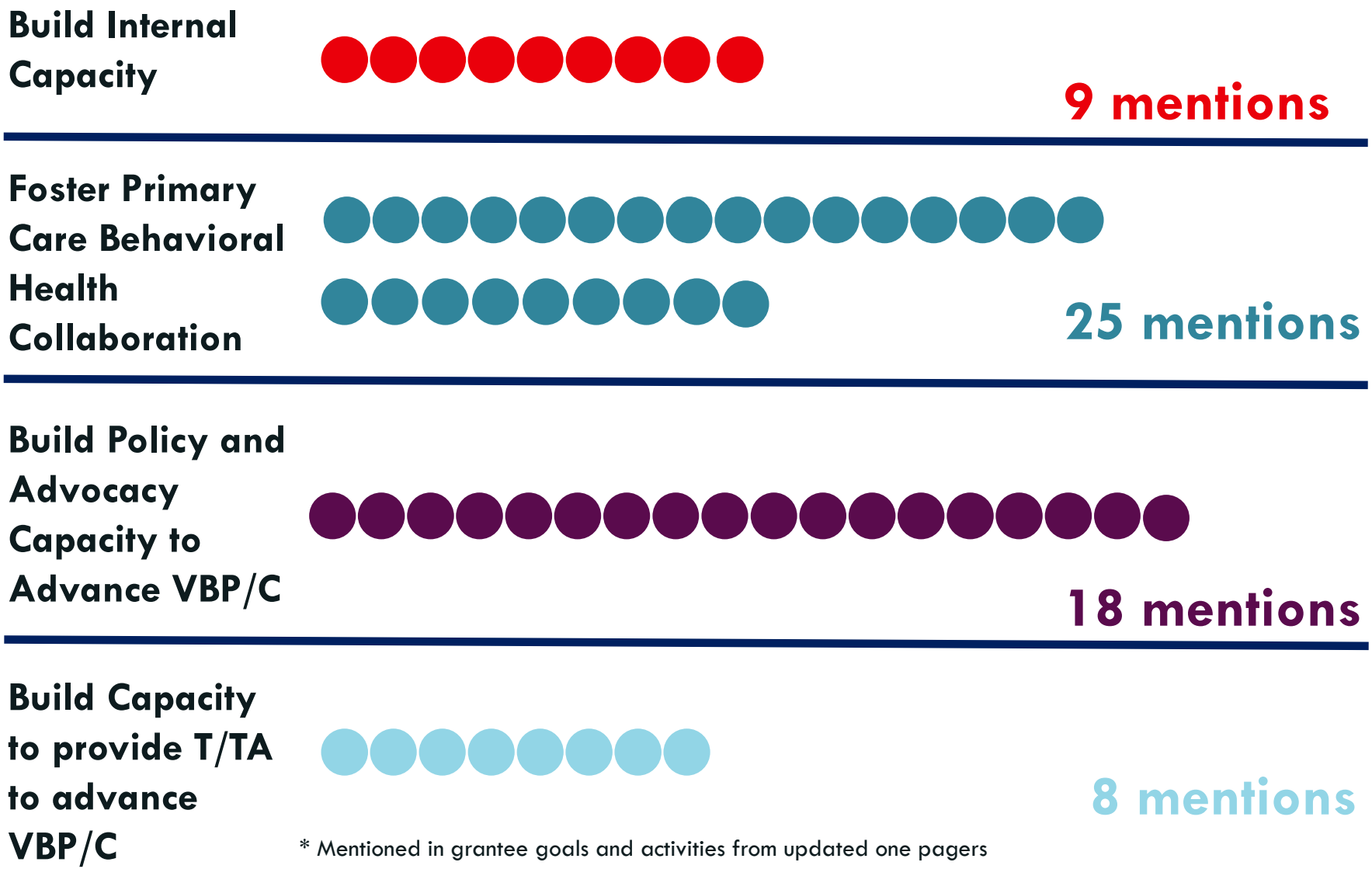
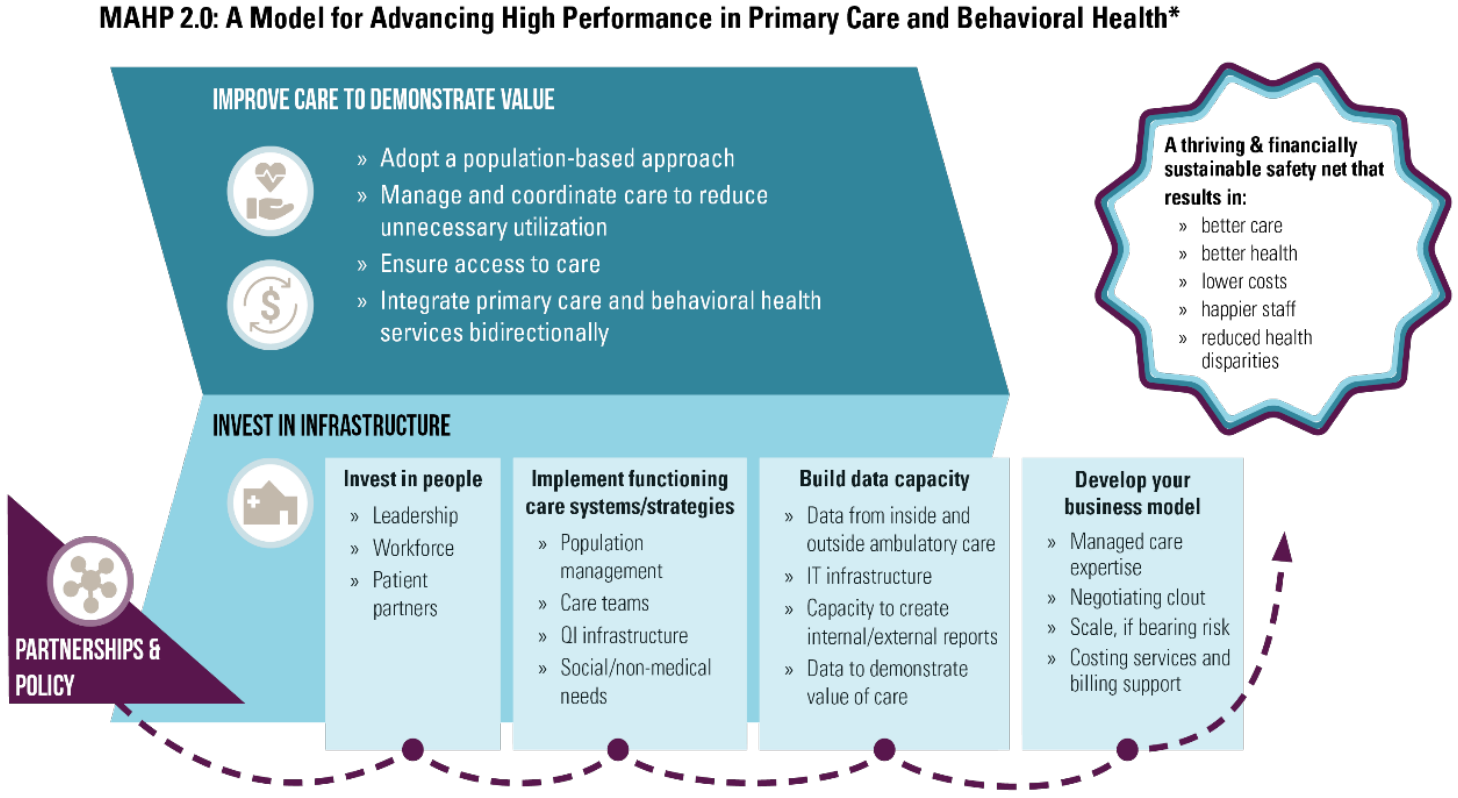
Delta Center Grantee Goals and Activities



* Mentioned in grantee goals and activities from updated one pagers from October 2018 and team time worksheet from June 2018 (n=13)

NACHC Payment Reform Summit

- Model for Advancing High Performance (MAHP) 2.0
- Peer networking dinner



*Adapted 8/20/2018 from The MacColl Center for Health Care Innovation and JSI Research & Training Institute, Inc. (2018). *Partnering to Succeed: How Small Health Centers Can Improve Care and Thrive Under Value-Based Payment,* California Health Care Foundation. Available at: https://www.chcf.org/publication/partnering-succeed-small-health-centers/

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Turning Data and Feedback into Action:
What you liked about Convening #1

- Facilitated Team Time
- Joe Parks
- Setting goals
- Mix of didactic and group activities

- Cocktail Hour

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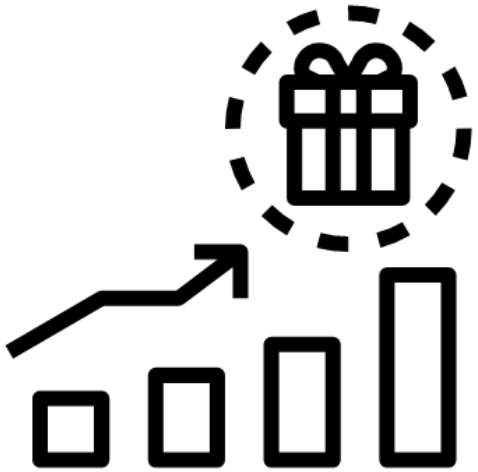
Turning Data and Feedback into Action:

Performance Incentives can work!

Day 1 Evaluation response rate

73% (with cocktails)



Day 2 Evaluation response rate

52%

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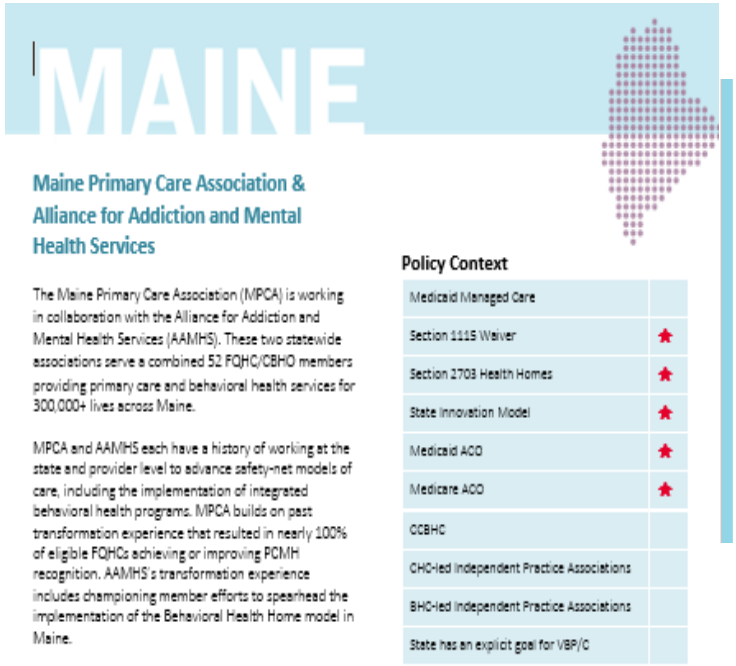
Turning Data and Feedback into Action:

What you wanted to change

More **ways to get to know each other**



Your Organization & State Name

Describe or show a picture of the value-based care or pay effort you've taken on that you're most proud of.

Things you might want to highlight:

- How did you work with your member organizations for this effort?
- What other stakeholders were important?
- How long did it take?

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More **breaks**

More **coffee**

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Turning Data and Feedback into Action

Mixed feedback

- Length of activities/sessions
- Amount of content
- Team time vs. hearing from other teams

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Agenda Overview

Day 1

- Storyboard Sessions
- Keynote Address: The Importance of Developing a Vision for Payment Reform and Care Transformation
- Partnerships and Policy Priorities: Setting the Stage and A Tale of Two Associations
- Partnerships and Policy Priorities: Creating Alignment
- Empowering Change Through Storytelling
- Happy Hour & Networking Reception

Day 2

- Storyboard Sessions
- Connecting with your peers: Reflections from Storyboard Sessions
- Improving Care in a Value Based Environment: What do our members need to succeed & how will we know?

