

June 20, 2017

Executive Director Update

Welcome to Our New Members!



IHME

Institute for Health Metrics
and Evaluation

loft⁹

McKinsey&Company



ISLAND HOSPITAL



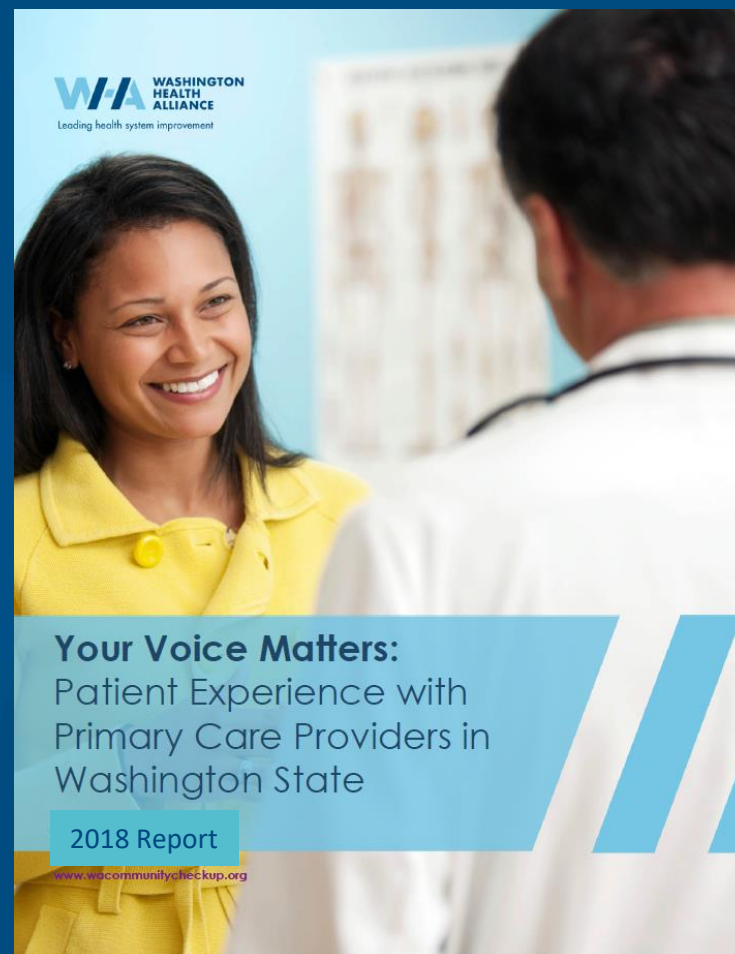
Quest
Diagnostics™



Convening Purchaser Affinity Group and Interested Insurance Plan Leaders

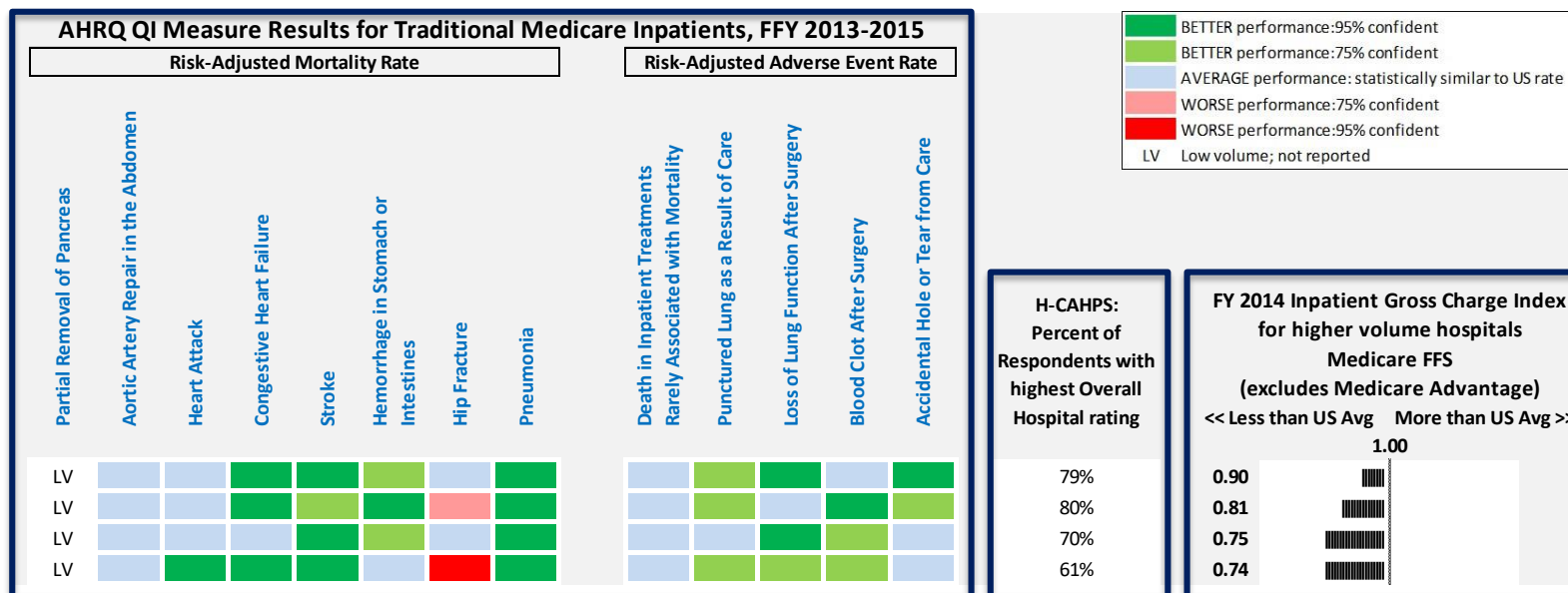


Your Voice Matters: 2017 Patient Experience Survey

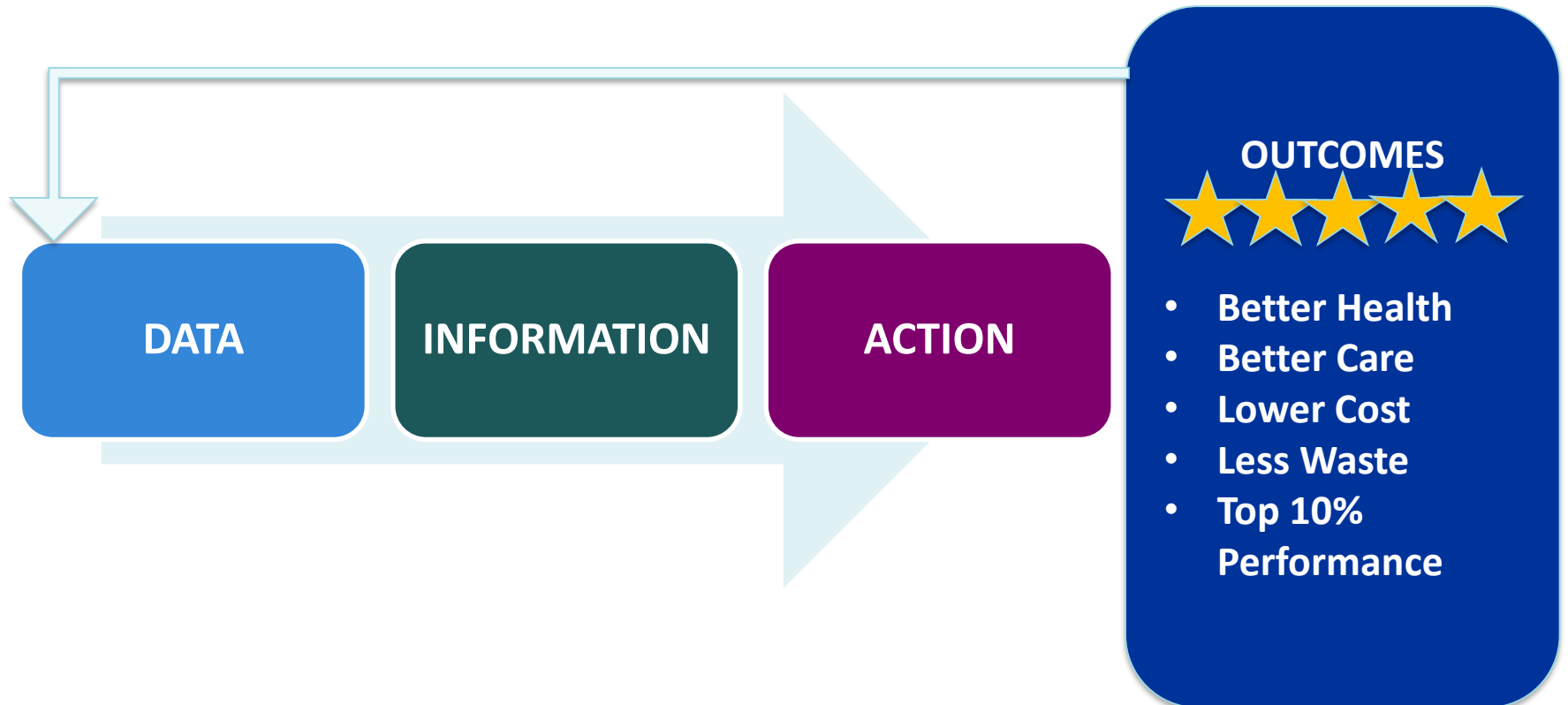


New Report Expected Next Month

- In July, the Alliance will release a report on hospital value that utilizes publicly available data based on the Medicare FFS population.
- The report will rank order 48 hospitals* based on 8 risk-adjusted mortality rates and 5 risk-adjusted adverse event rates from FFY 2013 - 2015
- Along with this information, the report will include each hospital's:
 - H-CAHPS result: % of respondents with the highest overall hospital rating
 - FY 2014 inpatient gross charge index



Alliance: Working Collaboratively with Stakeholders to Use Data to Drive Action



