CNY Behavioral Health Care Collaborative

All Partner's Meeting

March 19, 2019

CNY BHCC

All in for better health

Agenda

- Lunch/Welcome and Introductions
- Achievements Toward Success
- Status, Planning and Structure
- Goals and Action Steps

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Achievements Toward Success

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Achievements

- BHCC Director and assessment of need for other staff
- Sub-committees meeting bi-weekly to make progress toward their identified goals
- Governance structure developed and steps from finalization
- Individual visits to partners to better understand our network as a whole
- On-going work with MCO surrounding work plan/project plan
- Brand Development and strengthened Mission/Vision/Values
- Website Development including a Member's Portal

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A Strengthened Identity

Mission

Collaborating for better health by improving successful outcomes, ensuring quality and increasing access to care

Vision

CNY BHCC supports its network and affiliate partners by making the full spectrum of integrated health services available in our region, entering into contracts with Managed Care Organizations, providing ongoing education on contract performance expectations, fostering population health management around societal determinants of health, and organizing a network around collective goals to set and meet shared health outcomes

Values

At CNY BHCC we believe in person-centered integrated health services, team based approaches to care planning, addressing social determinants of health to break down barriers to successful outcomes, the use of data and evidence based practices to provide better care and decision making, performance monitoring in an effort to ensure quality to our communities and an overall commitment to excellence

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www.cnybhcc.health

http://cnybhccdev.wpengine.com/

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Status, Planning and Structure

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Why Are We Here?

Josh Rubin, Health Management Associates

CNY BHCC
All in for better health

HEALTH MANAGEMENT ASSOCIATES

WWW.HEALTHMANAGEMENT.COM

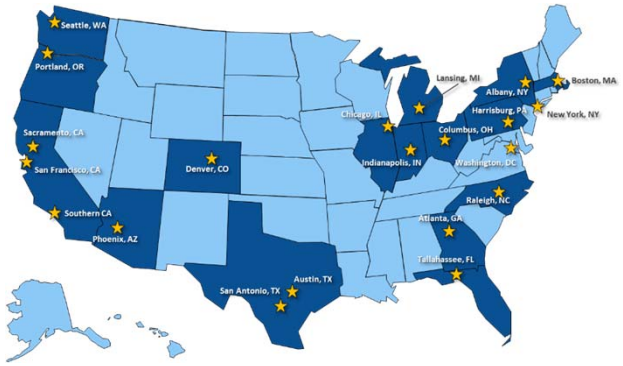
Joshua Rubin, Principal

Central NY BHCC
March 19, 2018

IPAs, ACOs, PLEs, CINs: Where does your agency fit in this alphabet soup?

OUR OFFICES

Albany, New York
Atlanta, Georgia
Austin, Texas
Boston, Massachusetts
Chicago, Illinois
Columbus, Ohio
Denver, Colorado
Harrisburg, Pennsylvania
Indianapolis, Indiana
Lansing, Michigan
New York, New York
Philadelphia, Pennsylvania
Phoenix, Arizona
Portland, Oregon
Raleigh, North Carolina
Sacramento, California
San Antonio, Texas
San Francisco, California
Seattle, Washington
Southern California
Tallahassee, Florida
Washington, DC



HMA OFFICES ACROSS THE COUNTRY

Some of the brightest minds in publicly funded healthcare. Working for you.

AGENDA

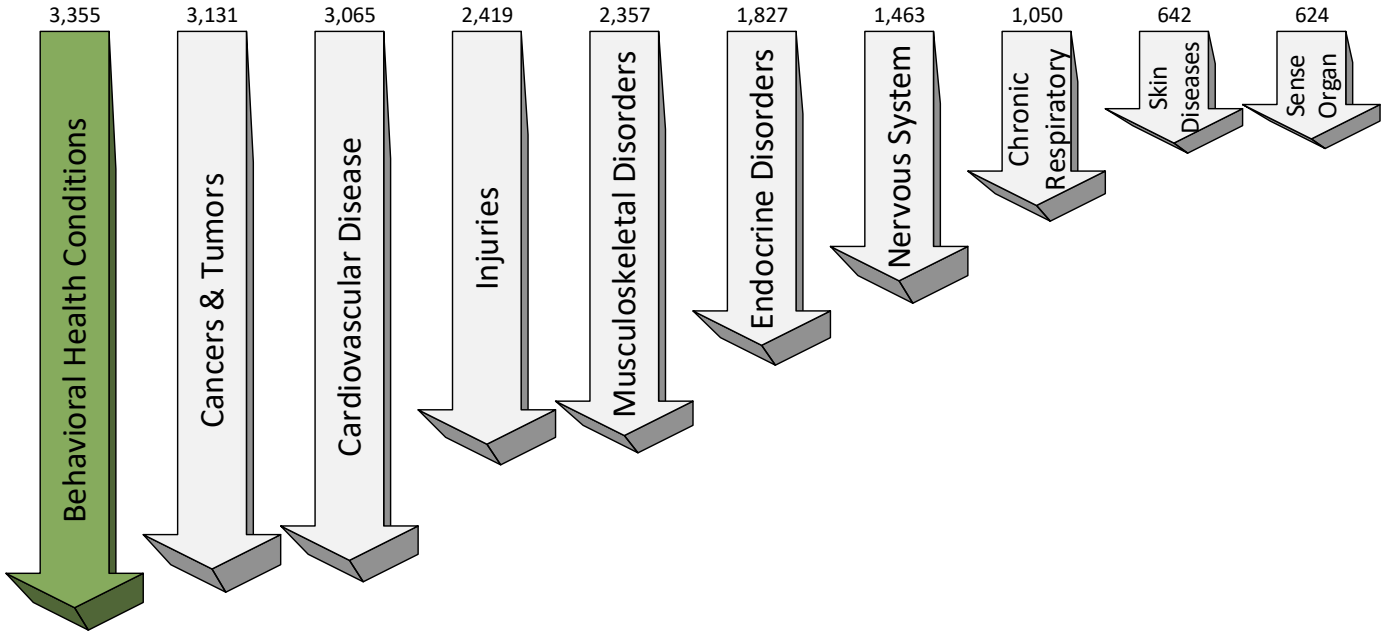
- A Gentle Reminder About What's at Stake
- A Brief Word of Preface
- Disentangling the Acronym Mush
- Thinking About Where to Go from Here

A GENTLE REMINDER OF WHAT'S AT STAKE

HEALTH MANAGEMENT ASSOCIATES

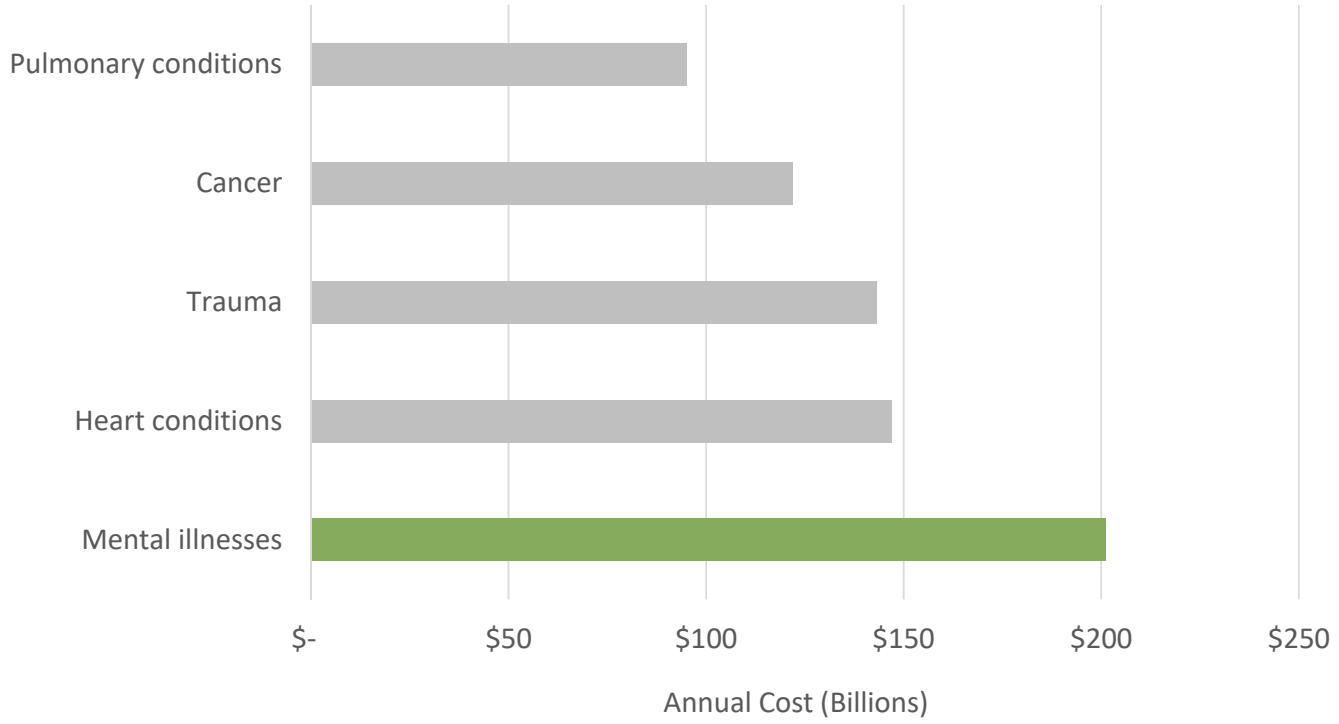
BEHAVIORAL HEALTH DISORDERS WERE THE LARGEST CAUSE OF DISEASE BURDEN IN THE UNITED STATES IN 2015