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The Importance of Developing a Guiding Vision for Payment Reform and Practice Transformation

Delta Center Convening
October 15, 2018

HOSTETLER GROUP

Objectives

- Present how Oregon developed its guiding vision or North Star for payment reform and practice transformation
- Compare to other states pursuing payment reform and practice transformation under a similar payment methodology
- Discuss lessons learned
- Identify steps for getting started on a guiding vision
- Consider how to get started on a guiding vision for behavioral health and primary care

Developing a Guiding Vision for Payment and Practice Transformation in Oregon

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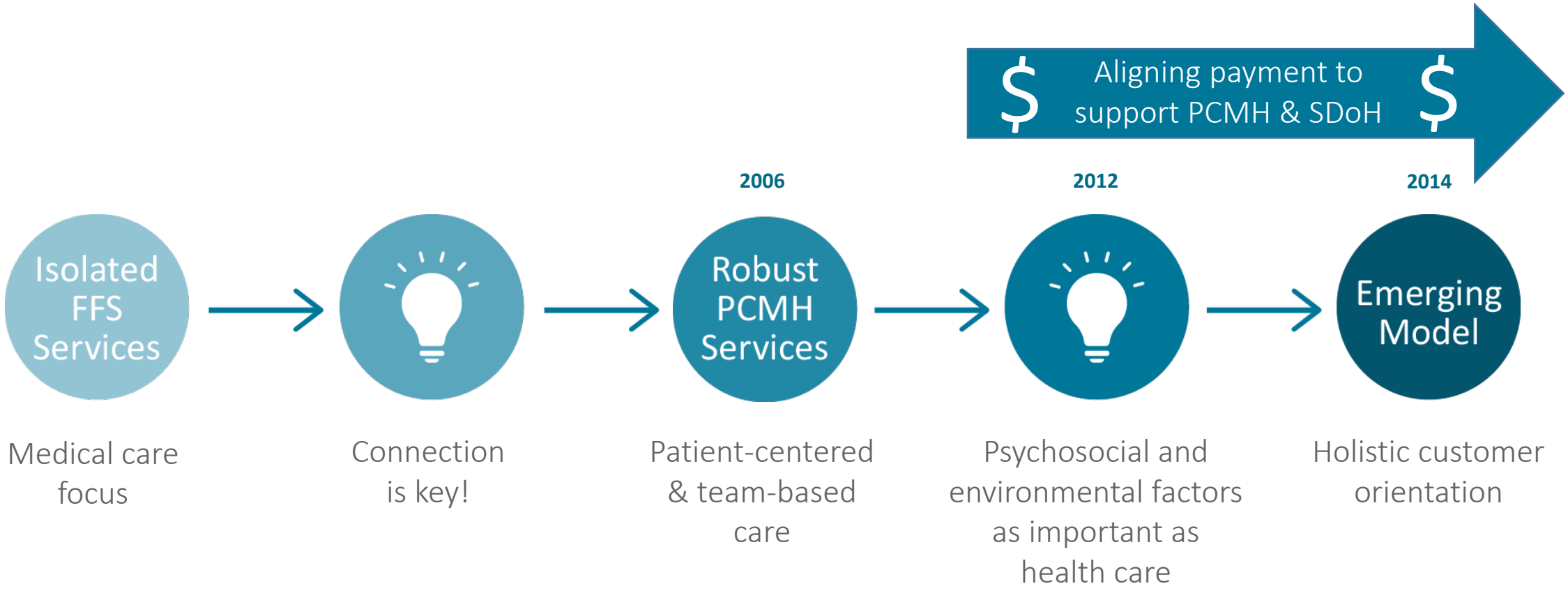
EVOLUTION OF APPROACH



Oregon Context

- Establishing the primary care association (PCA) as a leader for providing technical assistance took work
- The PCA didn’t start with a positive relationship with Medicaid
- Oregon was innovative
  - Established coordinated care organizations
  - Invested more $$ in primary care while trying to control health care inflation
  - Valued SDoH investments from Medicaid $$

Why Take the Risk?

- Our stakeholders wanted something better
  - Patients
  - Payers
  - Providers & support staff
- Recruitment getting harder
- Increased pressure
  - Transparency and accountability increasing
  - Payment moving from volume to value

OPCA's GOAL

FOR ALTERNATIVE PAYMENT ADVANCED CARE MODEL (APCM)

Lead the development of and align payment with an efficient, effective, and emerging care model that achieves the Quadruple Aim in Oregon CHCs

Know your North Star

Lead the transformation of primary care to achieve health equity for all

THE CALCULATION

APM RATE =

$$\frac{\text{Applicable wraparound} + \text{Reconciliation revenue}}{\text{Health center member months}}$$

- Applicable wrap and reconciliation revenue
  - (Total PPS payments – Managed Care payments) – PPS payments for OB, Dental, and MH
  - Carved out services defined by procedure or diagnosis codes
  - Member month calculation tracks active patients and their movement to other providers

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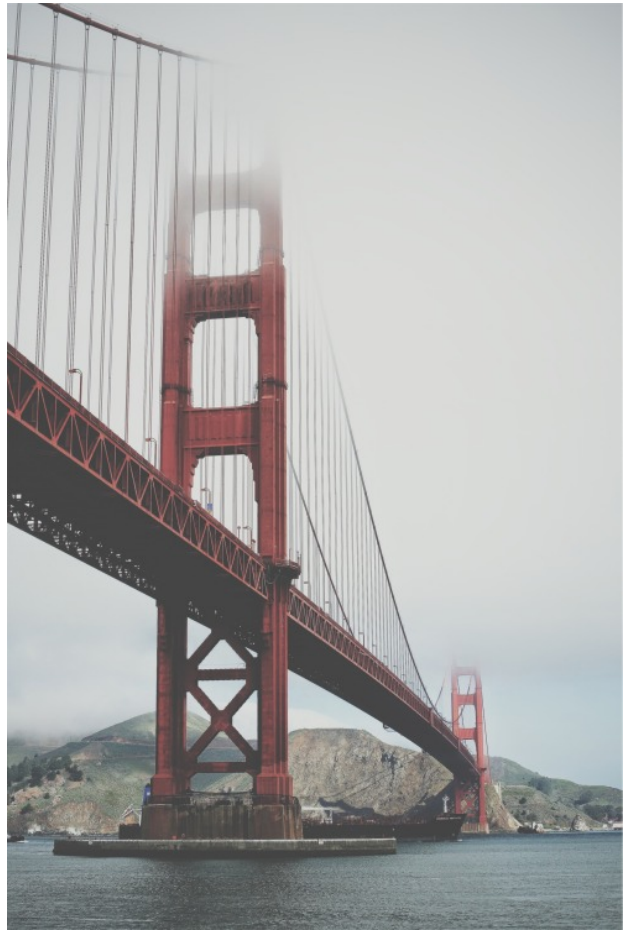
HOW FQHCs DEVELOPED AN INTEREST

- Patient centered, team based care is hard to implement if payment isn't aligned
- Provider burnout is related to visit production
- SDoH barriers have a large impact on health outcomes, but there's no time or incentive to test interventions
- PCMH looks different for vulnerable populations

Benefit for State Medicaid

- Moves away from volume based pay
- State gets all kinds of data: billable and non-billable access, cost, quality metrics, innovation work
- Predictable cash flow
- A bridge to VBP under 330 rules and regulations



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WORKING WITH MCOs/CCOs

- In alignment with state's APM requirement
- Supports Oregon's SDoH interest/direction
- Amount FQHCs get paid for F2F visits vs. CCO quality payments
- FQHCs are serving 25-30% of Medicaid patients
- >80% of FQHC payment will be off the visit

Developing Guiding Visions in Other States

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CHC Capitated Alternative Payment Methodologies

Reasons for Implementing

- Remove the incentive to produce billable visits
- Provide flexibility to implement robust team-based care, including SDoH interventions
- Align with state payment reform efforts
- Predictable cash flow – state, CHCs
- Increase focus on care coordination
- Integration of services
- Improve health equity

Guiding Vision for State APCMs

- Has to be broad enough so stakeholders see their interest captured.
- Common areas of focus
  - Practice transformation (e.g., holistic customer orientation)
  - Payment (e.g., reducing costs, shifting from volume to value)
  - Patient focused (e.g., better care, improve health equity)

Organizational Mission and Vision Statements

Can Give You Insight About What's Important to Stakeholders

- MCO
  - Healthy communities for all individuals, regardless of income or social circumstances
  - Improving the availability, reliability and quality of health care for our members
- State Medicaid/Health Authority
  - Helping people and communities achieve optimal physical, mental and social well-being
  - To improve health outcomes by providing access to comprehensive, cost-effective and quality healthcare services for residents
- Clinic
  - Providing access to quality care for those that need it most
  - To increase access to comprehensive primary and preventive care in order to improve the health status of our community, particularly underserved individuals

Keys to Getting Stakeholder Buy-In

- Meet them where they’re at
- Speak in their language – learn what matters to them
- Have their input shape the guiding vision
- Stakeholders should see how the guiding vision can support their own interests for payment reform and practice transformation

Examples of Guiding Visions

- Provide accessible, high quality and cost-effective services
- Align payment reform to support practice transformation that achieves the Triple Aim
- Support the medical, behavioral health and social services needs of underserved populations to improve their health status

Lessons Learned and Key Takeaways

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WHAT WE LEARNED

- The health care system is very stable and does not change quickly or easily.
- Changing payment does not change the front lines of care delivery.
- Payment is a barrier to delivering care that improves outcomes and retains staff.
- To change care, you must have a clear vision that reflects the evidence regarding the causes of health and wellbeing in patients and staff.
- There is never a good time, competing demands will always be there.
- Keep learning (co-design is messy)
- Partnerships require constant refinement and troubleshooting

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WORKING WITH STATE PARTNERS

- Our missions are aligned
- Payment reform has potential to make primary care more effective
- Value-based pay makes sense
- Must account for behavioral and socioeconomic barriers
- Let’s work together on a bridge to improve health equity

What Worked Well

- Developing a North Star and sticking to it
- Identifying our key stakeholders early
- Meeting stakeholders where they’re at
- Keeping the patient first
- Getting ahead of the discussion helped us shape payment
- Involving the state in our learning community built trust

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Getting Started

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Do You Start With a Large or Small Group?

- State associations that are ahead of their membership tend to start small
  - For example, a small group of members that is innovative and considered leaders amongst their peers
- When to take it to a larger group of members varies based on how decisions are made in the association
- Should the initial group include external stakeholders (e.g., Medicaid, other providers, MCOs)?

Narrowing Your Focus

- Aligning payment reform and practice transformation is not a small or narrow task
- What specifically do you want to focus on? What would success look like?
- How does it connect to what motivates your organization?
- How could practice transformation improve if you change payment? Could you accomplish the same thing if you didn’t change payment?

Developing a Guiding Vision

- Work with stakeholders to develop a guiding vision for payment reform and practice transformation
- Make sure stakeholders can connect the vision to their interests
- Develop a vision that is succinct, easy to memorize, and inspirational
- Create your own guiding vision – copying from another state doesn't take the local culture into account. Stakeholders also won't connect with the vision if they don't help create it.

Developing a Guiding Vision for Behavioral Health and Primary Care

- For the state behavioral health associations
  - Are there any similarities from the process that was described that resonate with your experience as a behavioral health association?
  - Are there key differences worth noting?
- Are there specific goals you want to see accomplished in practice transformation?
- What would you like to accomplish with payment reform?

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A Tale of Two Associations

Ann E. Christian, CEO

Bob Marsalli, CEO

Partnerships and Policy Priorities: A Tale of Two Associations

- Gain understanding of how state level transformation initiatives, member needs and association funding shape association policy priorities
- Build understanding about behavioral health and primary care funding with the goal of better understanding the underlying rationale for a PCA's or BHSA's policy priorities
- Build understanding about your partner association's policy priorities

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The Delta Center Project
WASHINGTON STATE

Develop improved understanding of our respective systems . . . including commonalties, myths and misunderstandings; as well as new opportunities and pathways forward.

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Our Common History: Sister Safety Net Systems

Public Law 94-63 94th Congress

July 29, 1975

An Act

To amend the Public Health Service Act and related health laws to revise and extend the health revenue sharing program, the family planning programs, the **community mental health centers program**, the **program for migrant health centers and community health centers**, the National Health Service Corps program, and the programs for assistance for nurse training, and for other purposes.

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Our Common History: Sister Safety Net Systems

- 1963 Community Mental Health Center (CMHC) Construction Act
- 1965 CMHC Act Amendments – staffing grants; added substance use disorders
- 1975 CMHC Act Amendments – federal definition; access to all; community board
- 1981 Mental Health Systems Act repealed; loss of "federally qualified" status; CMHC funding block granted to states
- 1984 RCW 71.24 Community Mental Health Services Act - prioritized funding
- 1964 Economic Opportunity Act
- 1965 first Neighborhood Health Centers
- 1975 Public Health Service Act, Section 330, Community Health Center Program established

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Divergent Pathways – CMHCs

- Narrowing
  - Target service population (Access to Care Standards)
  - Federal funding resources (loss of wrap-around funding and access to 340B drug pricing; became primarily a Medicaid funded system)
  - Funded services (narrowed scope, no more community outreach or consultation & education)

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Divergent Pathways – FQHCs

- Broadening
  - Population – broad community access
  - Payer mix (maintain federal FQHC funding &Medicaid, mix of private insurance & Medicare)
  - New services funded over time (incorporate behavioral health and dental)

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Association Background – WCBH

- Established 1979 as a statewide mental health association
- In 2015, became the Washington Council for Behavioral Health
- Our vision – *A world in which behavioral health is understood, and effective care is universally available*
- Our mission: support our members to be successful in carrying out their missions
- What we do
  - Public policy advocacy and analysis, legislative and administrative
  - Behavioral health education, TA, practice and system improvement
  - Connections and partnerships (members and system)

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Association Background – WCBH

- 5 FTE's; $1.5M budget
- 40 member agencies; governed by elected board of 13
- **Types of organizations**
- **People served in FY 2017**
  - **Mental health treatment: 225,000 adults, children and youth**
    (98% served in community; 2% in state psychiatric hospitals)
  - **Substance use disorder treatment: 47,000**

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Association Background – WACMHC

- At the Washington Association of Community & Migrant Health Centers, we bring FQHCs together to collaborate and expand access to high quality healthcare statewide. We help CHCs navigate state policy, provide evidence-based healthcare, and problem solve as a group.
- Our range of services includes workforce development resources, best practice trainings, and advocacy around state policy.