Adding the Final Piece of the Puzzle!



April 2017: Added Pricing Data to the Alliance's Data Warehouse

Commercial Insurers	Self-funded Purchasers
Aetna	Association of Washington Cities
Asuris NW Health	The Boeing Company
Kaiser Permanente Washington	City of Seattle
LifeWise Health Plan of Washington	Carpenters Trust
Premera Blue Cross	First Choice Health
Regence Blue Shield	King County
	Sound Health and Wellness Trust
	Teamsters
	Washington State Health Care Authority
	Washington State Health Insurance Pool

Price Variation by Clinical Condition/Episode of Care

Action: Purchasers and Brokers

- Reveals extent of real price differences
- Enables informed dialogue with health plans and/or provider organizations
- Identifies provider organizations for which price shopping and/or alternative contracts may be encouraged

Action: Providers

- Shows relative cost advantage/disadvantage to others
- Offers a guide for pricing for alternative contracts

Action: Health Plans

- Overview of variation by an independent, trusted third party
- Identifies organizations well positioned for alternative contracting

Price of Potentially Avoidable Services: 30-day All Cause Readmissions and Potentially Avoidable ER Visits

Action: Purchasers/Brokers

- Reveals what is being spent on these potentially avoidable services
- Enables informed dialogue with health plans and providers
- Tool for behavior change with employees/members

Action: Providers

- Insight into purchasers' view on potential waste in the system
- Identify and prioritize specific populations and/or provider organizations for improvement

Action: Health Plans

- Independent third party source for results
- Broad view on best practices for success

Spending Trend Analysis

Action: Purchasers/Brokers

- Tool to assess whether spending trends over time are attributable to changes in:
 - Age/gender mix
 - Service frequency
 - Treatment intensity
 - Price level
- Comparison to statewide trends
- Informs contracting and benefit design strategies

Thank You!