Disability Adjusted Life Years (DALYs) Lost per 100,000 population



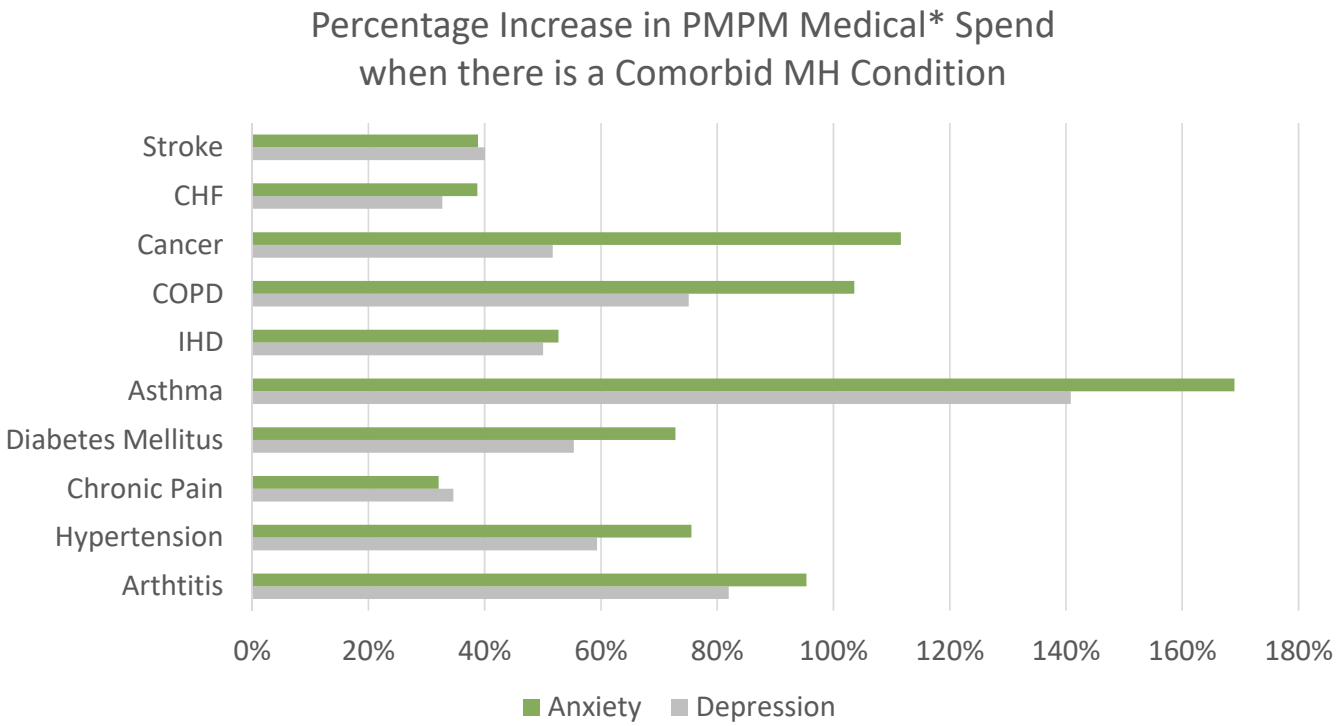
Source: Kamal R, Cox C, Rousseau D, et al. Costs and Outcomes of Mental Health and Substance Use Disorders in the US. JAMA 2017;318(5): 415.

MENTAL DISORDERS ARE THE MOST COSTLY CONDITIONS IN THE UNITED STATES



Source: Roehrig C, Mental Disorders Top The List Of The Most Costly Conditions In The United States: $201 Billion. Health Affairs 35, no. 6 (2016) 1130 – 1135.

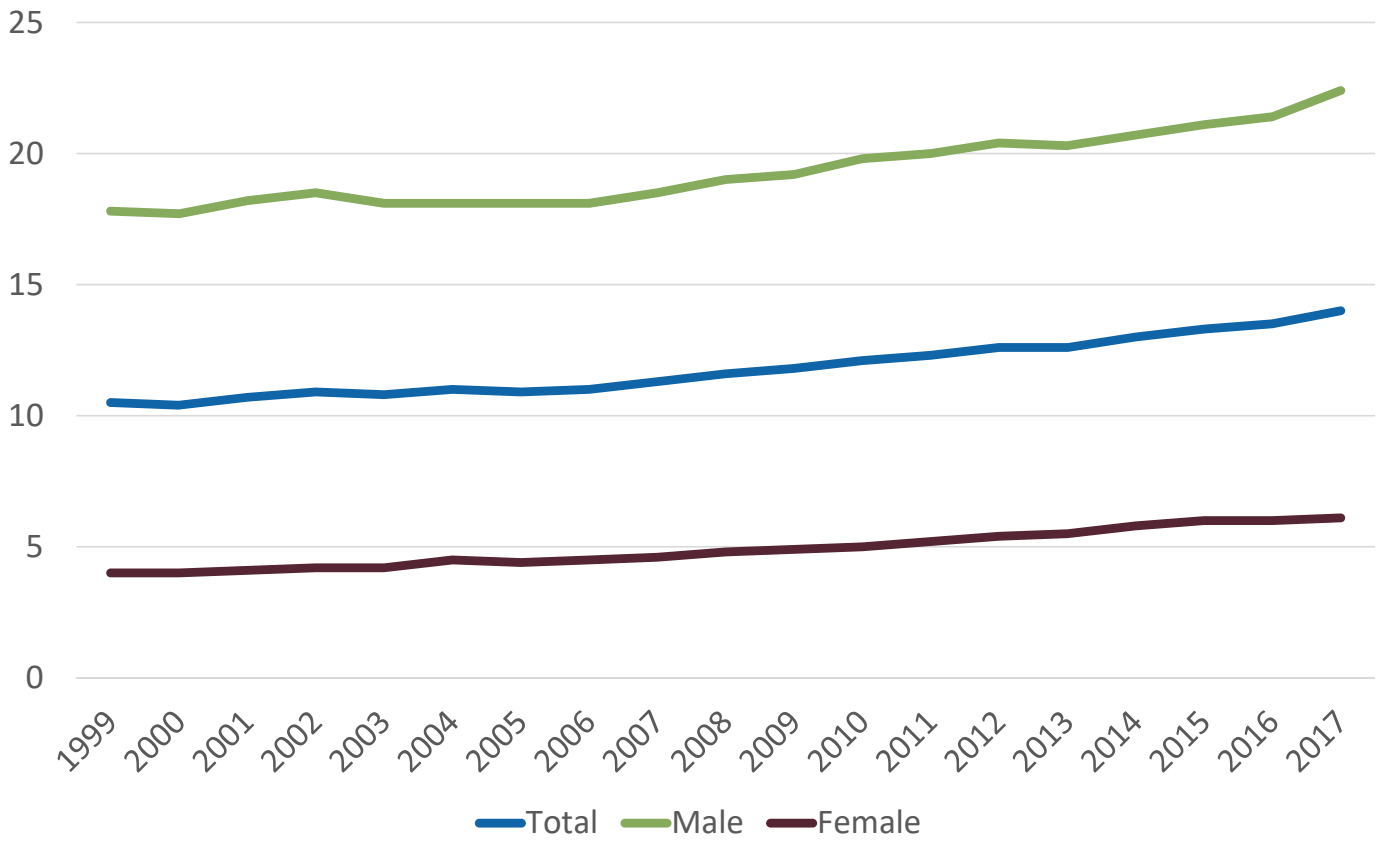
MENTAL HEALTH CONDITIONS INCREASE MEDICAL COSTS



*Note: Does not include any BH spend

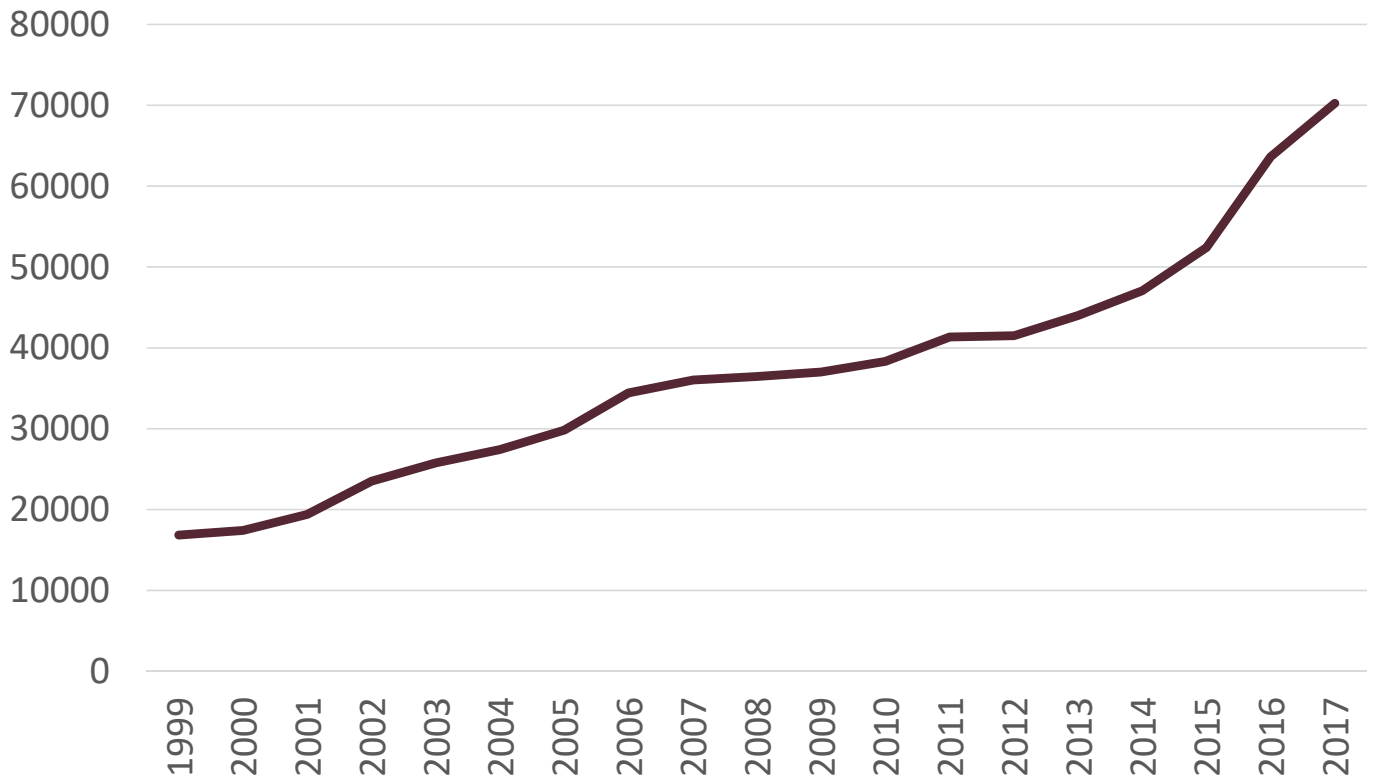
Source: Melek S, Norris D. Chronic conditions and comorbid psychological disorders. Milliman Research Report. July, 2008.