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Association Background – WACMHC

- Collectively operate over 300 PCMH-designated service delivery sites in 31 of 39 counties and serve over 1,000,000 patients per year – 1 in 7 Washingtonians.
- Washington's CHCs served as primary care health homes to 628,450 Washington Apple Health (WAH) enrollees in 2016, approximately 32% of the total Medicaid-enrolled population.

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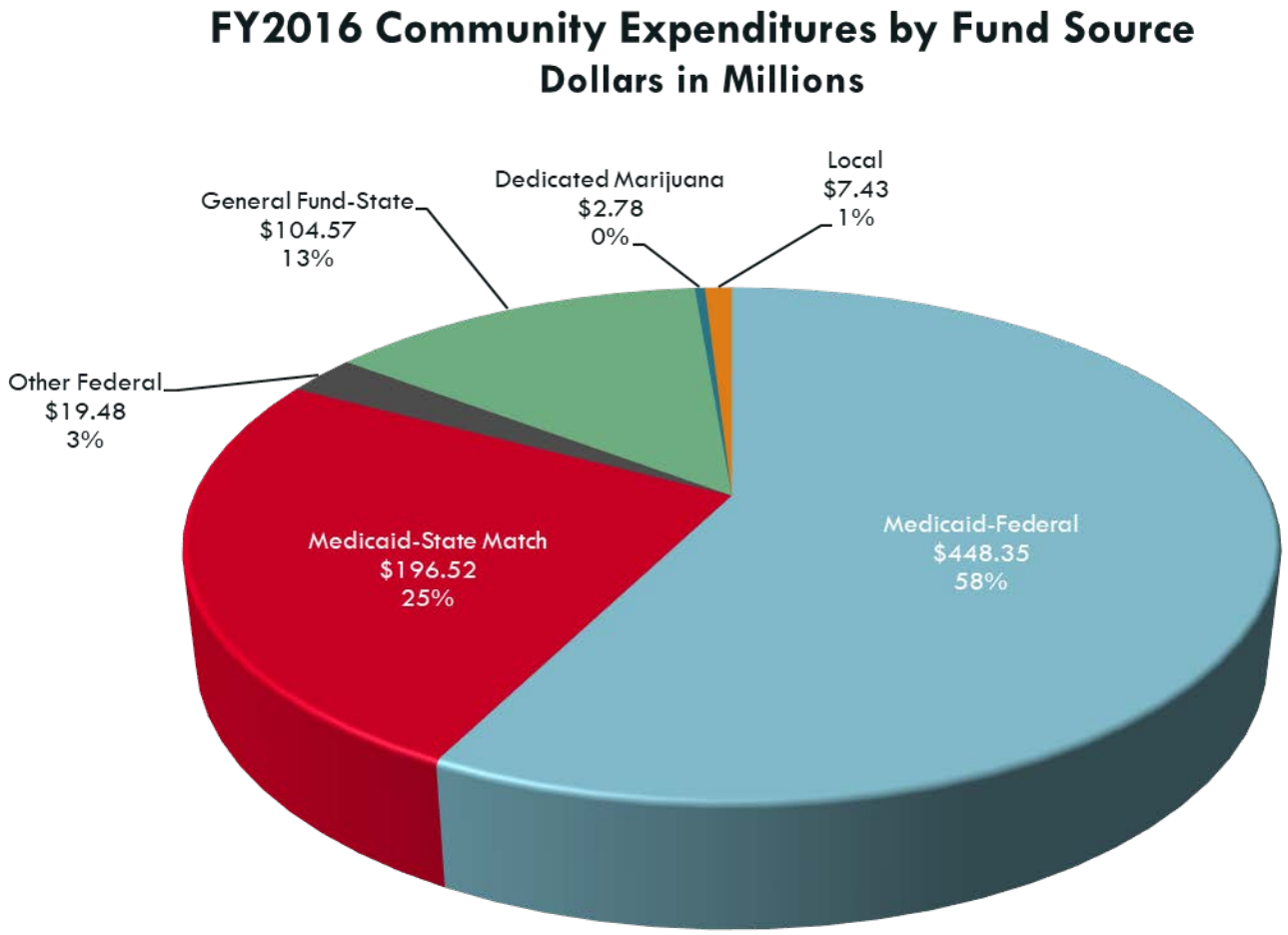
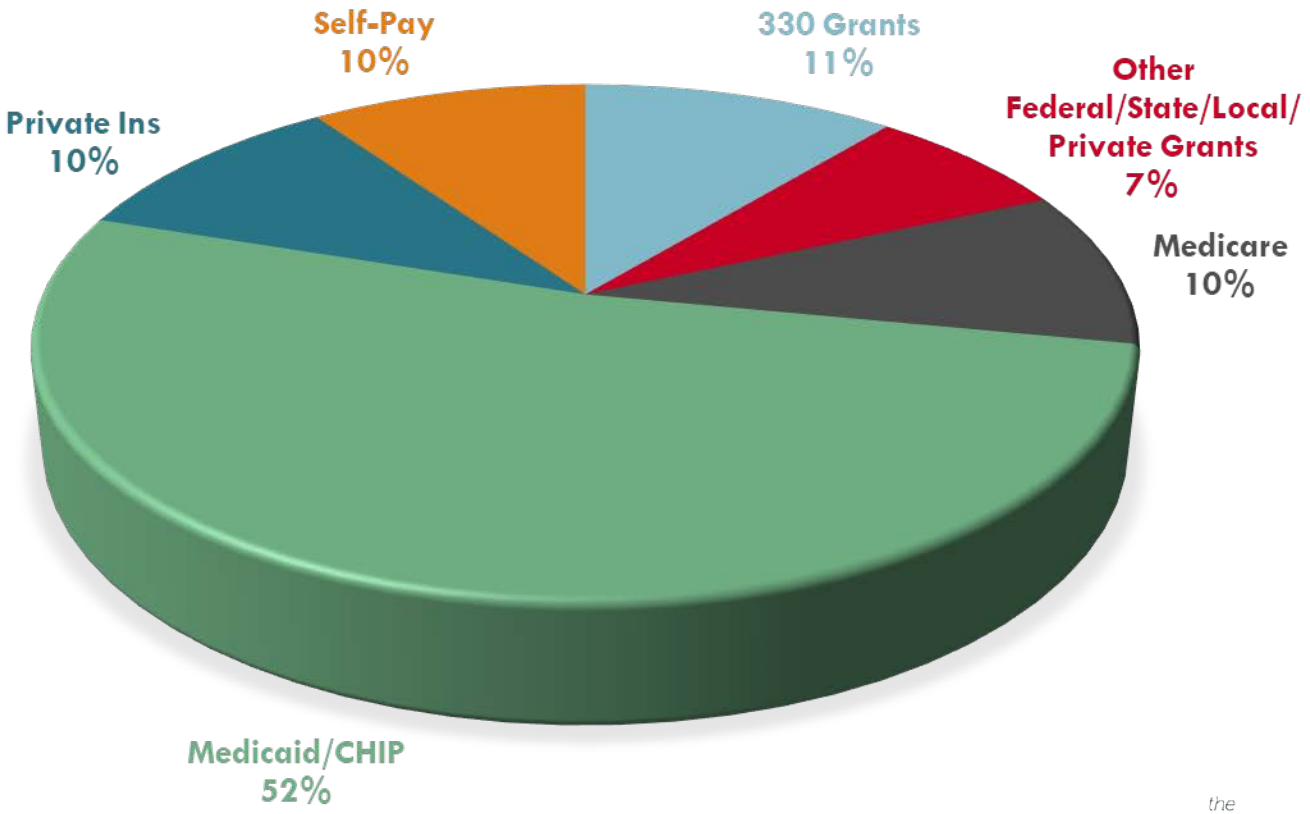
WA Community Mental Health Funding Mix



WA Health Center Payor Mix



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Where We are Now as a State

- Healthier Washington
- 1115 Medicaid Transformation Demonstration
- Washington state's Health Care Authority currently purchases insurance for 26% of the population (Medicaid/CHIP, public employee and school employee benefits)

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Current Behavioral Health System Issues

- Transition from behavioral health carve-out to integrated managed care purchasing: hopes and fears
  - Relief from Access to Care Standards
  - realizing the potential of bi-directional integration
  - health disparities and SMI/SUD population
  - resources and specialized services get lost
- VBP and behavioral health
  - history/challenges/barriers
  - experience with alternative payment methodologies
  - the Council's approach to readiness
- Our other reality – overlap with criminal justice system
  - Involuntary Treatment, *Trueblood lawsuit*, Western State Hospital, Governor's plan for transforming state hospitals
  - Risk of lopsided attention and investment in this aspect of the behavioral health system

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Behavioral Health Association Policy Priorities

- Medicaid rates & workforce
- Balanced state investments
  - Community treatment and inpatient/corrections
  - capital funds paired with operating (service) funds
- Early intervention for psychosis
- Meaningful licensing and regulatory framework for behavioral health agencies and clinicians

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Current Community Health System Issues

- High volumes of low-income, underserved populations while keeping a population health focus
  - Homelessness
  - Justice Involvement
  - Housing/Employment Instability
  - Food Insecurity
- Volume, velocity, and value of data
- Healthcare workforce recruitment and retention, especially in rural areas
- Substance Use Disorder, Co-occurring disorders, and primary care

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Potential Shared Policy Priorities

1. Access to Data
   - provider access to comprehensive health data for purposes of care coordination and population health management
   - provider access to cost data in order to demonstrate impact of provider interventions on overall health status and cost

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Potential Shared Policy Priorities

2. Full implementation of SB 5779

Sec. 1. Health transformation in Washington state requires a multifaceted approach to implement sustainable solutions for the integration of behavioral and physical health. Effective integration requires a holistic approach and cannot be limited to one strategy or model. Bidirectional integration of primary care and behavioral health is a foundational strategy to reduce health disparities and provide better care coordination for patients regardless of where they choose to receive care.

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Potential Shared Policy Priorities

3. Meaningful metrics and implementation of VBP arrangements related to behavioral health
   - The state of the art of performance measures for behavioral health is different from physical health
   - Need to include clinically relevant outcome and process measures
   - Must develop mechanisms for linking behavioral health interventions with impact on total health status and cost

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Questions?

Thank you!

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Partnerships and Policy Priorities: Creating Alignment

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Partnerships and Policy Priorities: Creating Alignment

- Identify overlapping policy priorities for primary care and behavioral health
- Prioritize 1-2 policy priorities to focus on in your state as a team*
- Begin to shape a vision for a joint approach to at least one shared policy priority

* Teams with one association: consider ways to engage with multiple stakeholders to strengthen your policy agenda

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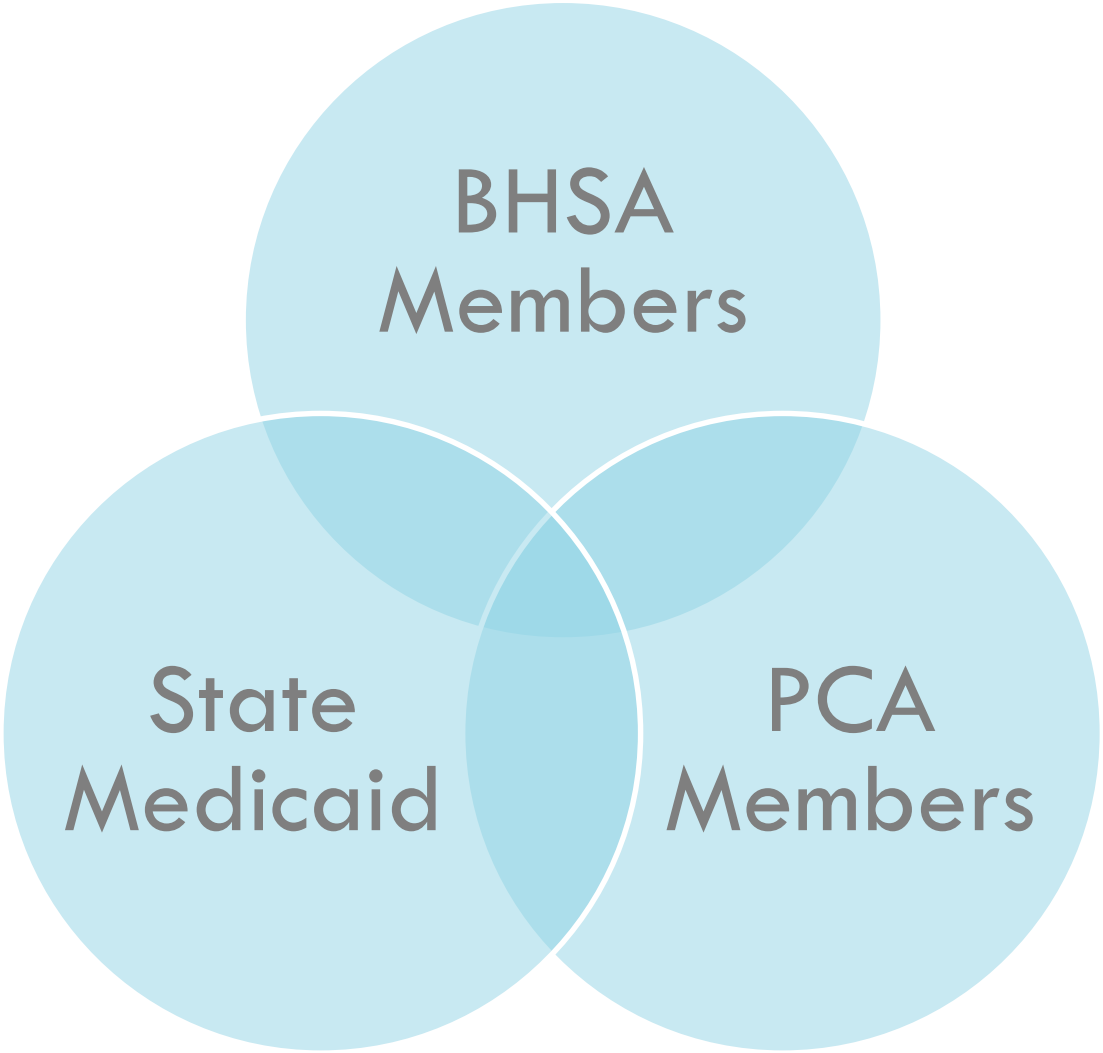
Policy Priority Mapping



