Be a Value Based Payment (VBP) VIP

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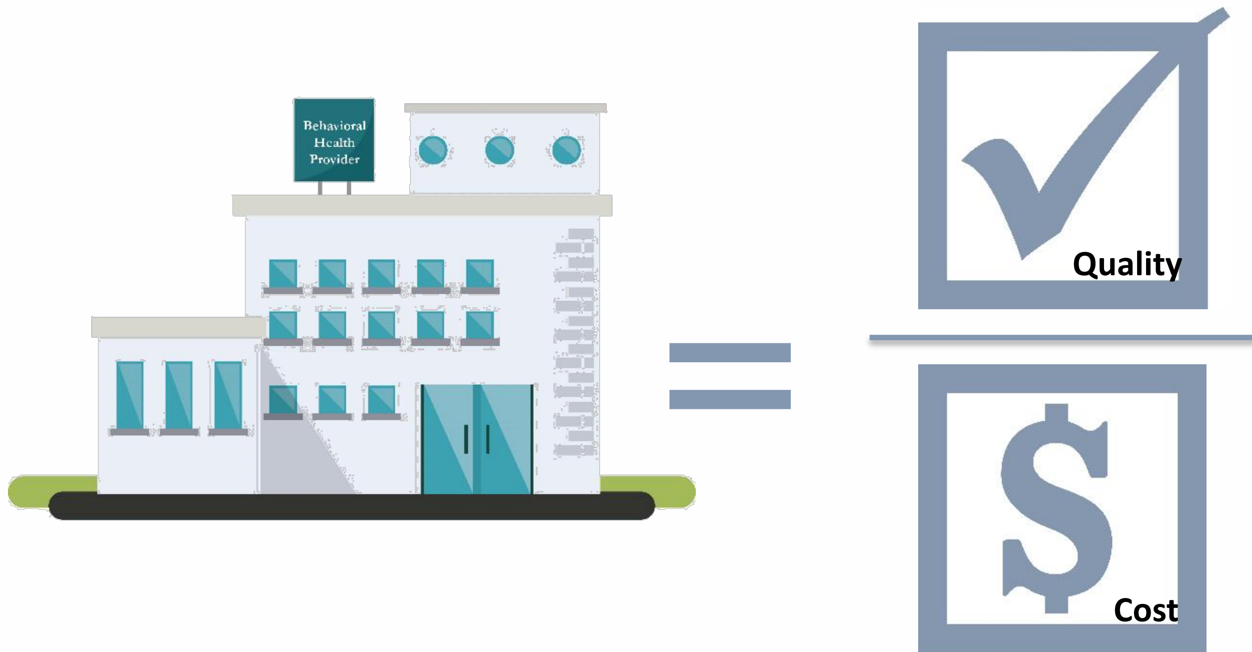
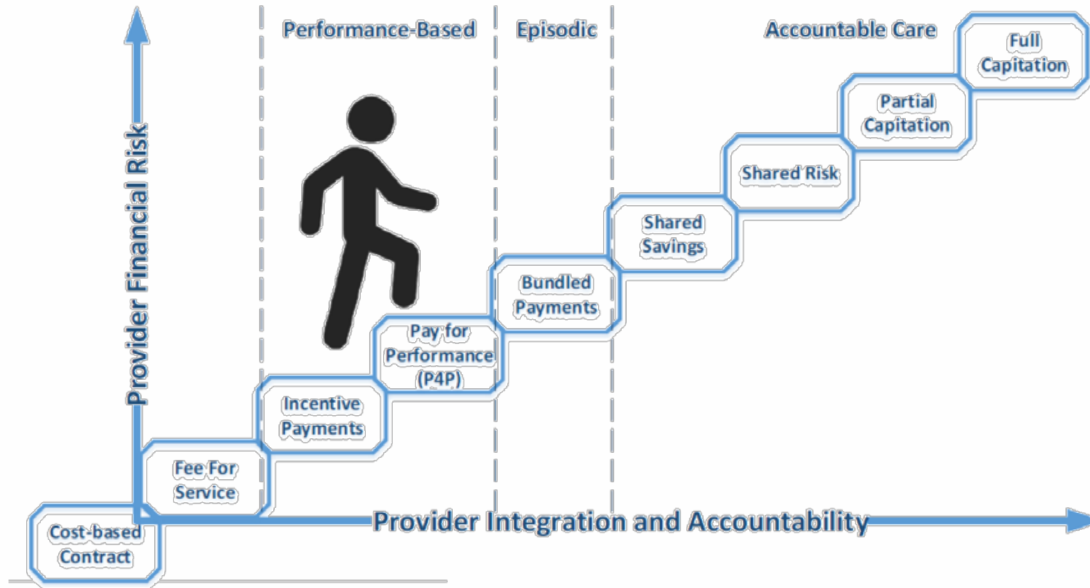
Value in Value-Based Payments