AGE-ADJUSTED SUICIDE RATES IN THE UNITED STATES



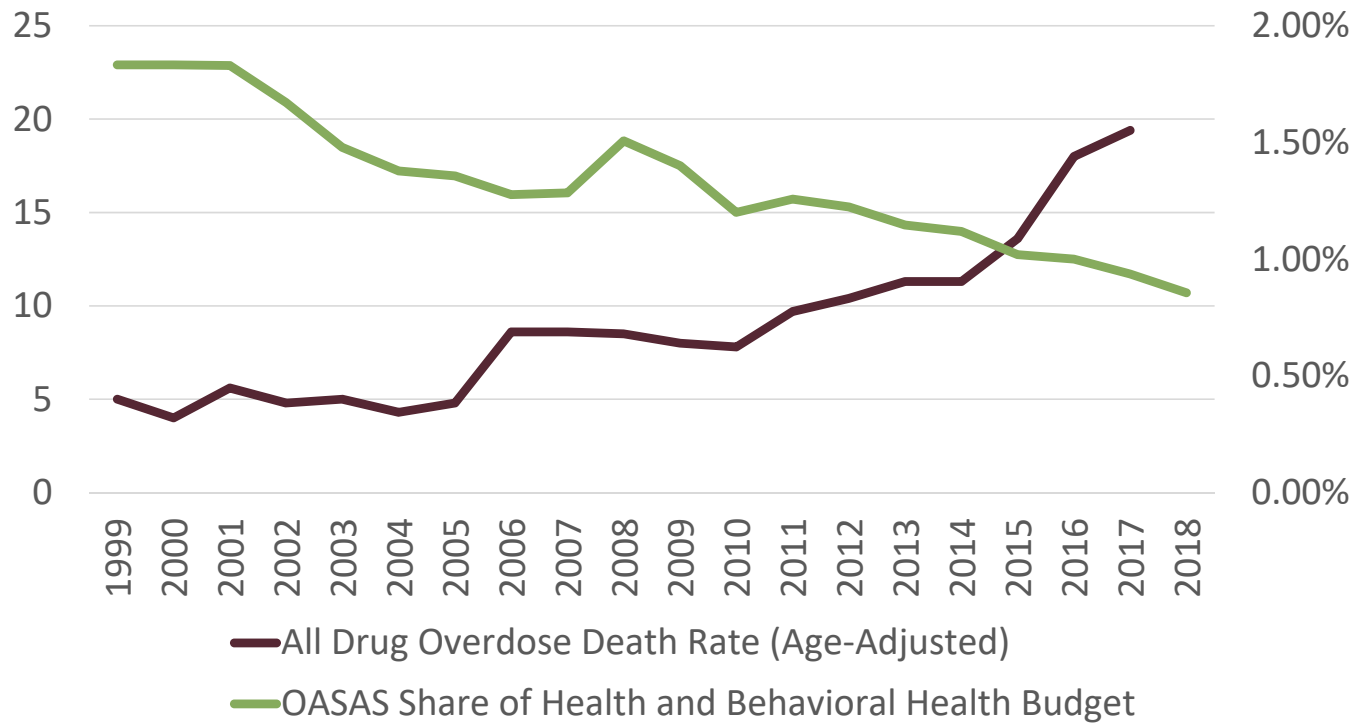
Source: NCHS, National Vital Statistics System, Mortality.

DRUG OVERDOSE DEATHS IN THE UNITED STATES



Source: NCHS: National Vital Statistics System, Mortality.

OASAS BUDGET AND OVERDOSE DEATHS PER 100,000 POPULATION



Budget data source: https://openbudget.ny.gov/, NYS Budget & Actuals, 1995-2018.
Note, Health and Behavioral Health Budget includes DOH, OMH, and OASAS.
Overdose data source: https://www.kff.org/other/state-indicator/opioid-overdose-death-rates.

FOLLOW THE MONEY

Medicaid Spending on people with mental health conditions is nearly **Four Times** as much as for other enrollees

$13,303

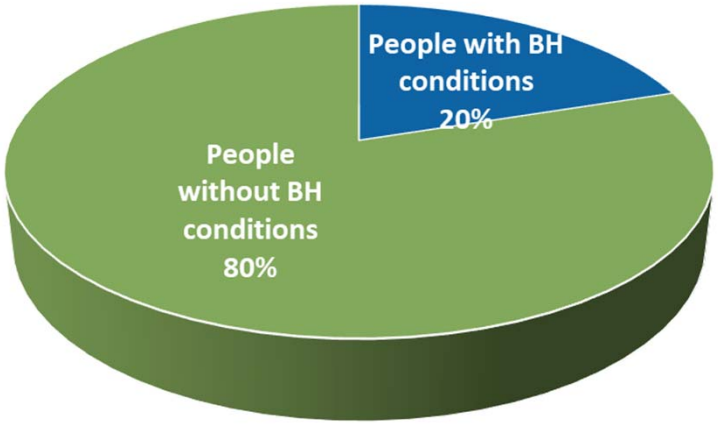
With BH conditions

$3,564

Without BH conditions

Nearly **half** of Medicaid spending is for enrollees with BH conditions…

…but only 20% of Medicaid enrollees have BH conditions



Source: Medicaid's Role in Behavioral Health, Henry J. Kaiser Family Foundation, May, 2017.

A BRIEF WORD OF PREFACE

HEALTH MANAGEMENT ASSOCIATES


We have a capitalist healthcare system

SOME OF THE BASIC RULES OF CAPITALISM

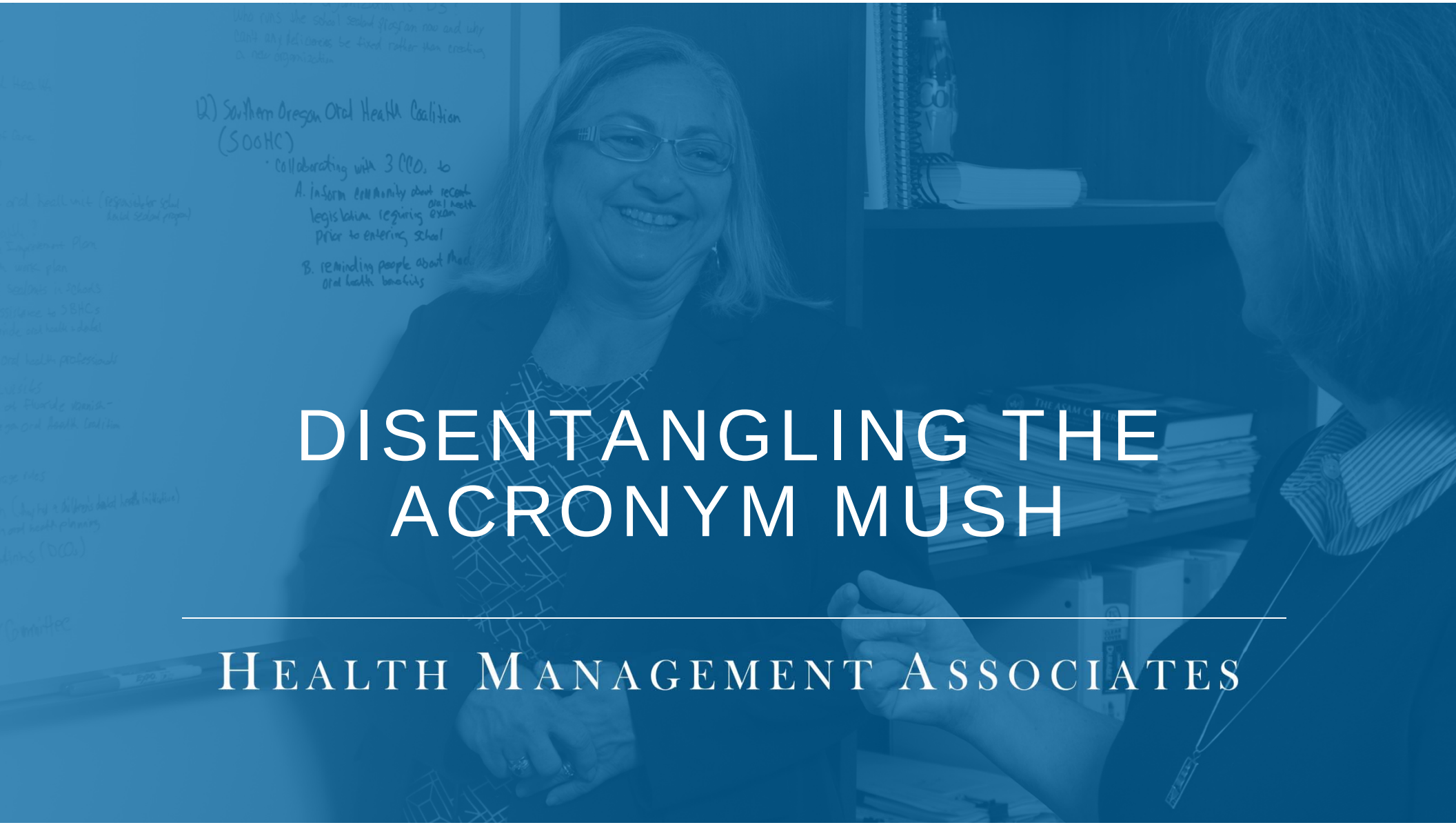
You ignore these rules at your own peril

Risk and reward go hand in hand

Whoever pays the piper calls the tune

People will do what they are incented to do

Money is an effective incentive



DISENTANGLING THE ACRONYM MUSH

HEALTH MANAGEMENT ASSOCIATES

WHAT IS AN IPA?