Today's Program

**Selena Bolotin, Practice Transformation Director
Qualis Health**

**Dr. Michael L. Schoenbaum, Senior Advisor for
Mental Health Services, Epidemiology, and
Economics, National Institute of Mental Health**

The Practice Transformation Support Hub

Provider-centered support for successful practice transformation

Selena Bolotin
Practice Transformation Director/Qualis Health





Today's agenda

- Describe the Hub in the Healthier Washington context
- Describe Hub services and supports available to providers/practices
- Describe progress to date
- Leave time for Q & A



Healthier Washington



Transforming the system with many public and private partners



Accountable Communities
of Health



Paying for Value



Shared Decision Making



Integrated Physical
and Behavioral Health



Practice Transformation
Support hub

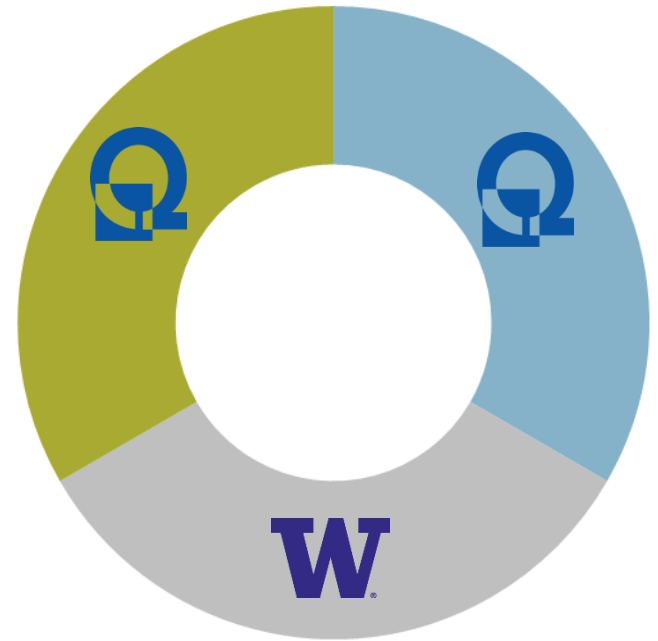


Analytics, Interoperability
and Measurement



The Hub: A Four-year, State Innovation Model (SIM) Testing Grant

- Three separate contracts, funded by DOH though 1/2019
- Qualis Health provides Practice Coaches and Regional Connectors programs
- Web Resource Portal offered through partnership with UW Department of Family Medicine Primary Care Innovation Lab



Qualis Health



- Non-profit quality improvement and population health management firm
- Established in 1974, headquartered in Seattle
- Regional offices in five states (Alabama, Alaska, California, Idaho, and New Mexico) and DC
- Products and services directly influence care delivered to approximately 13 million people

Qualis Health's Mission

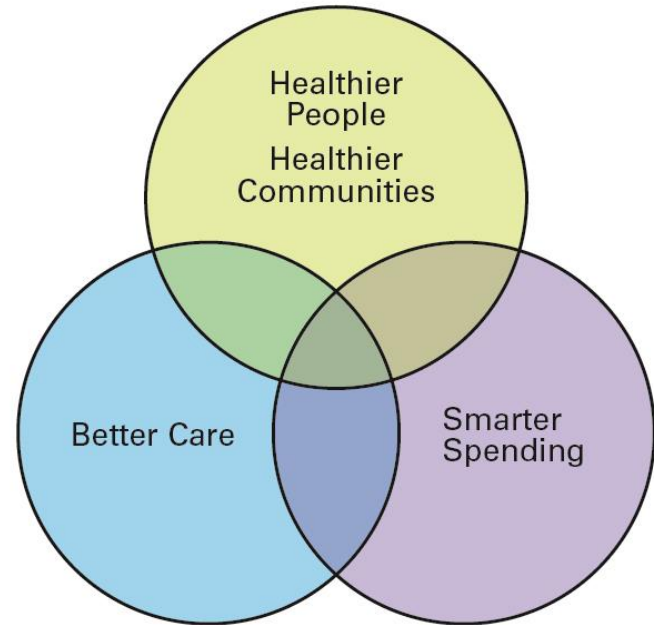
To generate, apply, and disseminate knowledge to improve the quality of healthcare delivery and health outcomes