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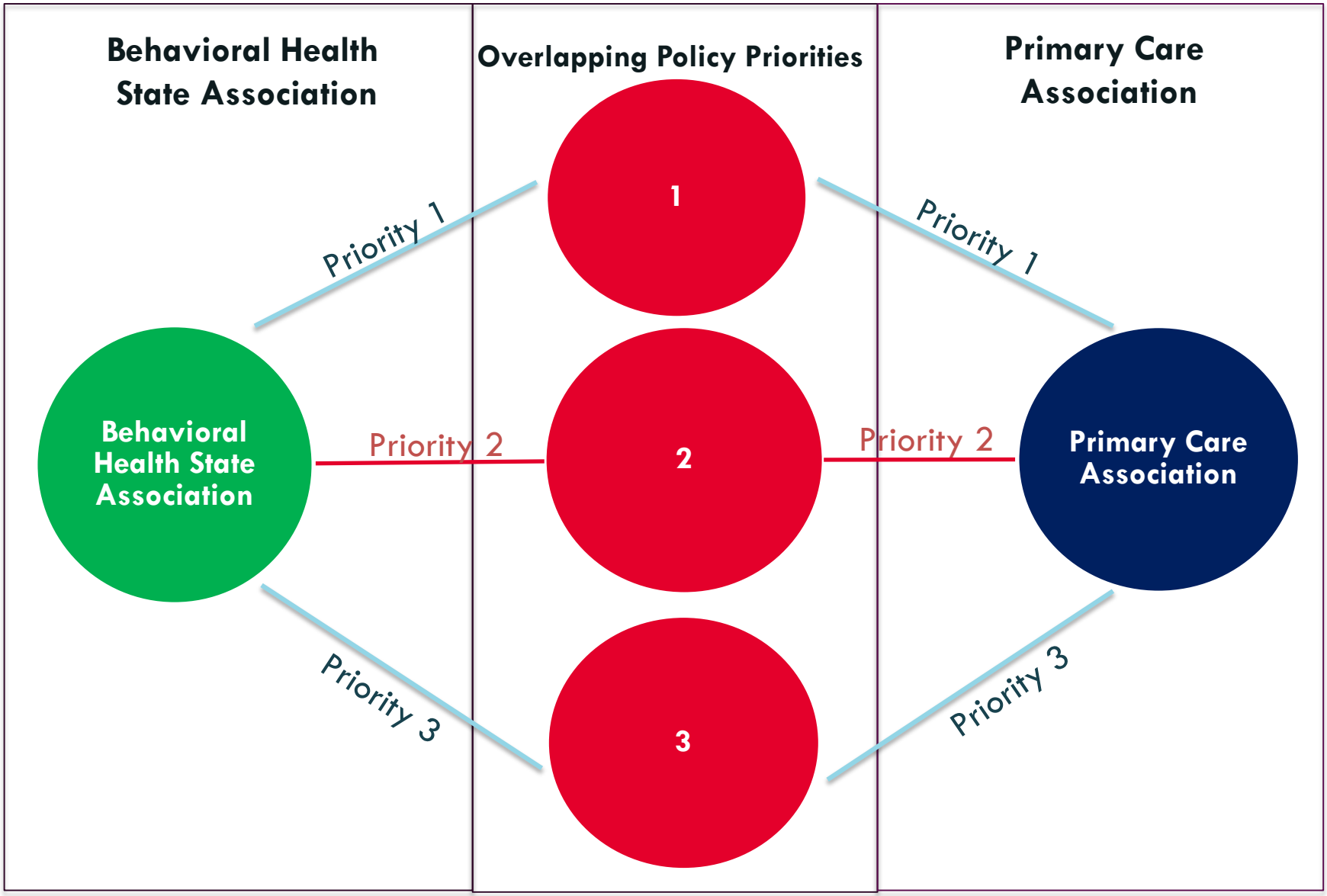
Behavioral Health State Association
Overlapping Policy Priorities
Primary Care Association
Priority 1
Priority 1
1
Behavioral Health State Association
Priority 2
2
Priority 2
Primary Care Association
Priority 3
3
Priority 3

Steps to Create Policy Alignment

- Center Shared Policy Priorities
- Establish Weighted Connectors for Policies
  - As you connect policy to your self and your partner, mark the relationships according to order of priority
  - Connect each policy with the proper priority weighting

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Break Out 40 Minutes

- Center Shared Policy Priorities
- Establish Weighted Connectors for Policies
  - As you connect policy to your self and your partner, mark the relationships according to order of priority
  - Connect each policy with the proper priority weighting

Teams with one association: consider ways to engage with multiple stakeholders to strengthen your policy agenda

Questions and Report Out

Thank you!

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Inspiring change through storytelling.

Don’t talk at your audience.
Tell them a story.

JOURNEY

The focus of this workshop is to create a simple approach for building trust and inspiring action. Nobody ever got to Oz without a heart, courage, and brains.

CREATIVE JUICES

WARM UP

Each person roll a die.

As a table craft a one minute story using what's showing on the dice.

Share your story with the group.

BUT, WHY?

The most successful leaders imagine and articulate the “what if” from a place of compassion before turning it into a reality.

GUIDE™ AS A FRAMEWORK

Your guide for blueprinting,
ideating and designing for impact.

G

Goal Clarity

Why are we doing this?

U

Unlock Commitment

What is?

I

Impactful Ideas

What if?

D

Decisive Action

Will it work?

E

Execution Excellence

How do we know?

CURIOSITY

GOAL CLARITY INSPIRES

COMPASSION

UNLOCK COMMITMENT ENGAGES

CREATIVITY

IMPACTFUL IDEAS CONNECT

COURAGE

DECISIVE ACTION MOTIVATES

COMMITMENT

EXECUTION EXCELLENCE EMPOWERS

SIX WORD STORIES

#PRACTICE

Develop and share your **personal 6 word stories** at your table.

For example: For sale,
baby shoes never worn.

6 WORDS ABOUT YOU!

Not my circus, not my monkeys.

MY MONKEYS FLY

THE NEXT STORY

POINT OF VIEW

PITCH VS. STORY

A REFRESH

Applying the Guide Principles to your project’s story

GOAL CLARITY

#INSPIRES

01 #ONE

WHY ARE YOU COMMUNICATING?

02 #TWO

WHAT DO YOU HOPE TO ACCOMPLISH?

03 #THREE

WHAT ARE YOUR EXPECTATIONS?

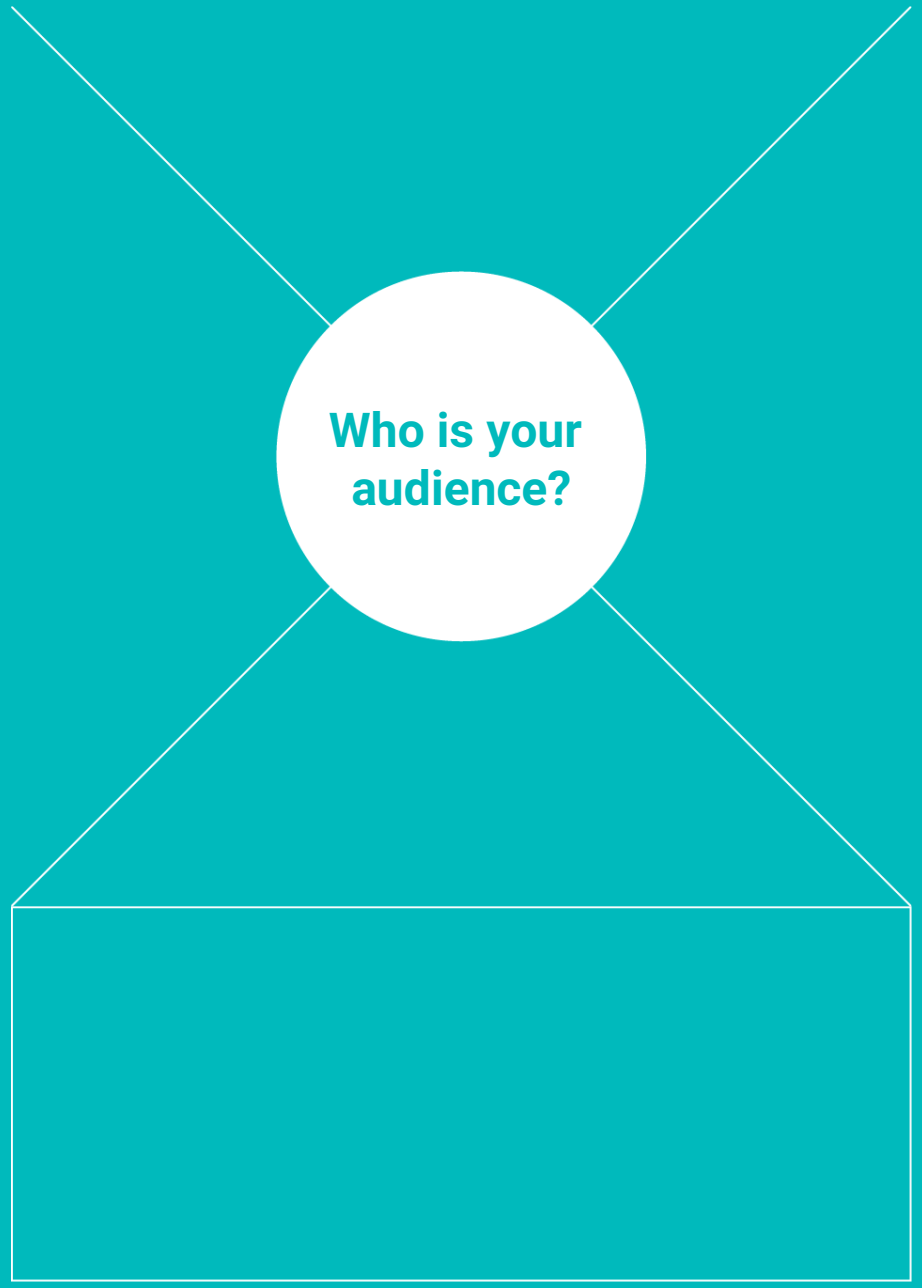
UNLOCK COMMITMENT

#ENGAGES

01 #ONE — WHO NEEDS TO HEAR THIS?

02 #TWO — WHAT DO THEY NEED TO KNOW ABOUT IT?

03 #THREE — WHY DO THEY CARE?



UNPACK YOUR AUDIENCE

What do you KNOW?
What do you NEED to know?
HOW do you know?

IMPACTFUL IDEAS

#CONNECT

01 #ONE

WHAT DO YOU ACTUALLY NEED TO COMMUNICATE IN THE STORY?

02 #TWO

HOW DO YOU SAY IT SO IT WILL RESONATE WITH YOUR AUDIENCE?

03 #THREE

HOW MUCH CONTEXT DO YOU NEED FOR YOUR AUDIENCE TO CONNECT?

DECISIVE ACTION

#MOTIVATE

01 #ONE

HOW DO YOU WANT THE AUDIENCE TO ACT, THINK AND FEEL?

02 #TWO

CAN? SHOULD? WILL?
DO YOUR IDEAS AND MESSAGE MOTIVATE THAT ACTION?

03 #THREE

WHEN DO YOU NEED ACTION?