Independent Practice Association

- A group of providers who have come together to integrate clinically and/or financially in order to contract as a collective without violating anti-trust laws
- IPA contracts are voluntary for the members of the IPA
- IPAs are usually made up of like providers

WHAT IS AN ACO?

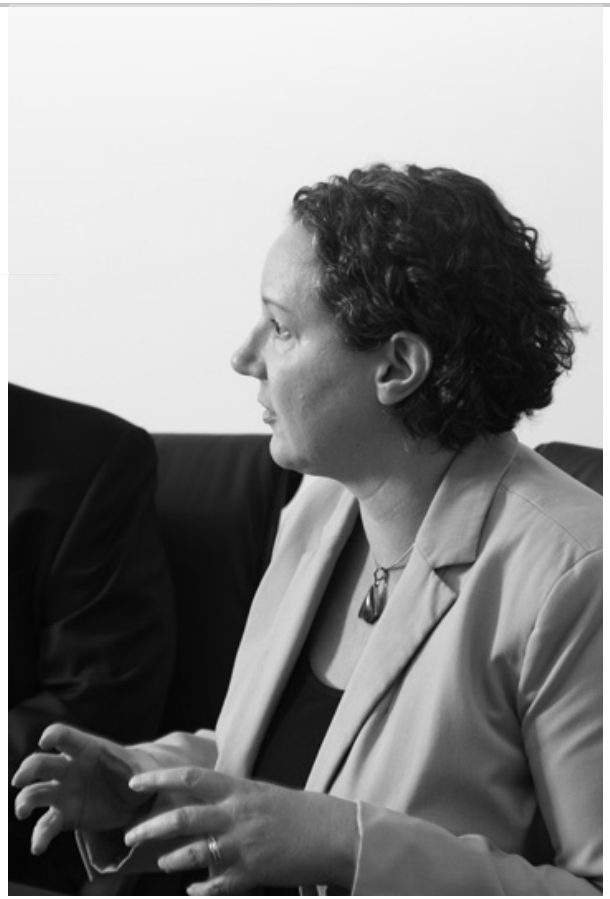
Accountable Care Organization

- Clinically integrated independent healthcare providers that work together to provide, coordinate, and manage care for a defined population
- Has the ability to negotiate, receive, and distribute payments, and to be accountable for the delivery, quality, and cost of health care services
- ACOs are usually made up of diverse groups of providers
- ACO contracts are mandatory for the members of the ACO

WHAT IS A PLE?

Provider-Led Entity

- Generic term for an organization led by providers for the purposes of organizing care and taking on risk
- In NY, Performing Provider Systems (PPS) were created for this purpose
- In other states, they're being called different things, but the conceptual model is the same



NO MATTER WHAT YOU CALL THEM, THE BASIC IDEA IS THE SAME

Medicaid is established: States bear all the risk

States push risk to MCOs: Approx. $225b of $525b of Medicaid flows through MCOs

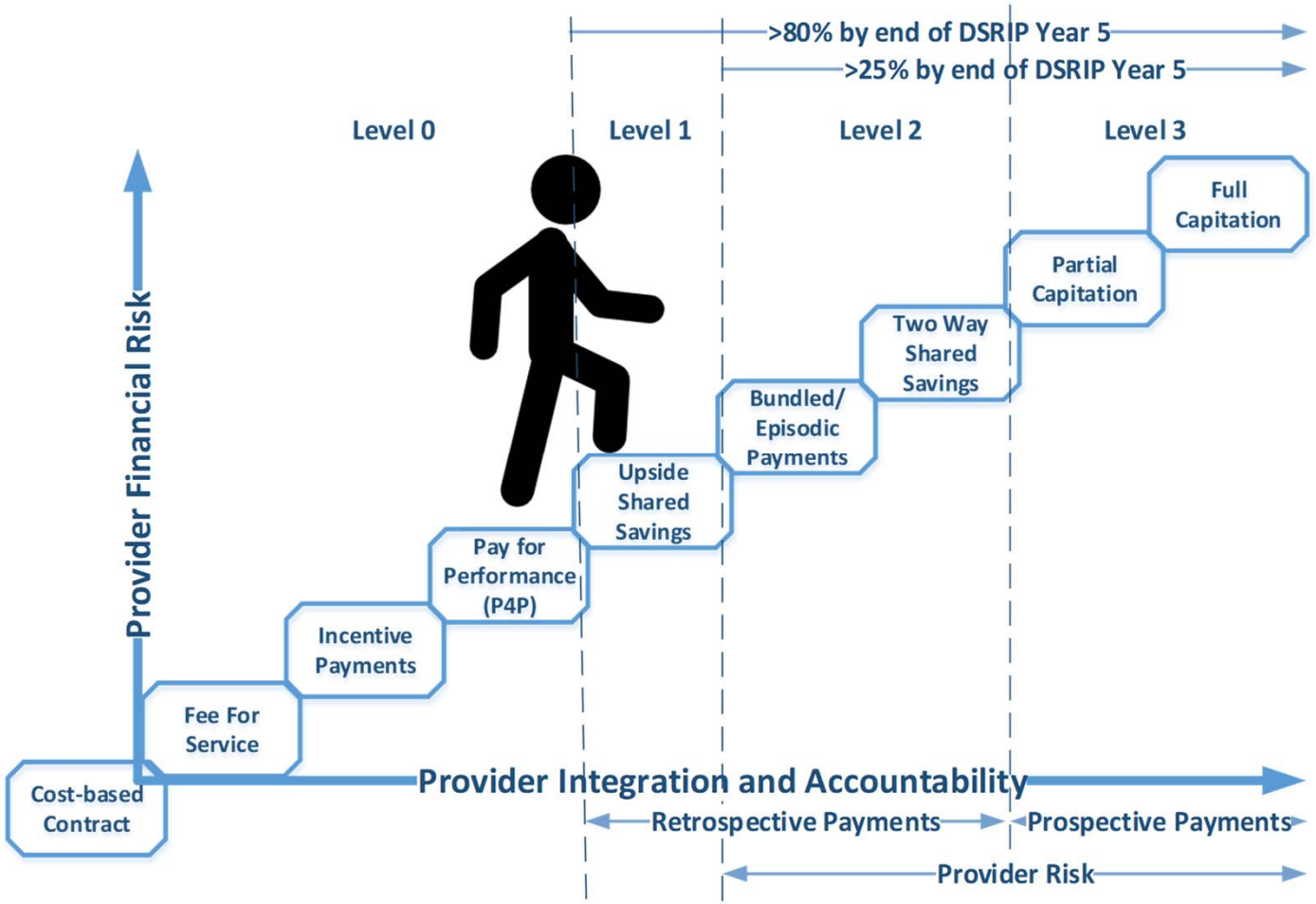
Today, risk is being pushed farther down in the system, to Provider Led Entities

WHAT IS A CIN?

Clinically Integrated Network

- A network of providers who have come together for three purposes:
  - To establish mechanisms to control the costs, and ensure the quality, of healthcare
  - Selectively choose a network of providers
  - Invest in the needed human capital and infrastructure capability to realize the claimed efficiencies

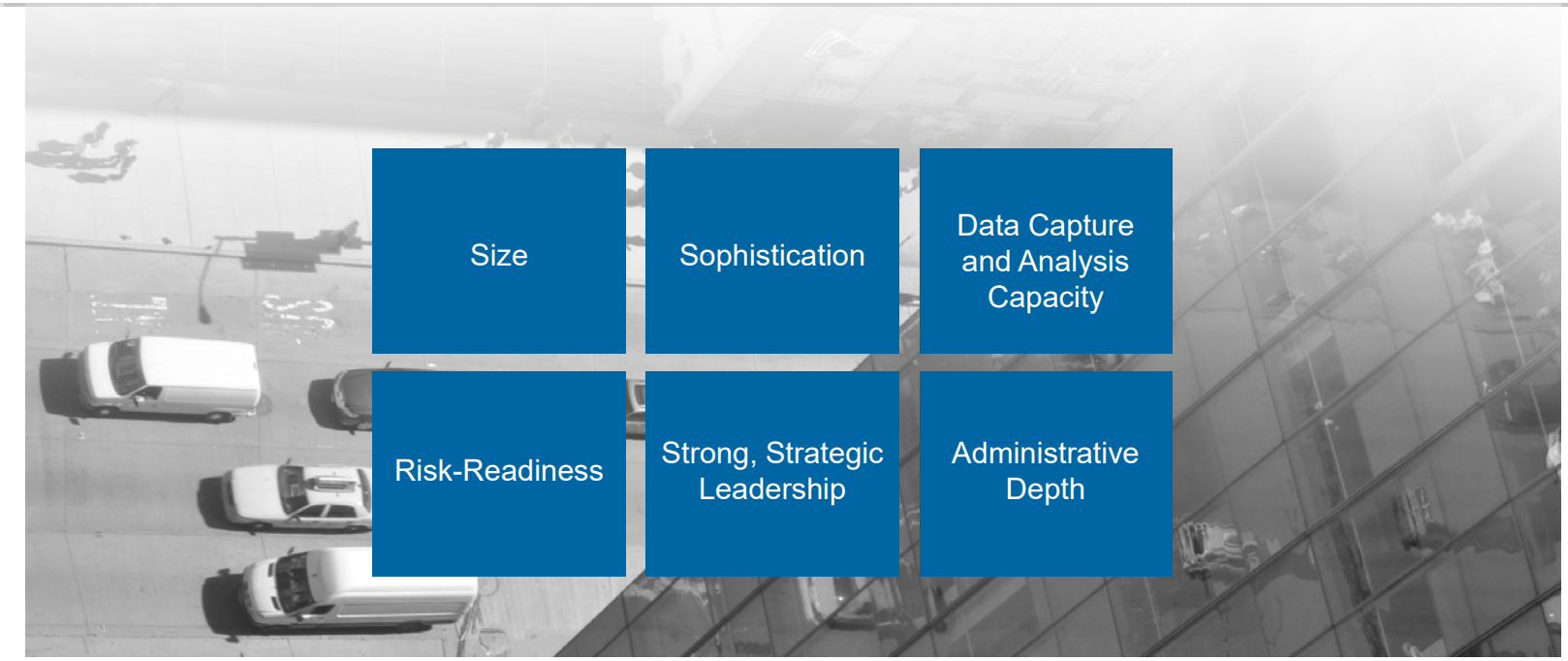
ACCOUNTABILITY, INTEGRATION, AND RISK GO TOGETHER



REMEMBER: VBP IS A MARKET BASED SOLUTION

- Competition
- The ‘invisible hand’
- Joseph Schumpeter
- What gets measured gets paid for
  - What gets measured is contested, complex and critical
  - How can we reduce the work of our community to a de Minimis set of performance indicators?