Hub Goals

Help providers to:

- Integrate physical and behavioral health
- Move from volume-based to value-based care
- Improve population health through clinical community linkages



To achieve the Triple Aim

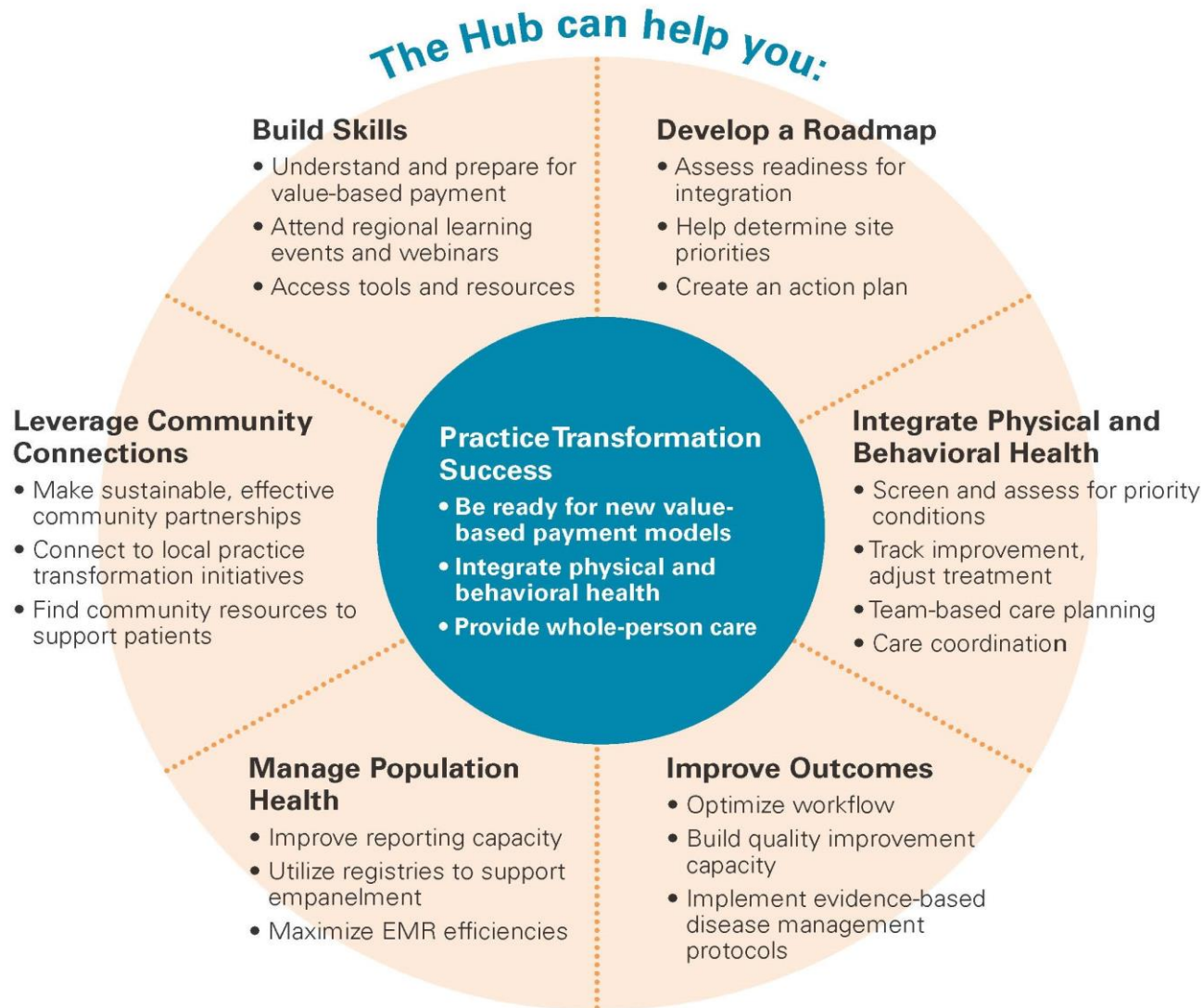


Hub menu of services for practices

- On-site practice coaching
- Personalized practice assessments
- Education, tools and resources
- Support for bi-directional physical and behavioral health integration
- Finding and coordinating community-based linkages



What connections do you need for successful practice transformation?