EXECUTION EXCELLENCE

#EMPOWERS

01 #ONE

HOW WILL YOU KNOW IF YOU WERE SUCCESSFUL?

02 #TWO

WHEN AND WHERE DO YOU TELL YOUR STORY?

03 #THREE

HOW WILL YOU KNOW YOU WERE SUCCESSFUL?

30 MINUTES TO CRAFT A 3-MINUTE STORY

CREATE

Recommended Timing

Set a Goal: 5 min

Unpack Audience: 10 min

Ideas: 5 min

Call to Action: 5 min

Put it Together: 5 min

FEEDBACK ROUND

Find a team, both share,
get feedback and refine your stories.

LIGHTNING ROUND

Find a team, both share, choose one. Then, find another pair, share two, pick one.

TIME TO REFLECT

#INSIGHTS

#GLINDA

You are more capable than you know.

#DO IT BY DESIGN

THANK YOU!

Delta Center Learning & Action Collaborative Convening #2: Day Two

Seattle, WA

Rachel Tobey
Director, JSI California and Delta Center for a Thriving Safety Net

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Where we are going

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Dates for Remaining Convenings

- **February 11-12, 2019** – Oakland, CA
- **October 2019** – RWJF Princeton, NJ
- **February 10-11 OR 24-25, 2020** – Washington D.C.

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DELTA CENTER FOR A THRIVING SAFETY NET THEORY OF CHANGE

Goals

1) Build internal capacity of state associations
2) Build policy & advocacy capacity to advance VBP/C at a state level
3) Foster collaboration between PC & BH at state level
4) Build capacity of state associations to provide T/TA to advance revised MAHP model

Delta Center Activities

- Convenings
- Financial support
- Webinars
- Coaching
- Local funder introductions
- Faculty consulting
- Issue briefs
- Peer learning
- T/TA Materials
- Curated resources and faculty lists
- Integration with existing NACHC & NCBH events

State Association Activities

- Develop vision & strategy for VBP/C
- Promote learning organization principles through adaptive leadership to manage change
- Develop skills related to partnership building

- Advance policy change in VBP/C
- Facilitate partnerships with other key state-level stakeholders
- Build capacity to influence managed care contracting

- Develop joint strategy for PC-BH collaboration at the state level
- Convene PCA-BHSA partners

- Understand member T/TA needs
- Understand different options for providing T/TA
- Address T/TA needs

Outcomes

0-1 Year

- VBP/C vision & strategy articulated
- Understanding of core principles of adaptive leadership and change management
- Use of effective techniques to communicate value proposition

- Increased knowledge of VBP options and policy vehicles
- Identification of policy mechanisms that support VBP/C
- Strengthened state-level partnerships
- Increased practical knowledge of managed care contracting through Medicaid

- Integration of PC-BH collaboration into VBP/C strategy at state level
- Strengthened PCA/BHSA relationships

- Increased capacity and consistency in assessing readiness/needs of members
- T/TA plan based on needs assessment
- Increased knowledge of co-design and continuous improvement re: T/TA provision
- Increased knowledge of T/TA options Enhanced capacity to provide T/TA on VBP/C to members
- Concepts from revised MAHP model incorporated into existing programming

1-2 Years

- Agreement on payment reform goals among stakeholders
- Identification of gaps in association capacity
- Increased planning for sustainability, including engagement of local funders and other strategic partners

- Major policy proposals developed
- Inclusion of rural considerations in VBP/C efforts
- Implementation of strategic goals to advance VBP/C policy
- Increased collaboration and convening of safety net MCOs and safety net organizations

- Boards and key provider members engaged in supporting strategy
- State associations work together in innovative ways to increase PC-BH collaboration

- Reassessment of members' needs
- Refined T/TA plan
- Increased use of co-design/ learner-centered design to improve offerings and reach goals
- Additional T/TA offered reflecting MAHP model concepts, readiness assessment results, and rural and other special populations

3+ Years

- Use of adaptive leadership and change management strategies to overcome gaps in capacity and VBP/C
- Increased engagement of other stakeholders as partners (e.g., local funders, MCOs)

- Major policy proposals advanced
- Advancement of shared initiatives and policy proposal with partners
- New entities that support safety-net sustainability
- Increased value-based requirements in Medicaid procurements

- Advancement of joint PC-BH initiatives and policy proposals at the state level
- Enduring relationships among grantees across states

- Improved understanding of readiness and needs of members
- Enduring materials developed and available to non-grantee state associations

Impact

A strengthened ambulatory care safety net that is achieving better care, better health, lower costs, happier staff, and reduced health disparities in a sustainable way

Condensed version, updated 10/12/2018

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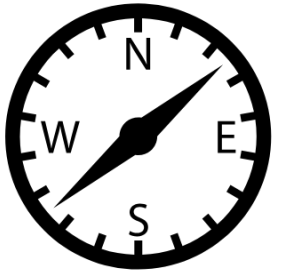
How do we know if we're getting there?



Change Assessment

- Designed and tested tool to align with 4 goals
- Next steps
  - Please complete online by end of October
  - Both PCA & BHSA should fill out
  - One assessment per state association
  - Talk through the assessment with your coach (by 11/9)

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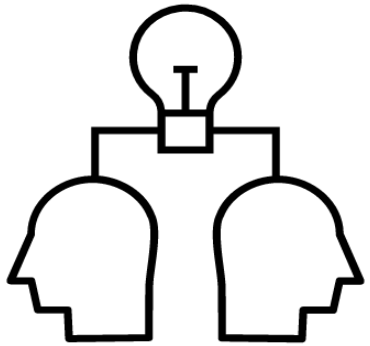
Peer Network: What to share and not share?

- What SHOULD be shared



- How to identify what shouldn't be shared

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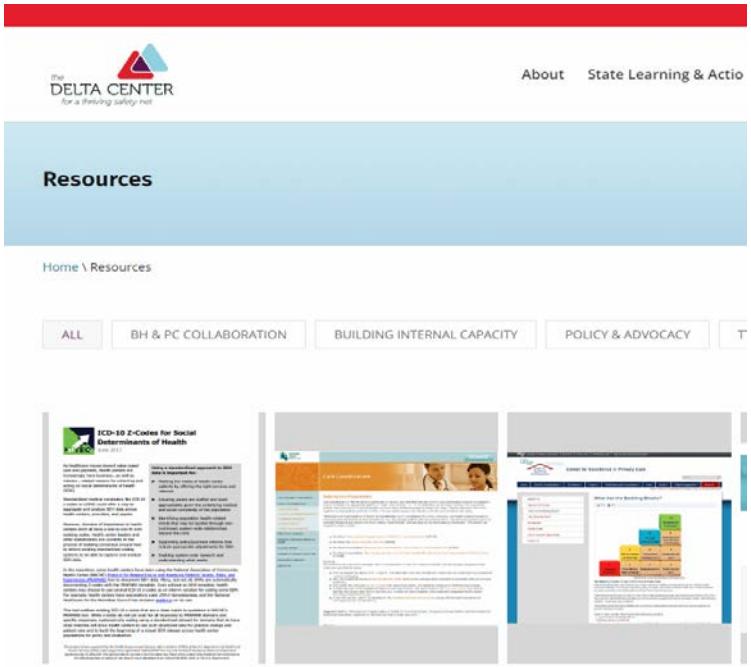
Materials are Online

Delta Center website deltacenter.jsi.com

- Public
  - Slides from all convenings
  - Grantee paragraph descriptions, primary contact information, & policy context
  - Curated Resource Set deltacenter.jsi.com/resources/
- Password protected section
  - https://deltacenter.jsi.com/state-learning-action-collaborative/for-grantees/



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Questions

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Improving Care in a Value Based Environment:

What do our members need to succeed & how will we know?

Veenu Aulakh, President Center for Care Innovation
Katie Coleman, Director Learning Health System Program KPWA
October 16, 2018
Seattle, WA

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Objectives for Our Discussion Today

1. Hear from leaders in Colorado and New York about how they support their members. [10:15-11:00]
2. Identify four levels of value-oriented [11-11:30] payment experimentation and understand how infrastructure, care strategies, and partnerships work together to enhance your members' ability to be successful.
3. Learn about & practice strategies to understand what your members need. [11:30-12:45]

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When you think about the top three things that you do for your members, how important is training and technical assistance?

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Understanding and Meeting Members' needs: First in a 3 part series

October 2018:
Learning about PC & BH members' needs

February 2019:
Designing with members at the center

October 2019:
Evidence- and practice-based tips and tricks for TA that activates members

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Learning From Your Peers

Lauri Cole, Executive Director NY State Council for Community Behavioral Healthcare Albany, NY

Jessica Sanchez, Vice President of Quality and Operations Colorado Community Health Network Denver, CO

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What are we supporting our members to do?

A Model for Advancing High Performance – MAHP 2.0

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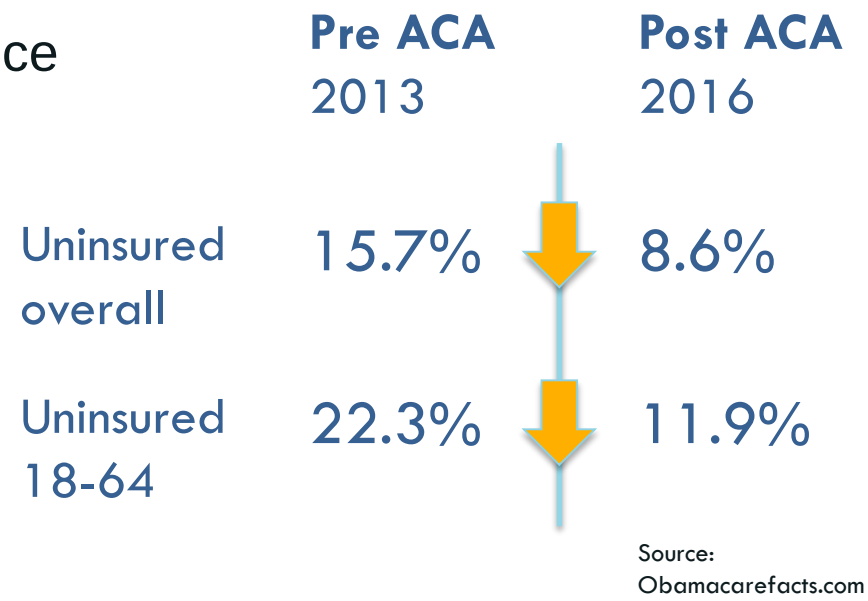
Health Care is Changing

Increased expectations for clinical, operational, and financial performance

- ACA created opportunities and new pressures for health centers and behavioral health organizations
- Integrated behavioral health
- Improve health outcomes/redesign
- Addressing social determinants of health
- Deliver relationship-based care



Source: Obamacarefacts.com

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Payment Experiments & Policy Uncertainty

Category 1: Fee For Service with No Link to Quality & Value

New FFS codes for discrete services or types of providers

New integrated behavioral health codes

Category 2: Fee for Service Linked to Quality & Value

Care coordination/mgt fees (Cat. 2A) - 21 states reported Health Homes (for PC and BH) in 2017

Payments for HIT investments (e.g., SIM $ to invest in HIT)

Pay-for-Performance payments (Cat. 2C) – ex. OR CCO performance payments to providers

Category 3: Alternative Payment Models Built on FFS

Shared Savings with upside risk only (e.g., Medicare MSSP)

Shared Savings with upside and downside risk (e.g., NextGen ACO)

Category 4: Population Based Payment

Episode-based payments for depression; FQHC Alternative Payment Methodologies (APMs) that pay a PMPM payment for PC services for defined population– e.g., OR APM, WA APM4, CO exploring PMPM

Source:
Health Care Payment Learning & Action Network
HCP-LAN.org
KFF Medicaid Policy Action Trends

California Health Care Foundation: Models for Advancing High Performance (MAHP)

- What functions and infrastructure must a health center have to address the needs of a low-income population in a value-oriented payment environment?
- How might small and medium-sized health centers either develop or acquire this infrastructure?
- What opportunities are there for health centers to partner with each other or other organizations to *share* resources with the goal of *improving* outcomes and *increasing* financial sustainability of the safety net?

Find the full report "Partnering to Succeed: How Small Health Centers Can Improve Care and Thrive Under Value-Based Payment" at http://www.chcf.org/PartnerToSucceed

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MAHP and MAHP 2.0 Approach

"We do anything you would think of that adds stability. The list is so big that what I can tell you is the human condition needs a multiplicity of services…

- Health Center Leader

- Literature Review (113 sources)
- Key Informant Interviews (22 calls) & accompanying survey
- Expert Advisor Meetings 2017
- Final Products: White Paper & Case Studies

- Series of 5 calls with National Council
- Ongoing email and phone conversations to adapt approach to a unified approach that would be applicable to support behavioral health and primary care.
- Work in progress!