VBP ADVANTAGES PROVIDERS WITH CERTAIN CHARACTERISTICS



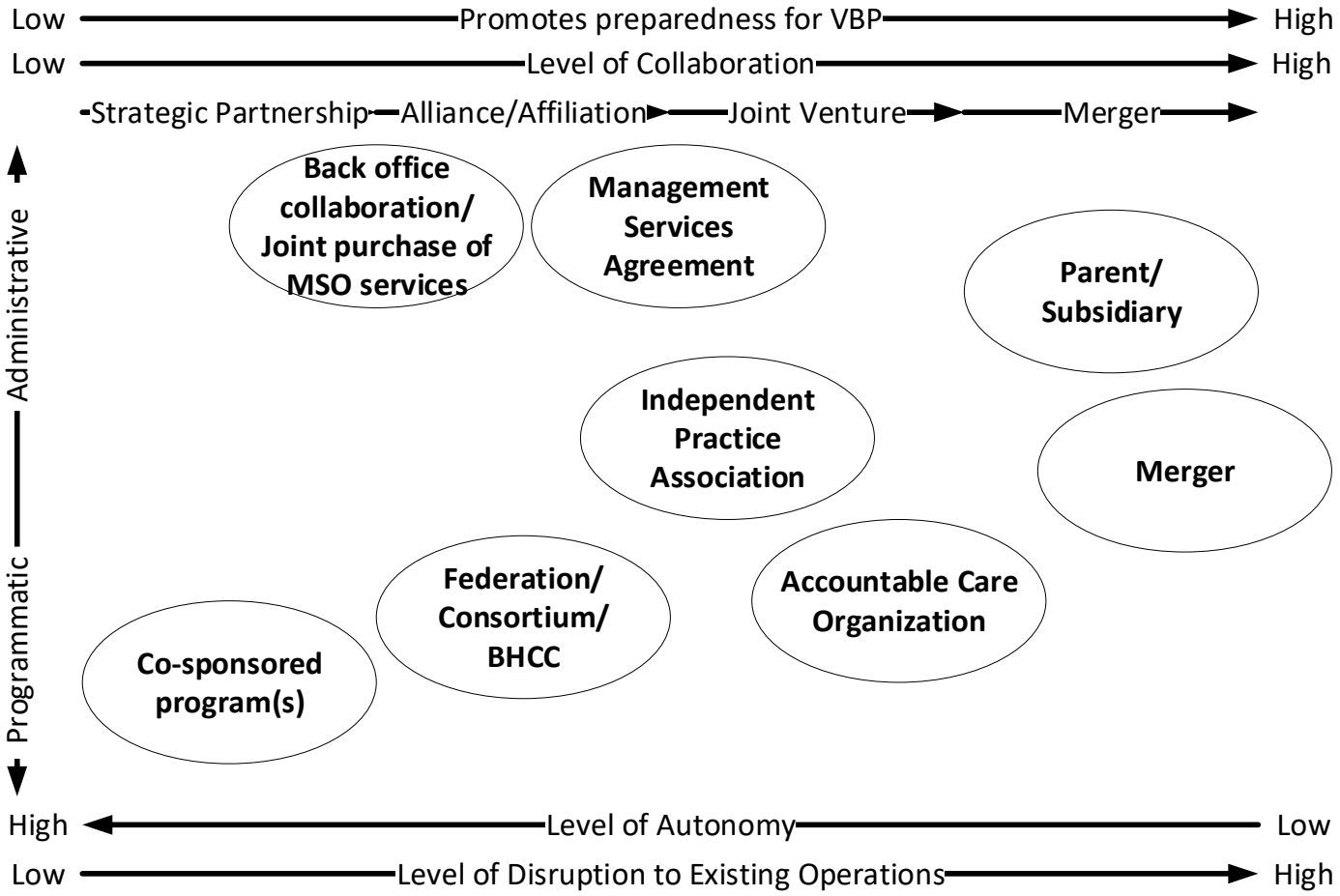
WHY GROW?


Coordinated care for your clients
Efficiencies and revenue maximization
Take on risk
Expand services and populations served
Human resources
Competitive position

THE RISING COST OF DOING BUSINESS: INFRASTRUCTURE

- ☑ Accounting
- ☑ Accounts receivable
- ☑ Benefits administration
- ☑ Compliance
- ☑ Consumer affairs
- ☑ Contracting
- ☑ Credentialing
- ☑ Data analytics
- ☑ Development
- ☑ Executive leadership
- ☑ Facility management
- ☑ Grant management
- ☑ Grant writing
- ☑ Informatics
- ☑ Information technology
- ☑ Insurance administration
- ☑ Internal audit
- ☑ Legal
- ☑ Marketing
- ☑ Medical records
- ☑ Payroll
- ☑ Prospective financial modeling
- ☑ Public relations
- ☑ Purchasing
- ☑ Quality Improvement
- ☑ Recruitment
- ☑ Research
- ☑ Risk management
- ☑ Strategic planning
- ☑ Training

STRATEGIC PARTNERSHIP OPTIONS

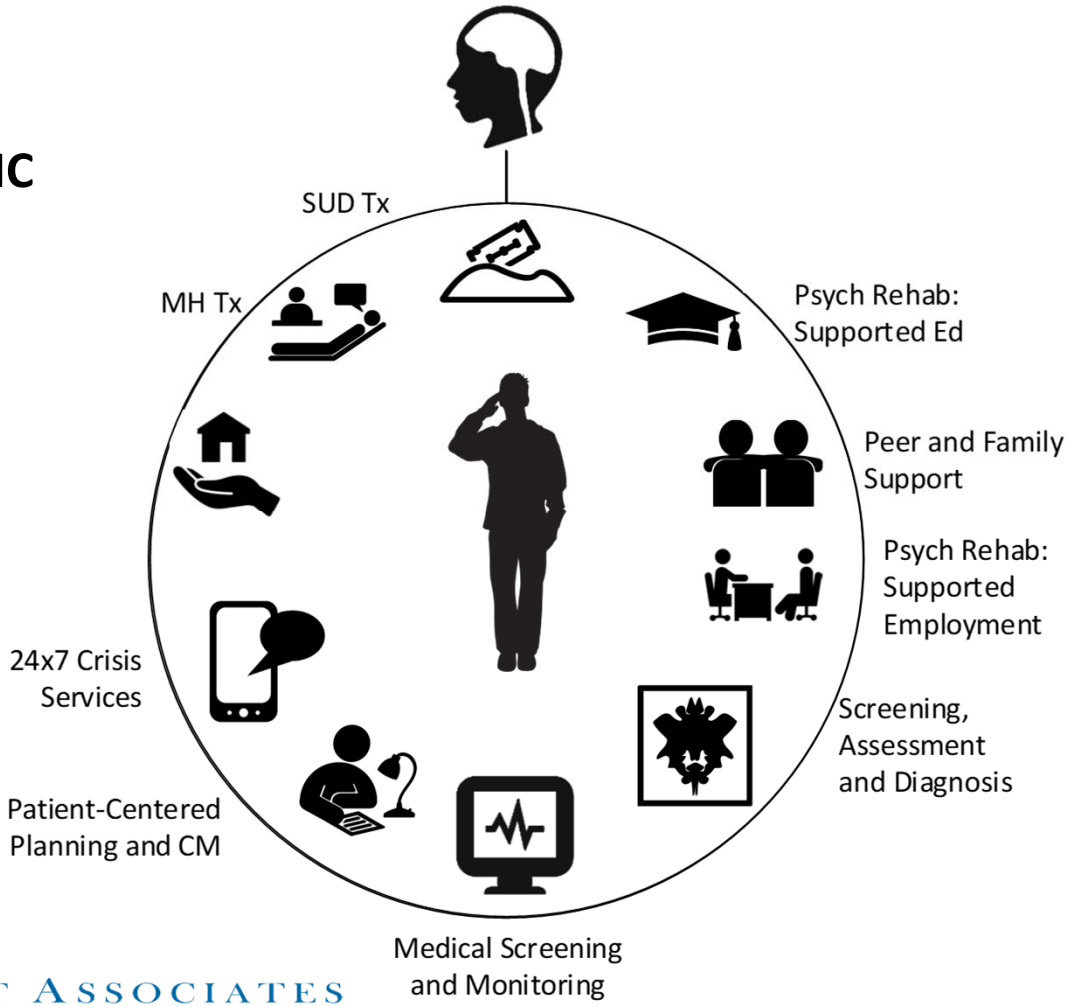


There are a lot of variations on these two main themes

- Mergers
- IPA-driven partnerships

WHAT SERVICES NEED TO BE IN THE SPECIALTY BH PORTFOLIO?