Payments Continuum



Source: J. Rubin Principle Health Management Asso. 2016

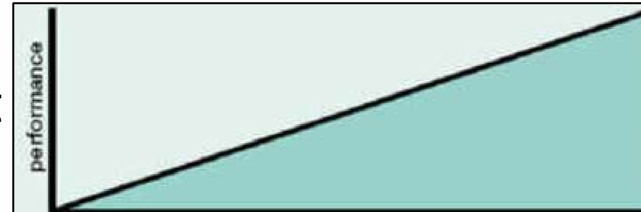
Contracting with a Payer

Bridge: Destination Unknown

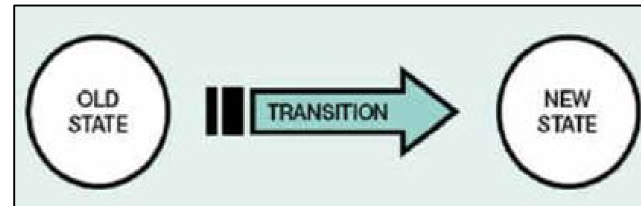
Image source: Kelley Grayson, Envolve, 9/5/17 for National Council's Practice Transformation Academy

Types of Change

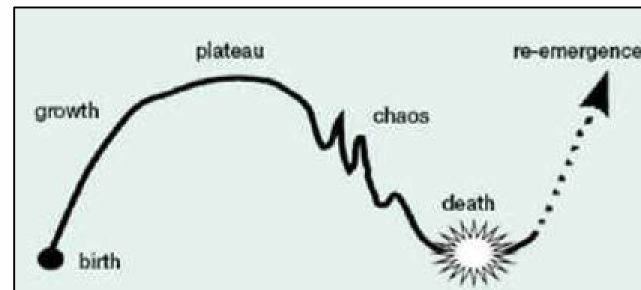
- Developmental
  - Improvement of what is



- Transitional
  - Movement towards well-defined new state



- Transformational
  - New state is largely unknown



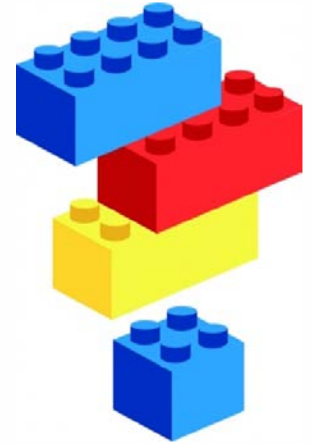
Transformational Change (a.k.a. Managing Chaos)

1. The future is unknown and only through forging ahead will it be discovered.

2. The future state is so different than the traditional state that a shift of mindset is required to invent it.

3. The process and the human dynamics are much more complex, partnership is critical!

Aligning our Terms!



Value-based Payments requires…

Care Pathways which requires…

Risk Stratification which requires…

Population Health Management

therefore…

these concepts are not loosely linked but are structurally contingent on one another.

Components of Population Health Management

1. Knowing what to ask about your population
2. Data registry to describe/risk stratify your populations
3. Proficiency with quality improvement tools to respond to the findings
4. Continuous quality improvement policies/procedures to sustain data specification targets

Risk Stratification

- Risk-stratified care management is the process of assigning a health risk status classification and using it to direct and improve care
- A Consumer is at Risk when he/she reaches an established threshold or cutoff that triggers a step in care (i.e., up or down)

Community
Transitions
DLA-20
Co-Morbidities
Medical
Choosing
Substance
Continuum
Prevention
Activation
Medication
PHQ-9
Based
Stability
Regulation
GAD-7
Contracts
Evaluation
Chronic
Determinants
Risk
ACO
Rates
Education
Staff
Diabetes
Monitoring
Quality
Care
Employment
Value
Patient
Outcome
Use
Child
IPA
Criminal
Conditions
Pathways
Process
Payers
Population
Hypertension
Justice
Primary
Housing
Health
Welfare
Making
Measures
Show
Wisely
Decision
Adherence
Compliance
Improvement
Emergency
Room
Collaborative
Evidence
Turnover
Social
Interventions
Visits
Engagement
Stratification
Hospitalization
Partnerships

Common Indicators Used to Stratify Risk

- Behavioral Health Diagnosis
  - Schizophrenia, Bipolar, Depression & Anxiety, PTSD & Stress, SUD
- Hospitalization Utilization Rates
- Re-hospitalization Rates
- Emergency Department Utilization Rates
- Medical Co-morbidities
- Social Determinants of Health
- Others include medication adherence, number of medications prescribed, inadequate monitoring and follow-up participation, lower levels of patient engagement, and lack of community infrastructure

What is a Care Pathway?