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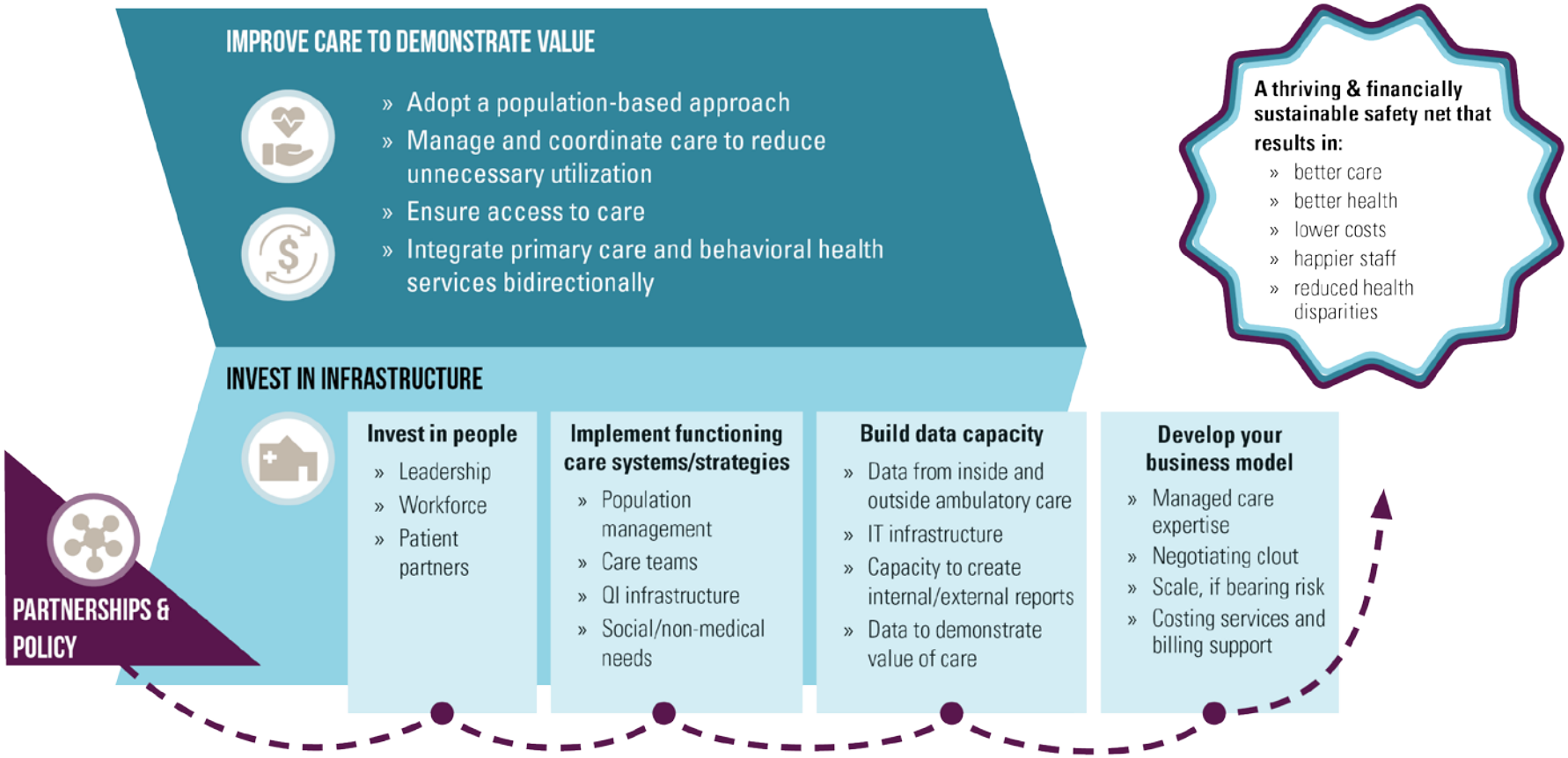
MAHP 2.0: A Model for Advancing High Performance in Primary Care and Behavioral Health*



*Adapted 8/20/2018 from The MacColl Center for Health Care Innovation and JSI Research & Training Institute, Inc. (2018). *Partnering to Succeed: How Small Health Centers Can Improve Care and Thrive Under Value-Based Payment,* California Health Care Foundation. Available at: https://www.chcf.org/publication/partnering-succeed-small-health-centers/

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Power of Partnership

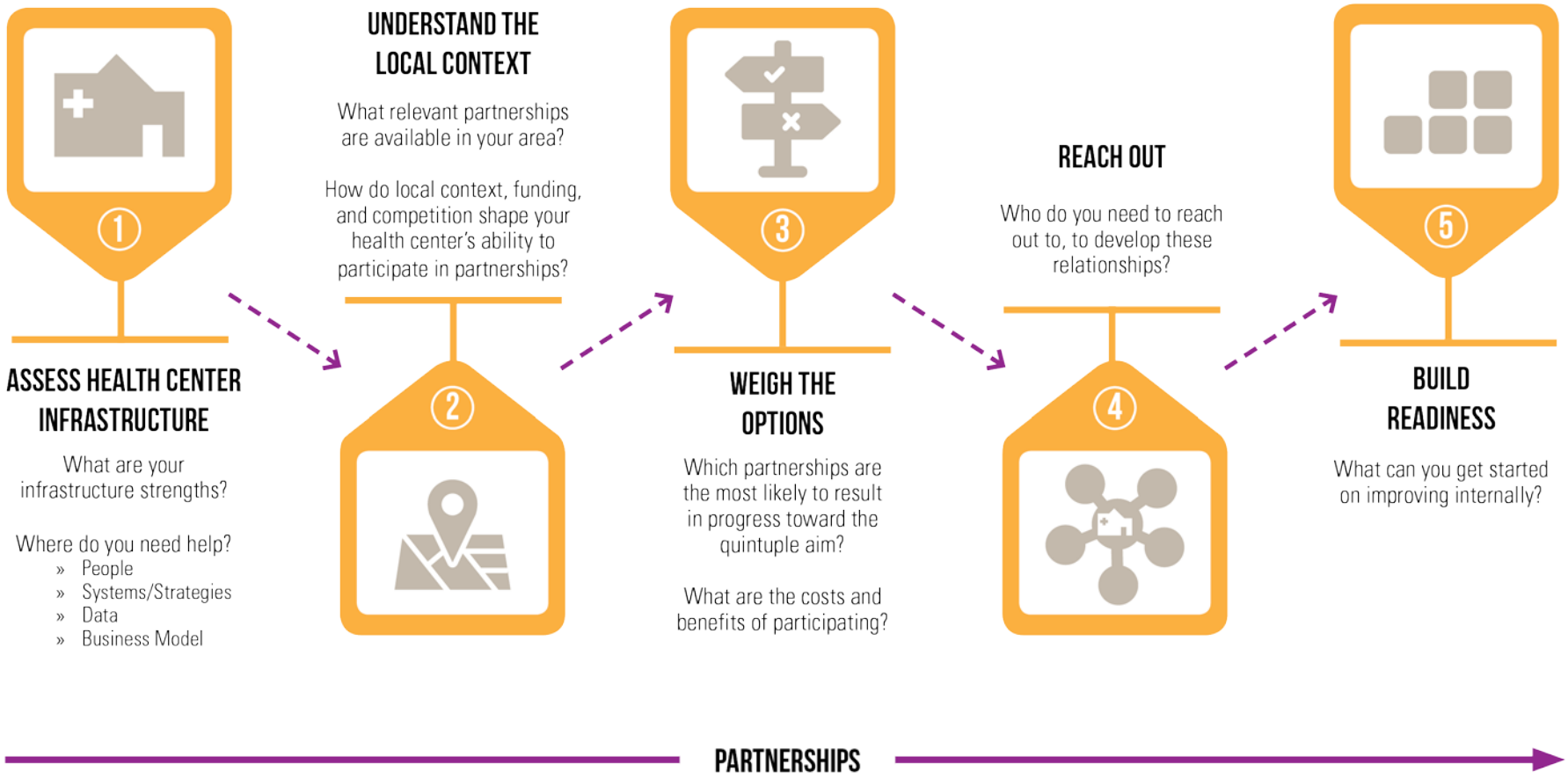
- Partnerships with Community-Based Agencies and Organizations
- Partnerships with Hospitals
- Partnerships with Behavioral Health &/or Primary Care
- Management Services Organzations (MSOs) and Clinically Integrated Networks (CINs)
- Health Center-led Independent Practice Associations (IPAs)
- Partnerships with Health Plans
- Mergers/Acquisitions

PARTNERSHIPS

"[Organizations] should not provide everything themselves. They need to find their strengths and then partner or buy other services."

- Consortia Leader

Road Map for Partnering: Key Questions



Eliciting and understanding member needs

Survey, Interview, Observation & Shadowing techniques

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Why partner with your members (or patients)?

- Members appreciate sharing their stories and ideas
- Help prioritize what problems to address
- Help ensure issues you cover are the right issues
- Challenge what you "know" and assume to be true.

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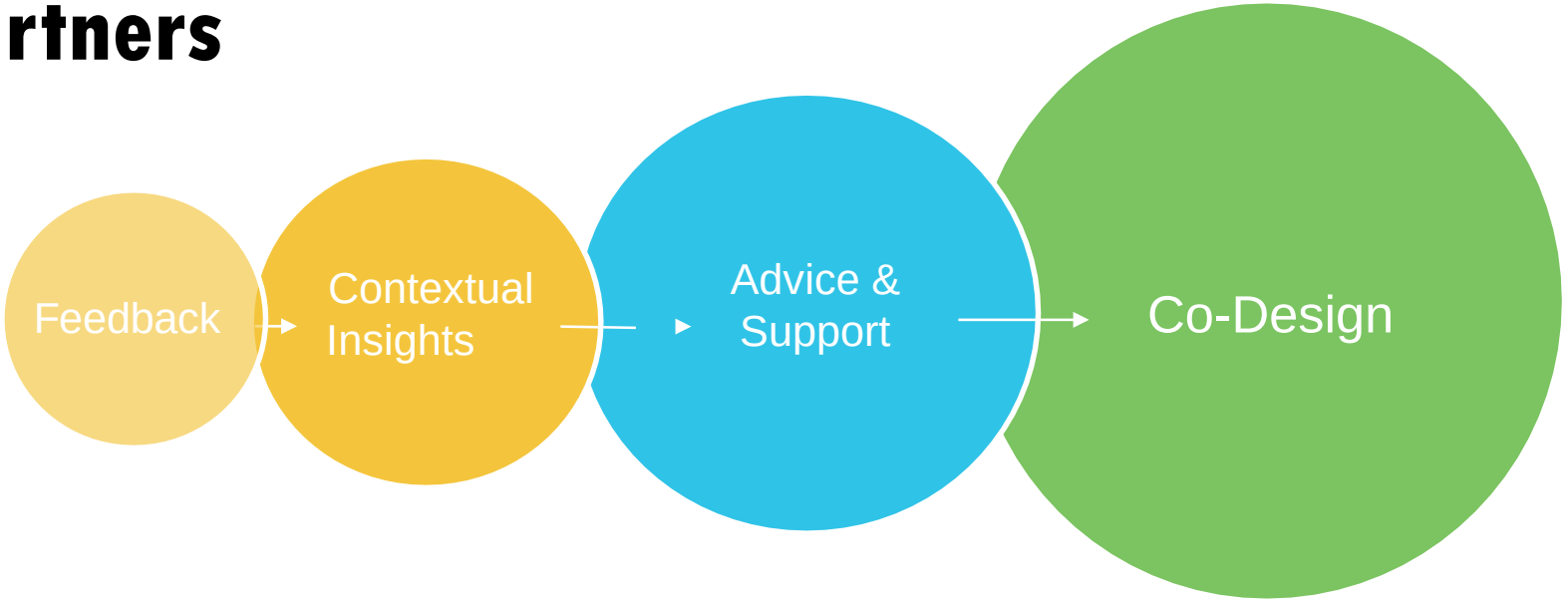
Partners vs. Patients / Clients

"Value is not created in the company
and then exchanged with customers;
rather, value is co-created
by the company and the customers."