Basically, CCBHC plus housing



IPA-DRIVEN COLLABORATION

- Matryoshka IPA

THINKING ABOUT WHERE TO GO FROM HERE

HEALTH MANAGEMENT ASSOCIATES

A BOLD(ISH) PREDICTION

Someday all of your agencies will be a part of a clinically integrated network

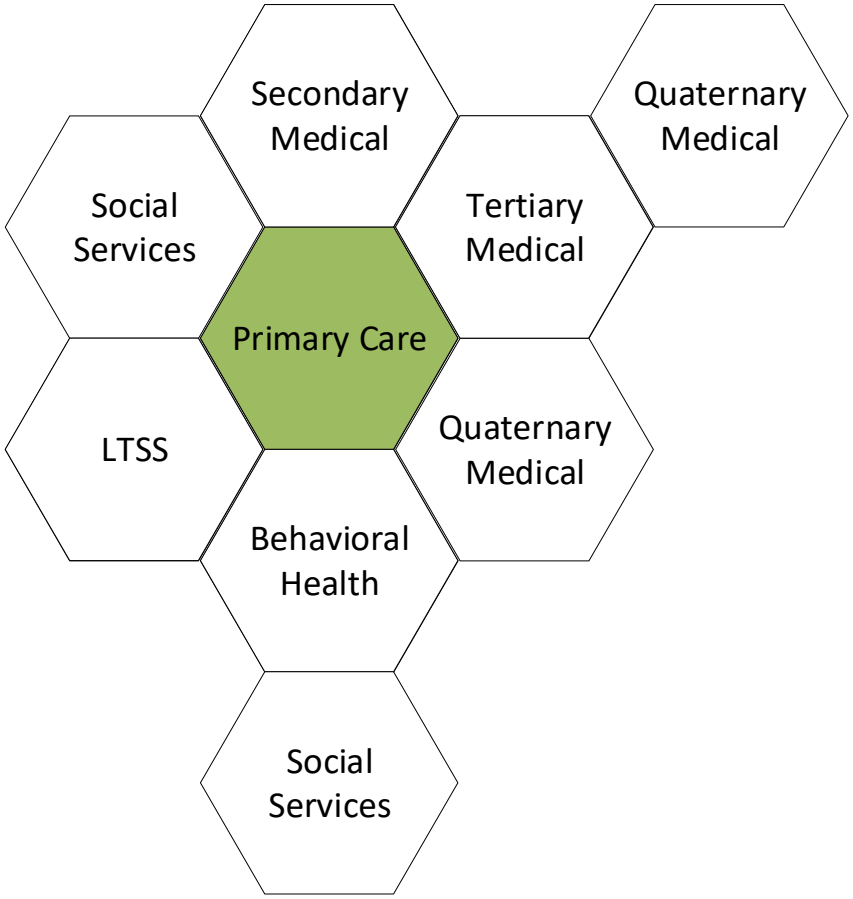
- Therefore, the question is not if, the question is how
- These PLEs will need to have a comprehensive package of medical (primary, secondary, tertiary, quaternary), behavioral, LTSS, and social services
  - How these different services agglomerate will differ from PLE to PLE based on a range of factors

AN IMPERFECT ANALOGY

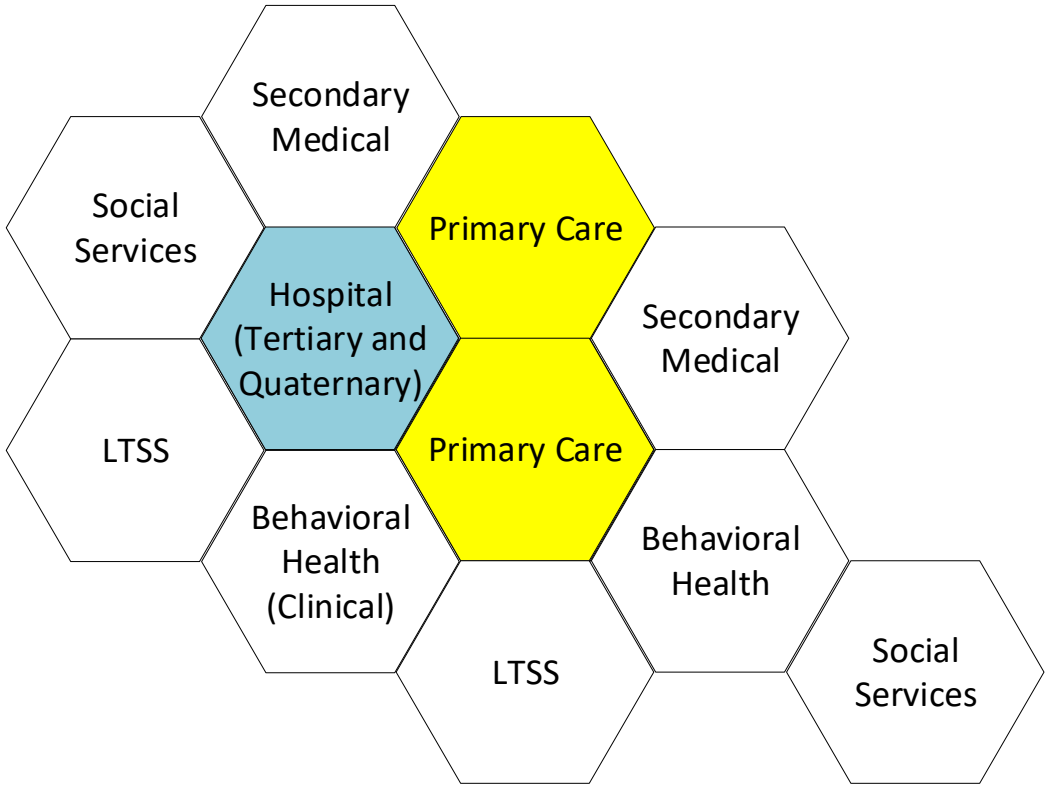
BIG QUESTION FOR BH PROVIDERS

How can you integrate with an organization that has attribution, infrastructure, and scale in a way that enables you to access medical care for your clients, and provide BH care to theirs, while maintaining your focus on the population about which you are most concerned?

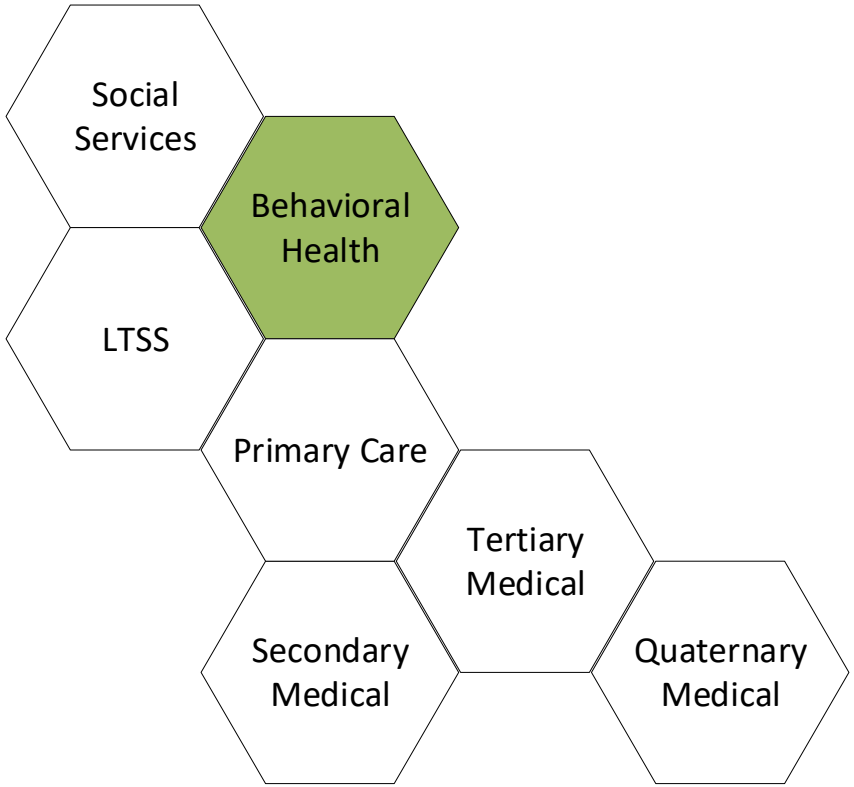
PLE STRUCTURES LED BY PC



PLE STRUCTURES LED BY HOSPITALS



PLE STRUCTURES LED BY BH PROVIDERS



PROS AND CONS OF JOINING/FORMING AN IPA

Pros	Cons
Requires less time, expense and burden than merging	Requires significant time, expense and effort
Enables each agency to maintain its own identity, Board, fundraising base, etc.	Does not generate the same kind of economies of scale and efficiencies as a merger
Clinical integration leads to better outcomes for consumers	Governance can be challenging
Enables collective bargaining with purchasers	In order to provide comprehensive and integrated services, other providers would need to be brought in, especially primary care
If coupled with an MSO, there can be administrative efficiencies generated	IPA members are liable for the quality of care provided by other members of the IPA, which can be problematic

PROS AND CONS OF JOINING A LARGER BH AGENCY

Pros	Cons
Consistency of mission	Mergers are costly, time consuming, emotionally challenging and difficult
Enhancement of the service continuum for your clients	Loss of control
Access to a much larger and mature infrastructure	Loss of organizational identity
Straightforward decision-making and governance process	May generate acrimony among your staff because of a feeling of having been 'acquired'
Programmatic economies of scale	
Obviates any need for potential additional mergers	
Creates negotiating leverage	

PROS AND CONS OF MERGER WITH A SIMILAR AGENCY

Pros	Cons
Consistency of mission and culture	Mergers are costly, time consuming, emotionally challenging and difficult
Programmatic economies of scale	No significant enhancement to the existing continuum of care for your clients
Less likely to generate acrimony among the staff because no agency has been 'acquired'	Merger may be insufficient to generate critical mass
Straightforward decision-making and governance process	
Doubles the resources available for infrastructure	

PROS AND CONS OF BECOMING THE BH COMPONENT OF A HEALTHCARE PROVIDER

Pros	Cons
Substantial enhancement of the service continuum for your clients	Mergers are costly, time consuming, emotionally challenging and difficult
Access to a much larger and mature infrastructure	Loss of control
Straightforward decision-making and governance process	Loss of organizational identity
Likely obviates any need for potential additional mergers	May generate acrimony among your staff because of a feeling of having been 'acquired'
Creates negotiating leverage	Inconsistency of mission
Potential access to attribution in a VBP environment	No significant programmatic economies of scale

CONTACT ME

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HMA

HEALTH MANAGEMENT ASSOCIATES

Who We Are As a Network?