Progress to Date

- Contracts started October 2016
- Hired / on boarded 9 practice coach/connectors in the ACH regions
- 105 enrolled practices (thru 6/15)
 - 43 primary care
 - 53 BH agencies
 - 9 integrated PC / BH practices
- 68 completed assessments



Hub Practice Coaches and Regional Connectors



Carolyn Brill, CPHIMS, CHP
North Sound



Gwen Cox, RN
North Central



Maria Klemesrud, MEd, LMHC
Olympic



Wei-Lin Huang, MSW, LICSW
Pierce



Kevin LeLacheur, RN, BSN
SW WA Regional Health
Alliance



Sharon Poch, MSW
King



David Stipe, RRT
Cascade Pacific Alliance



Dawn Sayers
Better Health Together



Sam Werdel
Greater Columbia



Support for Successful Bi-directional Physical and Behavioral Health Integration

- Regular, on-site technical assistance to make the best use of population health tools
- Screening
- Team-based care planning
- Patient engagement
- Care coordination





Finding and Coordinating Community-Based Linkages

- Sustainable, effective community partnerships for better coordination of care
- Information and links to other local practice transformation initiatives
- Community resources to engage and benefit patients



Personalized Practice Assessments

- Identify where practices are in the process of transformation and address specific needs and challenges
- Provide a gap analysis and action plan; help set goals for change
- Help implement specific, quality improvement strategies



Personalized Practice Assessment

Patient Centered Medical Home Assessment (PCMH-A)

- Intended to help sites understand their current level of “medical homeness” and identify opportunities for improvement
- 36 questions
- 12 point assessment scale



Personalized Practice Assessment

MeHAF (Maine Health Access Foundation)

- 21 questions
- Wording for both primary care and behavioral health providers
- 10 point assessment scale
- Closely aligned to the PCMH-A (Patient Centered Medical Home Assessment)



Engaging Practices

- Value proposition needs to be clear to practices, as they are inundated with information already
- Aligning federal and state programs
- Aligning integration models
- Initial conversations with practices to understand their concerns and priorities



Essential Alignment with Stakeholders

- ACH relationships and workgroup participation
- Cross walking Demonstration Project measures and Apple Health measures with MIPS
- MCO coordination for clinical and payment integration in SouthWest and NorthCentral ACH regions
- Rural TA alignment
- Tribal health customization
- APM4 coordination with WACMHC





Training via Partnerships

- AIMS Learning Series – 3 cohorts
 - Tribal clinic cohort planning
- Regional Conferences Fall 2017
 - WHA VBP track
 - AIMS BHA and Primary Care BHI tracks
- Statewide Webinar Topics
 - Behavioral Health Integration
 - Care Coordination
 - Financing & Sustainability Strategies for BHI - July 19



For More Information

Hub Help Desk: (206) 288-2540 or (800)
949-7536 ext. 2540 or by email
HubHelpDesk@qualishealth.org

Qualis Health Practice Transformation
Director: Selena Bolotin
selenab@qualishealth.org

Hub Resource Portal, www.waportal.org



The Practice Transformation Support Hub Resource Portal



UW Medicine

UW SCHOOL
OF MEDICINE

DEPARTMENT OF
FAMILY MEDICINE

www.waportal.wa.edu





Time for Q & A!