-Prahlad & Ramaswamy

Evolution of Engaging with Patients/Clients as Partners



- Surveys
- Focus groups

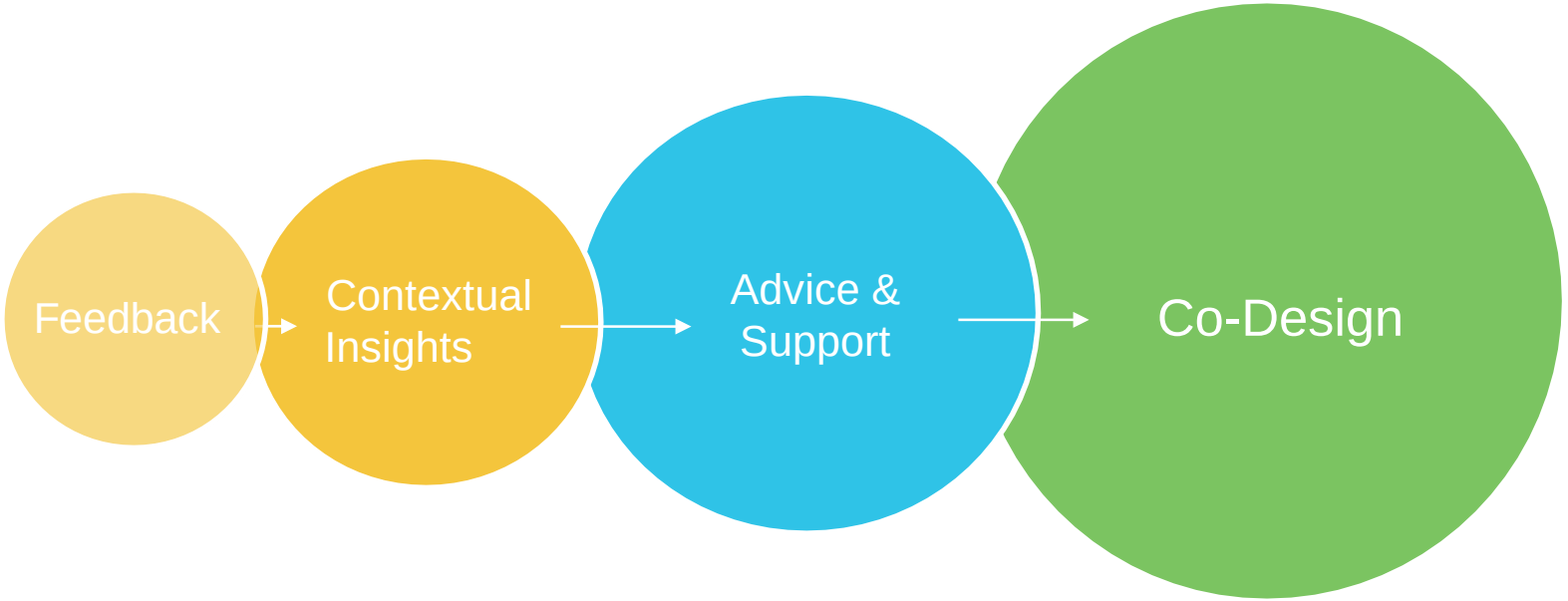
- Observation
- Shadowing
- Interviews
- Journey Mapping

- Patient Advisory Councils
- Peer Navigators

- Patients on project team longitudinally, creating value alongside staff.

Actively listen and create solutions with members at every touch point in their journey

Evolution of Engaging with Members



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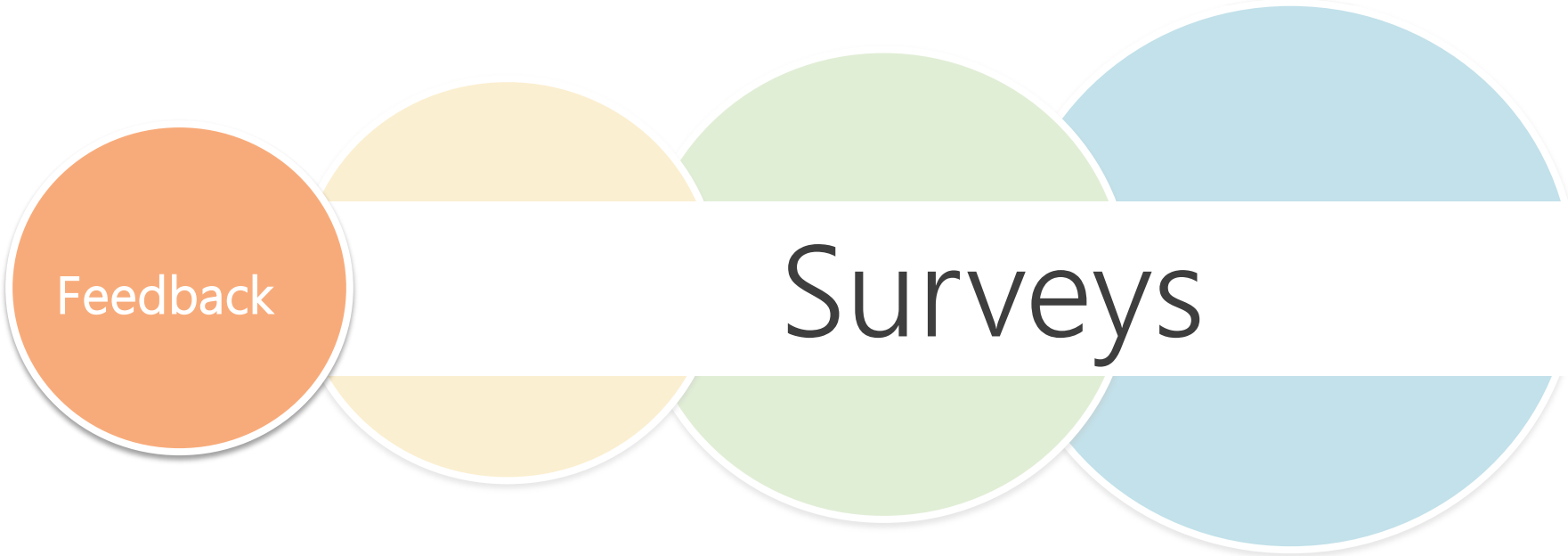
Member Surveys



- Surveys
- Focus groups

- Observation
- Shadowing
- Interviews/Intercepts
- Journey Mapping

- Patient & Family Advisory Councils
- Peer Navigators

- Patients on project team, creating value alongside staff

Member Surveys Used

NACHC Payment Reform Readiness Assessment Tool

- Arizona
- Colorado
- Maine
- Massachusetts
- New Mexico
- North Carolina

PCMH-A

- Missouri
- Colorado*
- Oregon*
- Massachusetts*

Integrated CCBHC Certification Feasibility and Readiness Assessment Tool (I-CCFRT)

- Oregon
- Texas

VBP Readiness Assessment Tool for Behavioral Healthcare & Primary Care

- New York

Value Transformation Assessment (VTA)

- Washington

TCPi Practice Assessment Report Template

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Might we use surveys …

- ✓ In conjunction with a clearly defined intervention?
- ✓ As part of a conversation?
- ✓ To support sites' needs?

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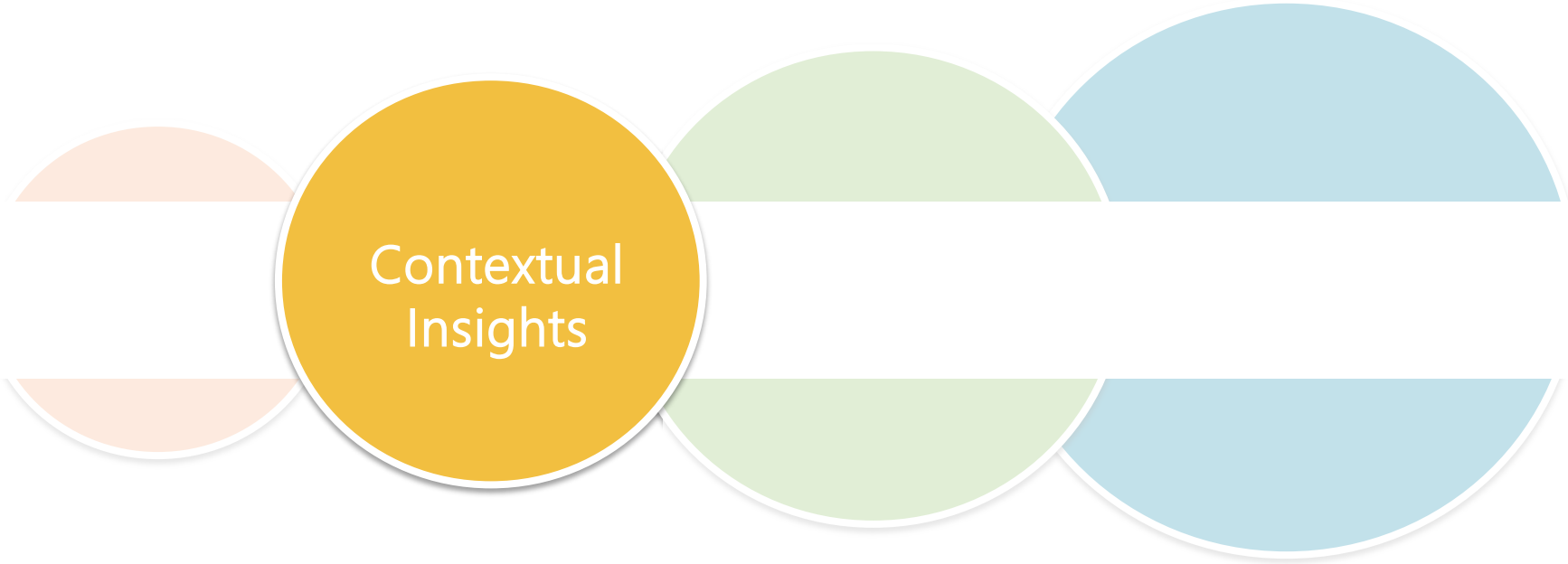
Partners in Providing Context



- Surveys
- Focus groups

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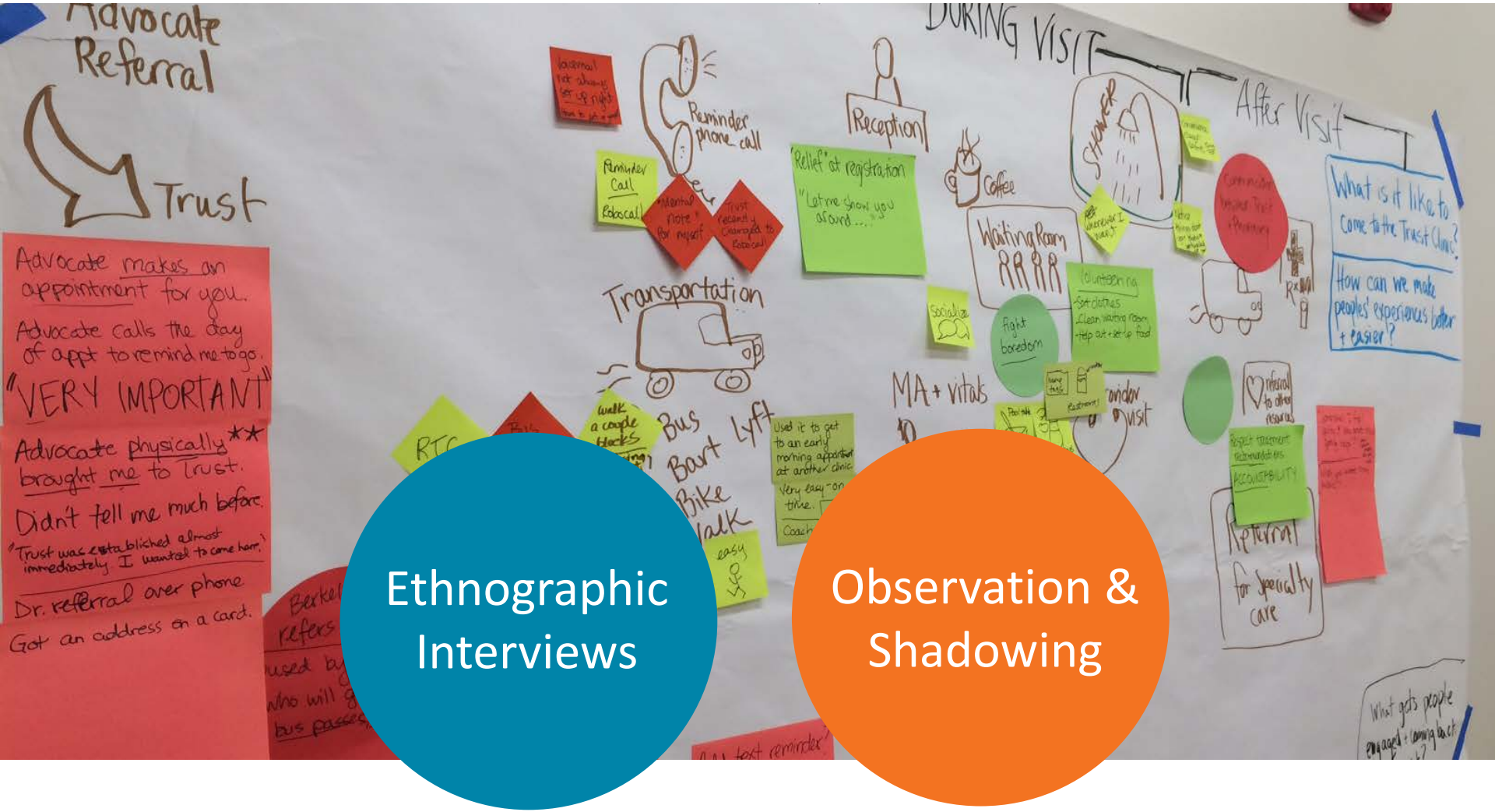
Techniques that Bring Out the Context



Interview Question Types

Questions should be open-ended, not multiple choice or yes/no. Use them to explore the user's experience and context as well as deepen your understanding beyond stereotypes.

Open-Ended Topic
"Tell me a little about the department..."

Naïve/Outsider Perspective
"I'm not a nurse, tell me about this medication thing."