Gerald Archibald, Bonadio Group

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Who We Are As A Network

- Financial survey information has been requested of all network providers
- We are still in the process of summarizing and verifying accuracy of data
- This data is extremely important for purposes of identifying service and access gaps
- The size of the network is impressive in terms of the total breadth of services offered
- The key to success as an IPA will be how well competitors can collaborate with each other
- The State wants integration of services, particularly Behavioral Health with Primary Care

How Ready Are We As a Netwo

Josh Rubin, Health Management Associates

CNY BHCC
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CNY BHCC VBP READINESS RESULTS

HEALTH MANAGEMENT ASSOCIATES

A REMINDER ABOUT OUR PARTNERS

COHN REZNICK
ACCOUNTING • TAX • ADVISORY

DCPCA
DISTRICT OF COLUMBIA
PRIMARY CARE ASSOCIATION

ONE NOTE

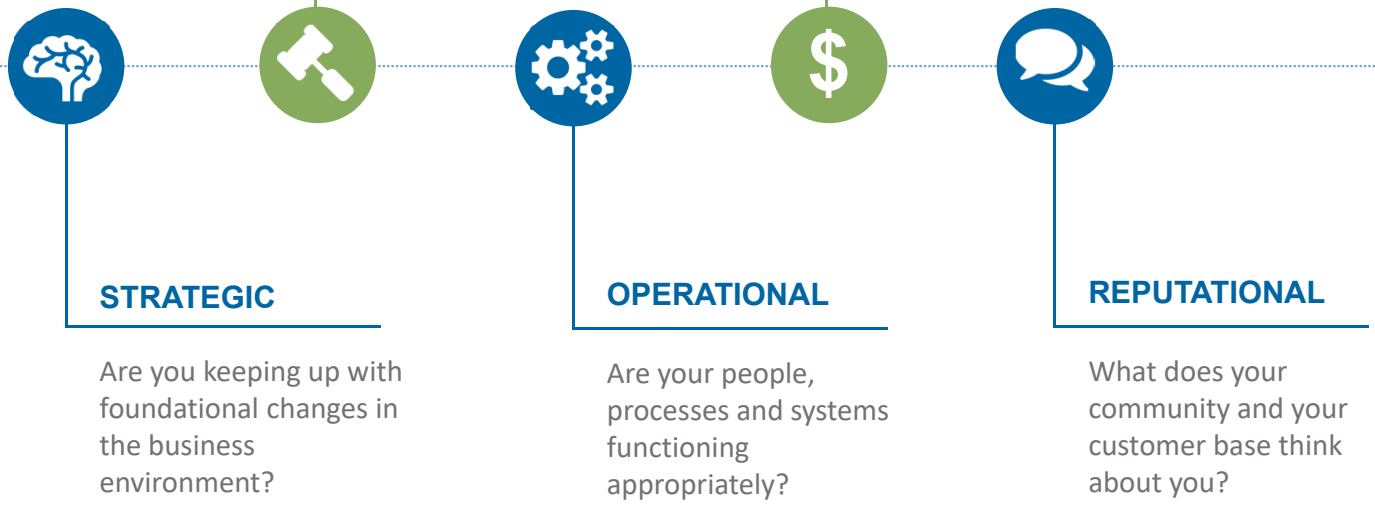
18 of 41 eligible agencies completed the assessment tool

- Nearly all of the Network agencies completed the tool
- Five other agencies requested the tool but never completed it
- Based on a brief analysis, it appears likely that given the responding agencies, that the data is skewed in a positive direction

BOARD ENGAGEMENT

	% Cohort Responded Yes/Fully
1. Has your behavioral health agency engaged in a comprehensive strategic planning process with your Board and other key stakeholders that prepares for the transition to value-based payments while maintaining fidelity to your organization's mission, vision and values?	33%
2. Has your behavioral health agency determined the level of risk your organization is willing to take in relation to value-based payment through a process that included executive leadership and members of the governing Board?	17%

TYPES OF RISK (BROADLY SPEAKING)



VBP WILL FORCE YOUR AGENCY TO DECIDE WHETHER TO TAKE ON FINANCIAL RISK TIED TO OPERATIONAL RISK

You have been managing all of these different kinds of risk for many years

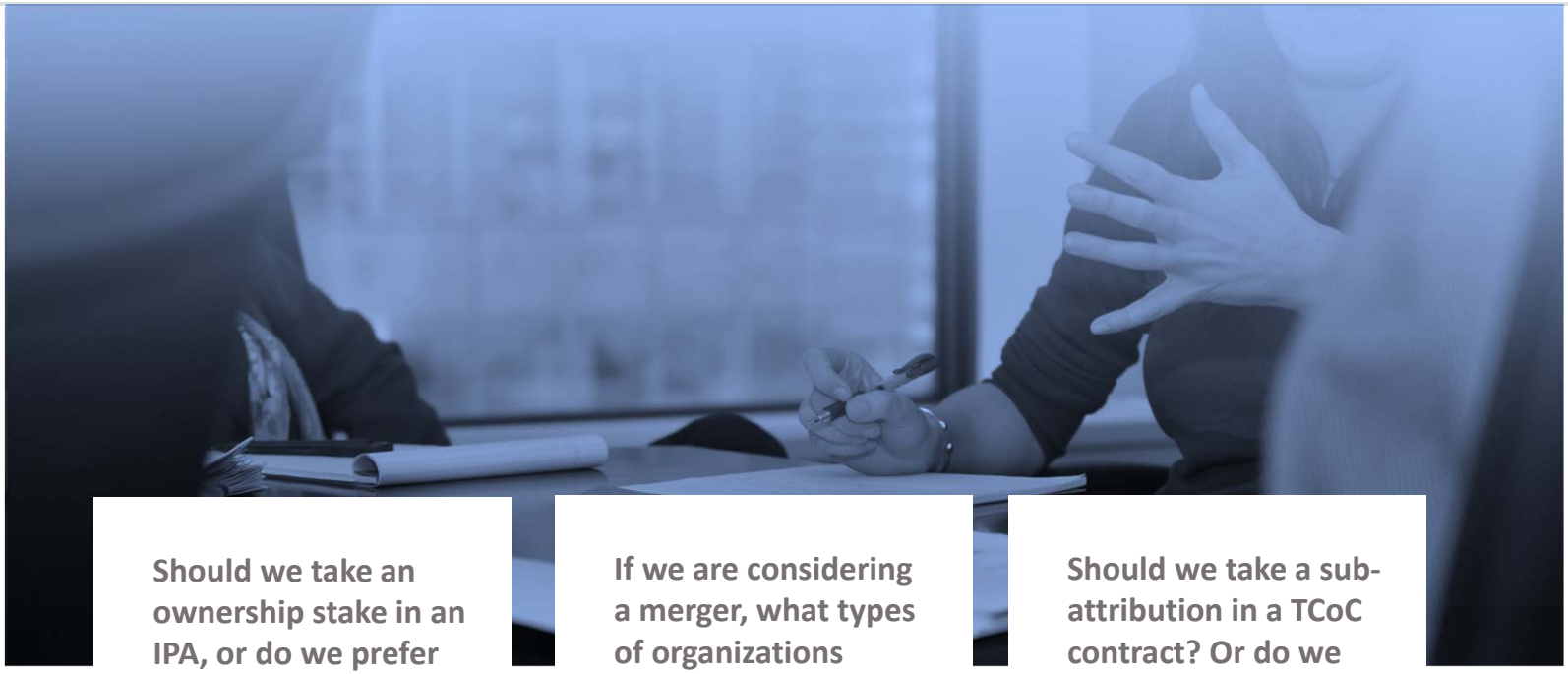
- The real difference is just the interrelatedness of the different types of risk
  - They can no longer be managed separately (if they ever were)
- This is just a new and different kind of risk, so it feels different, but it is risk you should be well equipped to handle

AGENCY EXECUTIVES NEED GUIDANCE FROM THEIR BOARDS ABOUT RISK TOLERANCE

You don't want to be too far out in front of them, or too far behind… Either one is a mistake

- If you're too far in front, you may position yourself to take on risk (and reward) in a way that makes them uncomfortable
- If you're too far behind, you will miss out on opportunities that they will want you to pursue

QUESTIONS ABOUT RISK TOLERANCE WILL IMPACT LOTS OF STRATEGIC DECISIONS



Should we take an ownership stake in an IPA, or do we prefer to serve only as a network provider? What about ACO membership?

If we are considering a merger, what types of organizations should we pursue as potential partners?

Should we take a sub-attribution in a TCoC contract? Or do we just want to stay fee-for-service?