- A protocol-based/standardized set of clinical & administrative work flow process steps that staff engage in to assist a consumer with a social determinant, physical and/or behavioral health need.
- A Care Pathway operationalizes Care Management components into replicable, measurable work flow steps.
- Care pathways are considered to be one of the best tools organizations can use to manage the quality in healthcare concerning the standardization of care processes, since care pathways promote organized and efficient patient care based on evidence. It has been proven that their implementation reduces the variability in clinical practice and improves outcomes.

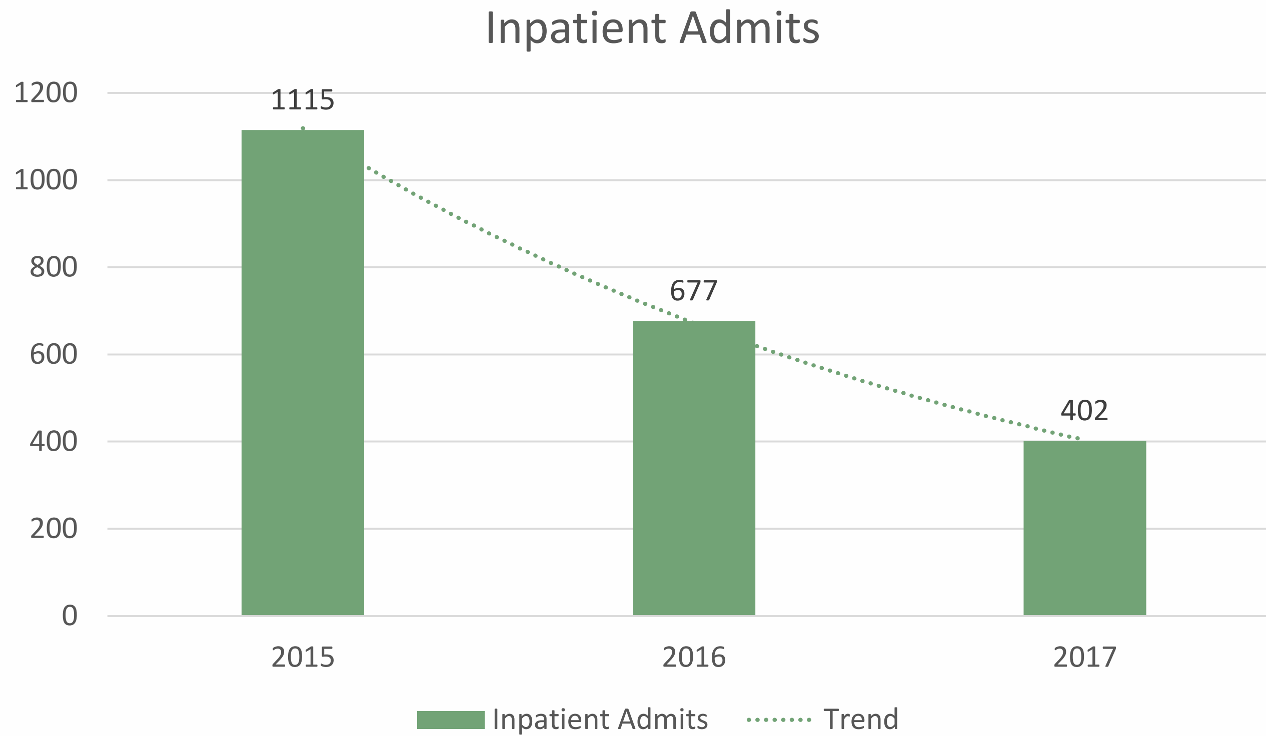
The Link Between Clinical and Financial

- Populations are defined by:
  - The severity of each individual's illness
  - Its quantifiable impact on their lives
  - As evidenced by their individual circumstances and needs
- Reimbursement Rates are determined by Population
  - The cost of providing appropriate services to ensure quality outcomes within each identified population
- This is the beginning of "Population Health Management"

Population Definitions & Requirements

Population	Description	Potential Costs be based on…
Standard Population	All consumers not fitting into Special Pops defined below	Charges and Costs for Services: At or Below the Outlier (Special Populations) Threshold
Special Population 1	High Risk SMI or Co-Occurring	a minimum of 3 or more hours per month CMHC services and 1 hour per month of care coordination activities.
Special Population 2	High Risk SED or Co-Occurring	a minimum of 12 or more hours of service per month. This may be a combination of and treatment services.
Special Population 3	Adults with significant substance use disorder	according to the ASAM intensive outpatient placement criteria which equates to 9+hours of services per week.
Special Population 4	Adolescents with significant substance use disorder	according to the ASAM intensive outpatient placement criteria which equates to 6+hours of services per week.
Special Population 5	Chronic homelessness or First Episode Psychosis	Intensive Outpatient Services to assist individual to attain and maintain a safe and stable living environment, and to stabilize Psychosis

Hospitalization Reduction



If a tree falls in the forest and no one collected the data, it didn't make a sound.