Quantity
"How many times does that happen? In a day, a week a month?"

Changes Over Time
"How are things different now than a year ago? How could they be different a year from now?"

Sequence
"Walk me through a day in the life of a medical assistant..."

Compare to others
"How do other clinicians handle situations like this?"

Decode Jargon & Special Language
"What does that acronym mean?"

Clarification
"...and when you say 'the principals will eat you alive,' what do you mean exactly?"

Specific Examples
"Let's take your last experience: what was your favorite part?"

Projection
"What do you think would happen if..."


VISA

Activity

- Find 2 partners that you don't know well. One person will lead the interview, one will take notes and one will be the interviewee
- Interview each other for 4 minutes on your wallet. Rotate roles.
- Start with overall story of your wallet. Interviewer will use specific point to ask more questions and understand.
- Tell me more about…; Show me how you...
- Reflect on what you learned about the person through their wallet

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Reflection

What did you do during the silence?

Were you able to learn something interesting?

What's important/of value in this technique?

What is challenging about this technique?

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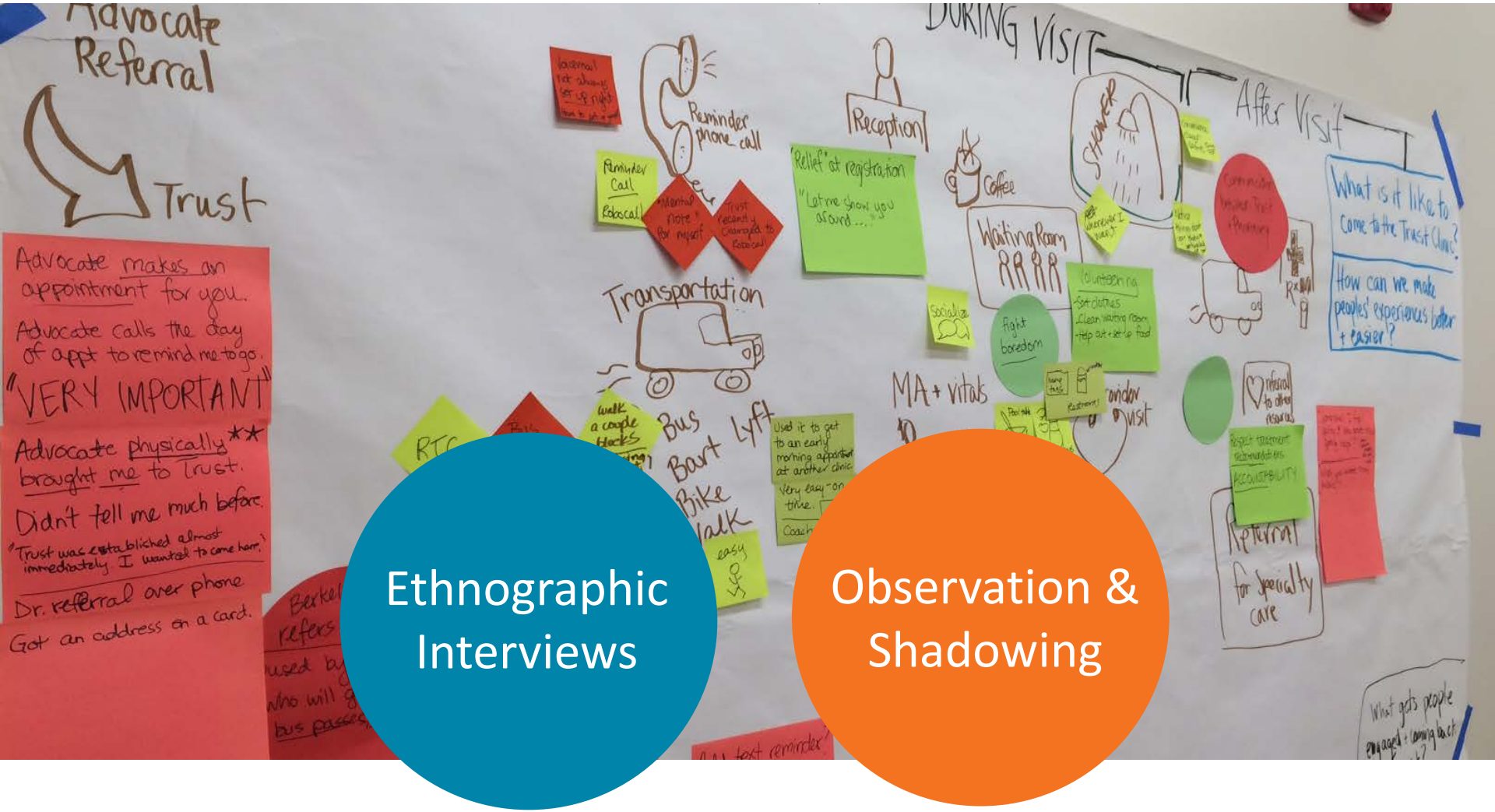
Techniques that Bring Out the Context




EXIT
NURSE

Observation – See & Experience

See the existing context with fresh, curious eyes

Understand what really happens

Develop empathy and insight

Identify specific pain points or challenges

Observe the real world context

Adding depth to research

	Quantitative	Qualitative
	How many...	Nature of...
Customer segments	Percentage of each	Bring them to life
Behaviors	How often, when	How they do things
Satisfaction	Percentage	Why & why not
Language	Comments	Values, intent
Context (environment)	N/A	See relationships
Discovery	In the data, cross-tabs	In the field & in the data
Time	Duration	Perceived
Questions & Anwers	Discrete	Rich

Overall process

Plan

What would we like to understand?

What kinds of questions do we have?

Where should we go?

What methods will we use?

Recruit & Schedule

Who can we engage?

How can we recruit their participation?

How will we build trust and keep their confidentiality?

What's our schedule?

Immerse in the Field

Use a discussion/observation guide

Be comfortable, transparent

Let the user guide you

Gather evidence & examples of user experience

Review & Analyze

What are the top ten stories from the field?

What are we surprised by?

How can we see this in a new way?

Create Useful Outputs

Customer journey

Key pain points

Frameworks

Priorities

Activities to do back home

1. Where are there opportunities to interview, shadow or observe your members?

2. Brainstorm a list of people's activities/experiences that could be relevant to strengthening your TA

3. What would you want to learn? What might you count or observe?

4. Develop a plan for doing it

SEE & EXPERIENCE

OBSERVATION

Given our familiarity with workplaces and the routines of everyday life, we don't see and reflect on what's really going on. Focused observation is a powerful tool.

HOW TO

1 Think about and decide what environment or context you'd like to spend time observing.

2 Take a notebook, pen, and a simple note taking framework of AEIOU (Activities, Environment, Interactions, Objects, and Users).

3 Find a place to sit and observe without being in the way. Don't hide, but don't impede. Let the people know you're there to learn, not to evaluate.

4 As you observe the action, note what grabs your attention and what raises questions in your mind.

5 Sketch out the environment. Make a list of things for a specific category. Count things. What's interesting?

6 Take pictures and record video. Watch the video and pin up pictures. In reviewing, you'll often see things you didn't notice the first time.

TIPS & TRICKS

Be yourself, not a sterile observer. Build rapport with the people. Take a moment to help someone or ask a question. Show interest in what they do and tell them so! Note how they are feeling and what their experiences are like.

PAIRS WELL WITH

- Empathy Map
- "Ways of…" Statements

MINDSET OF

Empathy

TIME *45–60 minutes*

TEAM SIZE *1 or 2 people*

MATERIALS *Video camera with good mic, camera phone, consent form*

SEE & EXPERIENCE

SHOW AND TELL INTERVIEW

The best way to get better at learning from users and your colleagues is to have them "show and tell" you about what they do. You listen, capture, and learn.

HOW TO

1 Prepare before meeting your participant by writing down things about their situation, job or life you'd like to see and understand.

2 Be transparent with your participant about what you're trying to learn. Emphasize you'd like to know how things really are, not the conventional notion of how we think things should be.

3 Start out with a broad background question. "Tell me a little about yourself and how you got here." Use what the participant says to ask more specific questions. Use, "Tell me about..." on every topic.

4 Make sure you cover ground, don't get caught on one topic too long.

5 Collect things or pictures of things that support the user's experience: references, diagrams, tools, etc.

TIPS & TRICKS

Avoid assumptions. Have participants explain details in their own words. Have them demonstrate the activity.

"Tell me about…" and "Can you show me…?" should be the primary question forms. This avoids short yes/no or discreet choice answers.

PAIRS WELL WITH

- Observation
- Empathy Mapping

MINDSET OF

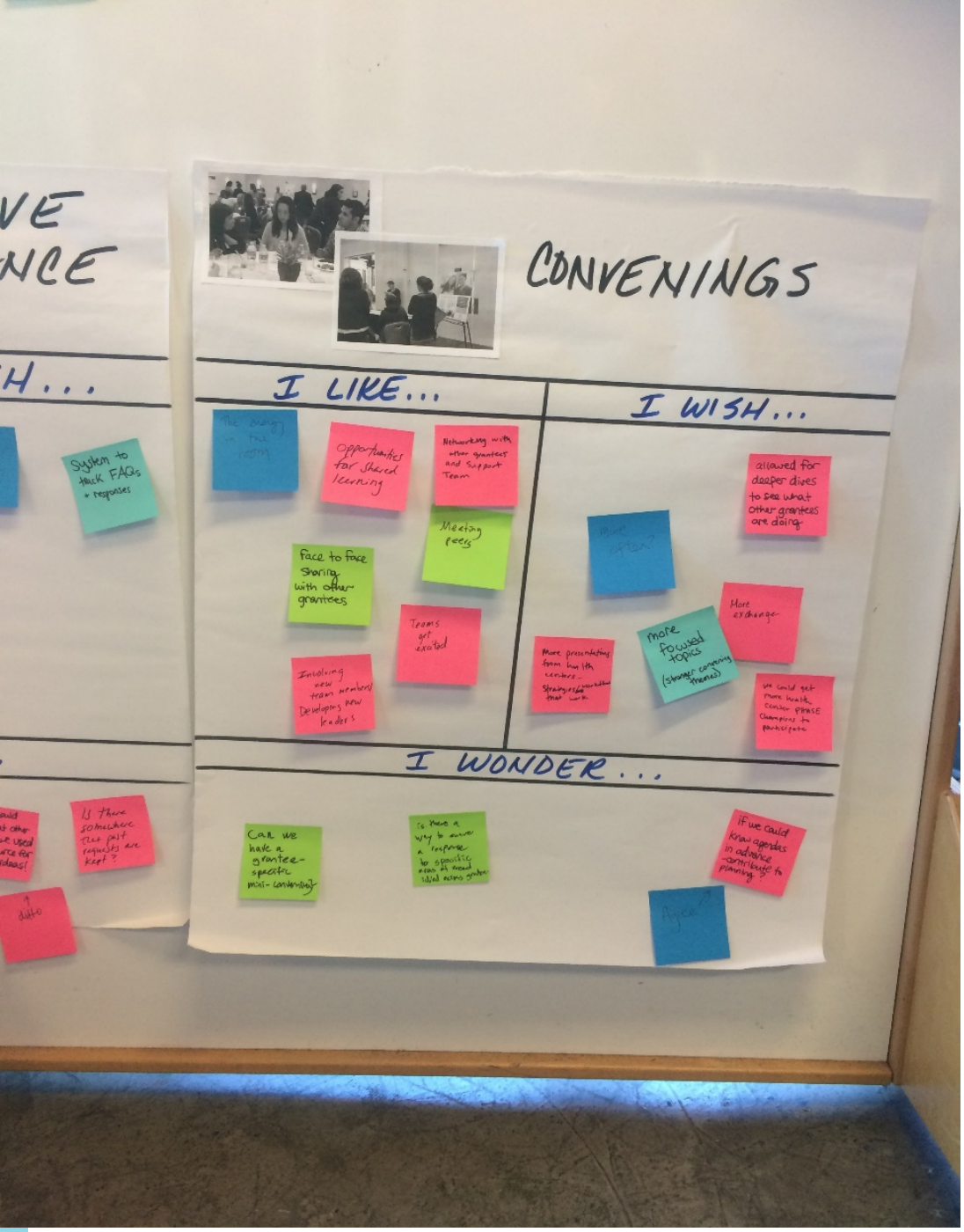
Empathy

TIME *45–60 minutes*

TEAM SIZE *1 or 2 people*

MATERIALS *Video camera with good mic, camera phone, consent form*

www.careinnovations.org/programs/catalyst



I LIKE

I WISH

I WONDER

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LAST Activity – room divided into three groups

- Take 5 minutes to reflect on our meeting
- What did you Like About it
- What did you wish could be different
- What did you wonder about? What questions do you have or what possibilities do you see for future
- Write ideas on sticky notes. Post them on flip charts.

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Invitation for Trying Something New

- Convene again February 11 & 12 in Oakland California
- Before then, try a new technique for learning more about what your members or your partner's members needs
- Come with your feedback for our next session on Designing with Members at the Center.

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