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National Institute
of Mental Health

Behavioral Health: Advancing Integrated & Measurement-Based Care

Presented by:

Michael Schoenbaum, PhD

Senior Advisor for Mental Health Services Epidemiology & Economics

National Institute of Mental Health

June 19, 2017





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Senior Advisor for Mental Health Services, Epidemiology & Economics
Division of Services & Intervention Research
National Institute of Mental Health



- **DISCLOSURES**

- My comments may not represent the views of NIMH/NIH/DHHS
- No (known) conflicts
- Other affiliations
 - University of Washington AIMS Center
 - University of Michigan Population Studies Center
 - PALTOWN Development Foundation





Key Points

- Mental illness and substance use (**behavioral health problems**) are major drivers of disability & costs
- Effective treatments exist, but most people who need them don't get them
- These problems are not limited to behavioral health specialty care settings & populations
- Effective solutions exist! But stakeholders need to incentivize them, via
 - Payment
 - Measurement





Burden of Behavioral Disorders


- **Common**

- **>1 in 4** Americans struggle with a mental health or substance use problem at some point in their lives
- No family goes untouched

- **Disabling**

- Cause nearly **25% of all disability worldwide**
- Premature mortality, via **suicide & medical comorbidity**

- **Costly**

- Health care costs
 - Productivity: unemployment, absenteeism, “presenteeism”
 - Social costs: homelessness, criminal justice system
- 



Usual Care is Poor


- Half or more of people with mental disorders get **NO CARE***
- Of those who receive any care, half receive sub-therapeutic or even contraindicated care*
- ~30 million people receive a prescription for a psychotropic medication in primary care each year; **only 25% improve**

No (Specific)
Treatment

Inadequate
Treatment

Minimally
Adequate
Treatment

*Wang PS et al., *Arch Gen Psychiatry*, 2005





How do we close the gap?

- **Develop better treatments**
- **Train & retain more mental health professionals** (>50% of US counties don't have a single practicing mental health professional)
- **Improve delivery of existing treatments, via integration & measurement-based care**





Proactive, measurement-based care

- Screen routinely, & assess positive screens
- If positive assessment, start appropriate treatment
 - Indicated medication at appropriate dosage
 - Indicated psychotherapy
- Assess clinical progress at defined intervals
- If patient isn't improving, adjust treatment
- Expect $\geq X\%$ of patients to achieve target outcome in defined timeframe



Usual Care



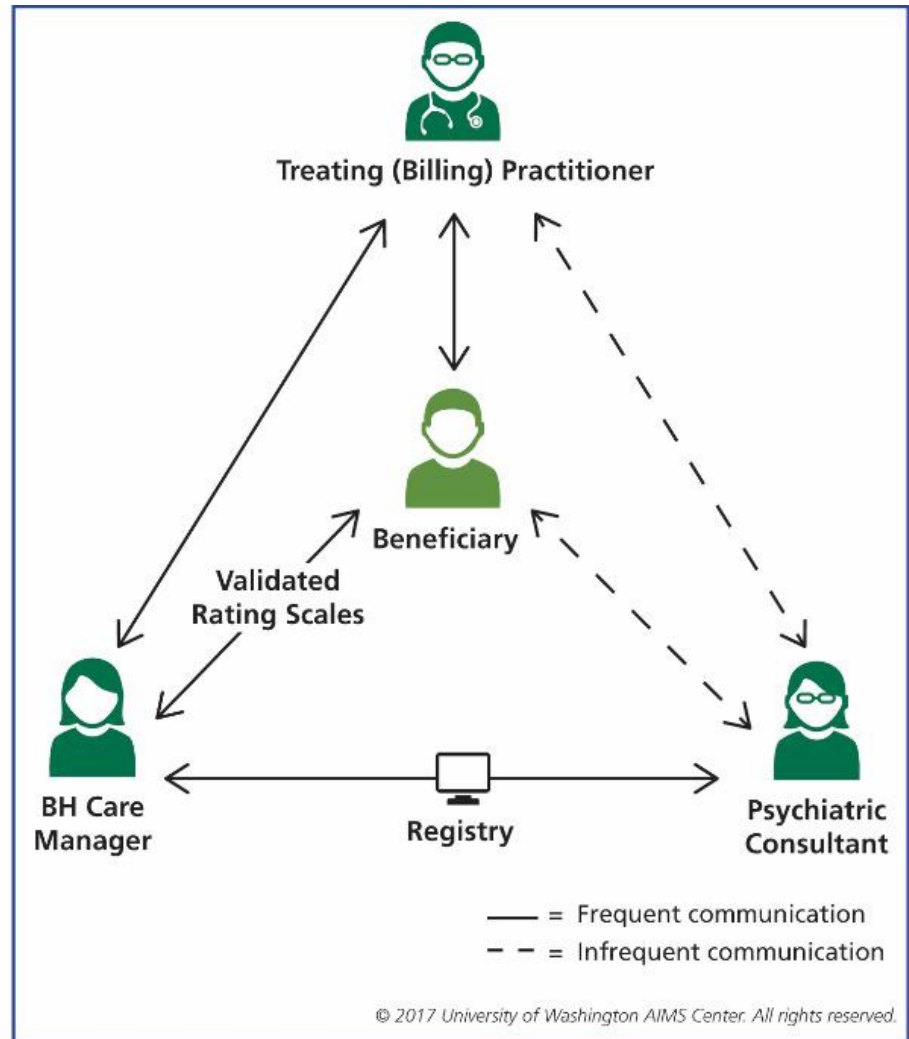
Collaborative Care

An evidence-based model for treating behavioral health conditions in primary care

EXISTING TREATMENTS

- Medications
- Psychotherapy

DELIVERED VIA:





Incentivizing Collaborative Care

- **Payment of core components**
 - Care management (especially via telephone)
 - Psychiatric consultation
 - *On January 1, 2017, Medicare added payment for Collaborative Care via HCPCS codes **G0502, G0503, & G0504***
 - Medicare also added payment for “general BHI” via G0507
- **Measurement / Treatment to target**
 - At minimum:
 - Universal screening via standardized instrument
 - Benchmark for % of cases who remit within 12 months
 - *CMS requires for depression in Medicare ACOs, as of 2015; also being added to HEDIS*
- **Pay for Performance**





Additional Resources:

- University of Washington's **AIMS CENTER**
 - <https://aims.uw.edu>
 - <https://aims.uw.edu/collaborative-care/financing-strategies/financial-modeling-workbook>
- **Kennedy Forum: *Fixing Behavioral Health Care in America***
 - *A National Call for Integrating & Coordinating Specialty Behavioral Health Care with the Medical System*
 - *A National Call for Measurement-Based Care in the Delivery of Behavioral Health Services*
 - <https://www.thekennedyforum.org/resources>





Incentivizing Effective Care

- **Payment**
- **Measurement**
 - Standardized clinical workflows
 - Reporting & accountability
- **Pay for Performance**





Questions?

Michael Schoenbaum, PhD
michael.schoenbaum@nih.gov



Resources from CMS:

- **Fact Sheet: Behavioral Health Integration Services**
 - <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Behavioral-Health-Integration-Fact-Sheet.pdf>
- **Frequently Asked Questions about Billing Medicare for Behavioral Health Integration (BHI) Services**
 - <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Behavioral-Health-Integration-FAQs.pdf>





Payment for Collaborative Care (G0502/3/4)

- **Care Team**
 - **Treating (billing) practitioner**
 - **Care manager** – designated individual with behavioral health training; must be available for face-to-face patient contact
 - **Psychiatric consultant** – medical professional trained in psychiatry & qualified to prescribe full range of medications; can be located remotely
- **Eligible Conditions** – Any mental, behavioral health, or psychiatric condition being treated by the billing practitioner, including substance use disorders, that, in the clinical judgment of the billing practitioner, warrants BHI services
- **Service Components**
 - (Elements of measurement-based care described earlier)





Payment for General BHI (G0507)

- **Care Team**
 - Treating (billing) practitioner
 - Care manager – optional
 - Psychiatric consultant – optional
- **Eligible Conditions** – Any mental, behavioral health, or psychiatric condition being treated by the billing practitioner, including substance use disorders, that, in the clinical judgment of the billing practitioner, warrants BHI services
- **Service Components**
 - Initial/repeated assessment, using applicable validated clinical rating scales
 - Care planning, with care plan revision for patients whose condition is not improving



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Thank You!