EXECUTIVE DATA

3. Does your behavioral health agency's leadership team have access to a performance management dashboard that enables it to monitor and respond to critical organizational indicators in real time?	22%
4. Has your behavioral health agency established a performance indicator related to client engagement that the organization's leadership is tracking on a regular basis?	17%
5. Does your behavioral health agency's management team regularly track the results of a client experience survey?	56%

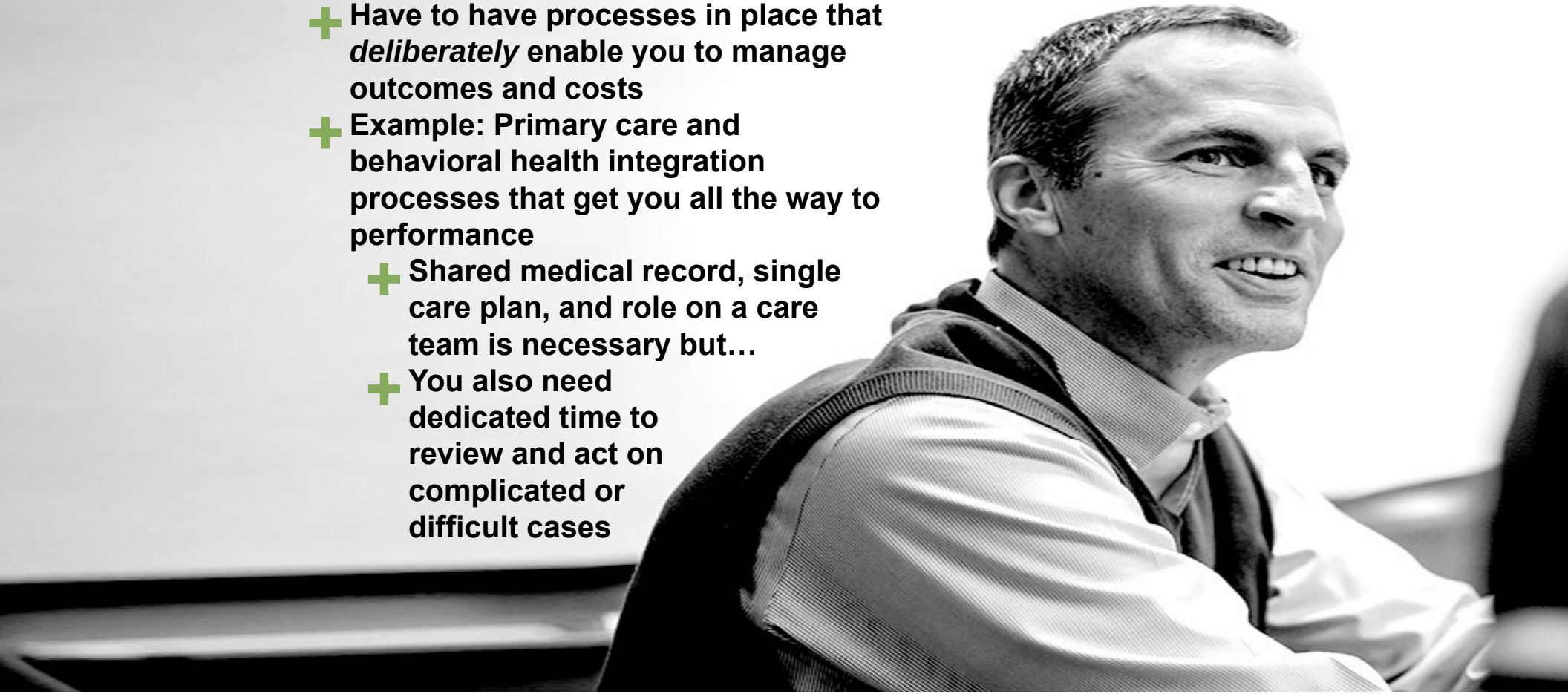
TIMING PRIORITY

THE FIRST COMMANDMENT: KNOW THY PERFORMANCE…ALWAYS

- Knowing what your clinical, operational, and financial performance is all the time and what is driving performance issues
  - Performance Management Dashboard that gets baked into how your agency functions on a daily basis
    - Highly visible/unavoidable across organization
    - Linked to specific actions and performance expectations
    - Includes the measures that payers care about
      - Preventable ED visits and admissions, including 30-day readmissions
      - Advanced analytics and informatics capabilities to pinpoint what to focus on and how to respond to modifiable/impactable threats to performance

RELYING ON YOUR PERFORMANCE

- Performance under VBP is not a naturally occurring phenomenon
  - Have to have processes in place that *deliberately* enable you to manage outcomes and costs
  - Example: Primary care and behavioral health integration processes that get you all the way to performance
    - Shared medical record, single care plan, and role on a care team is necessary but…
    - You also need dedicated time to review and act on complicated or difficult cases



STAFF READINESS

6. At this time, in general, are administrative and clinical leadership knowledgeable about and on board with the movement toward payment reform models?	44%
7. At this time, in general, are direct service and other staff knowledgeable about and on board with participation in value-based payment models?	6%
8. At this time, in general, are direct service and other staff active in or willing to participate in change management?	22%

TIMING PRIORITY

AGREEMENTS/PARTNERSHIPS

1. Does your behavioral health agency have agreements in place with a full range of social service providers, including:	% Cohort Responded Yes/Fully
Housing	56%
Education/Schools	61%
Child Welfare	28%
Department of Corrections	17%
Supported Employment Agencies	67%
Other	61%
2. Does your behavioral health agency have agreements in place that enable it to serve people with the entire range of behavioral health disorders?	39%
3. Does your behavioral health agency have agreements in place with a full range of behavioral health service providers, including:	
Hospitals	83%
Home Health	33%
Skilled Nursing/Long-Term Care	28%
Mental Health Clinics	61%
Primary Care Providers	56%
Substance Use Providers	61%
Other	28%

TIMING PRIORITY

QUALITY IMPROVEMENT/DATA MONITORING

	% Cohort Responded Yes/Fully
1. Have you undertaken any major quality improvement initiatives in the past 3 years (e.g. participated in a learning collaborative)?	67%
2. Do you have the technology to support retrieving, storing, calculating and reporting out on clinical quality measures?	33%
Quality incentive payment provisions of third party payer contracts	33%
Utilization of screening and assessments	33%
3. Are quality/outcome measures reviewed with clinical/programmatic leadership and direct service staff?	61%
4. Does your behavioral health agency utilize quality reports/data to inform client outreach when appropriate?	28%
5. Do you have the ability to use client/member data from payers in conjunction with program data for measures reporting, retrospective analytics and continuous program improvement purposes? This capability is usually found in so-called "business intelligence/decision support/data analytics" applications that work off large, multi-dimensional databases or warehouses.	11%

TIMING PRIORITY

PROVIDER ALERTS, DECISION SUPPORT TOOLS, AND REGISTRIES

11. Does your behavioral health agency create or receive an actionable list of:	
"Super utilizers" (e.g. clients who have frequent ED use or hospital readmissions)	33%
Other clients at-risk for hospital admission (e.g., recently discharged, recently left jail/prison, individuals experiencing their first episode of psychosis)	28%
Is there a workflow in place to reach out for ongoing follow up?	67%
12. Do you have access to a database/data warehouse that serves as an actionable "registry" and contains client data for reporting and program improvement purposes?	33%
13. Does your behavioral health agency utilize actionable lists to monitor clients (e.g., list of all clients on antipsychosis medication, date of their last appointment and the date and result of their last medication management visit)	22%

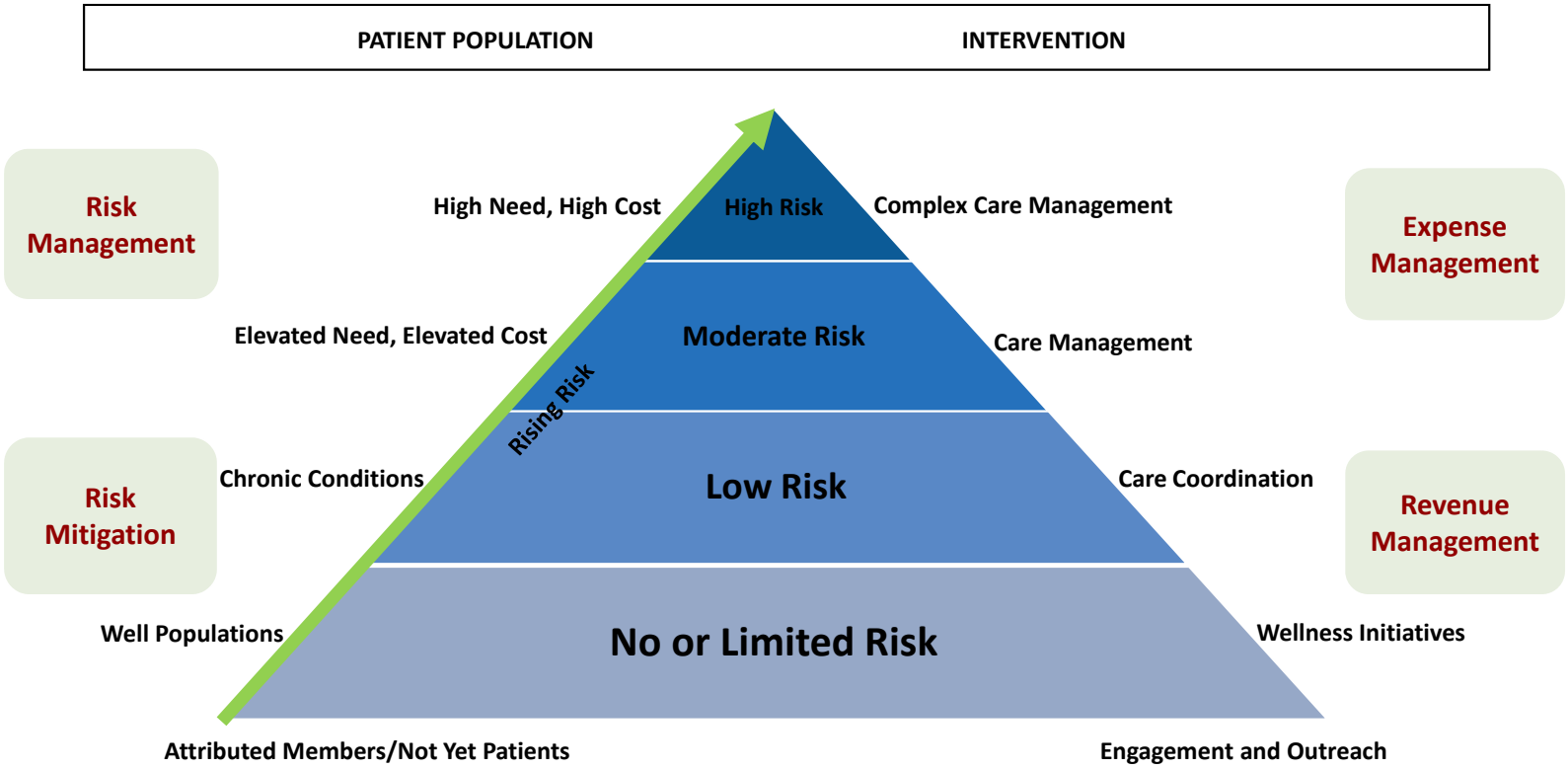
TIMING PRIORITY

CARE MANAGEMENT

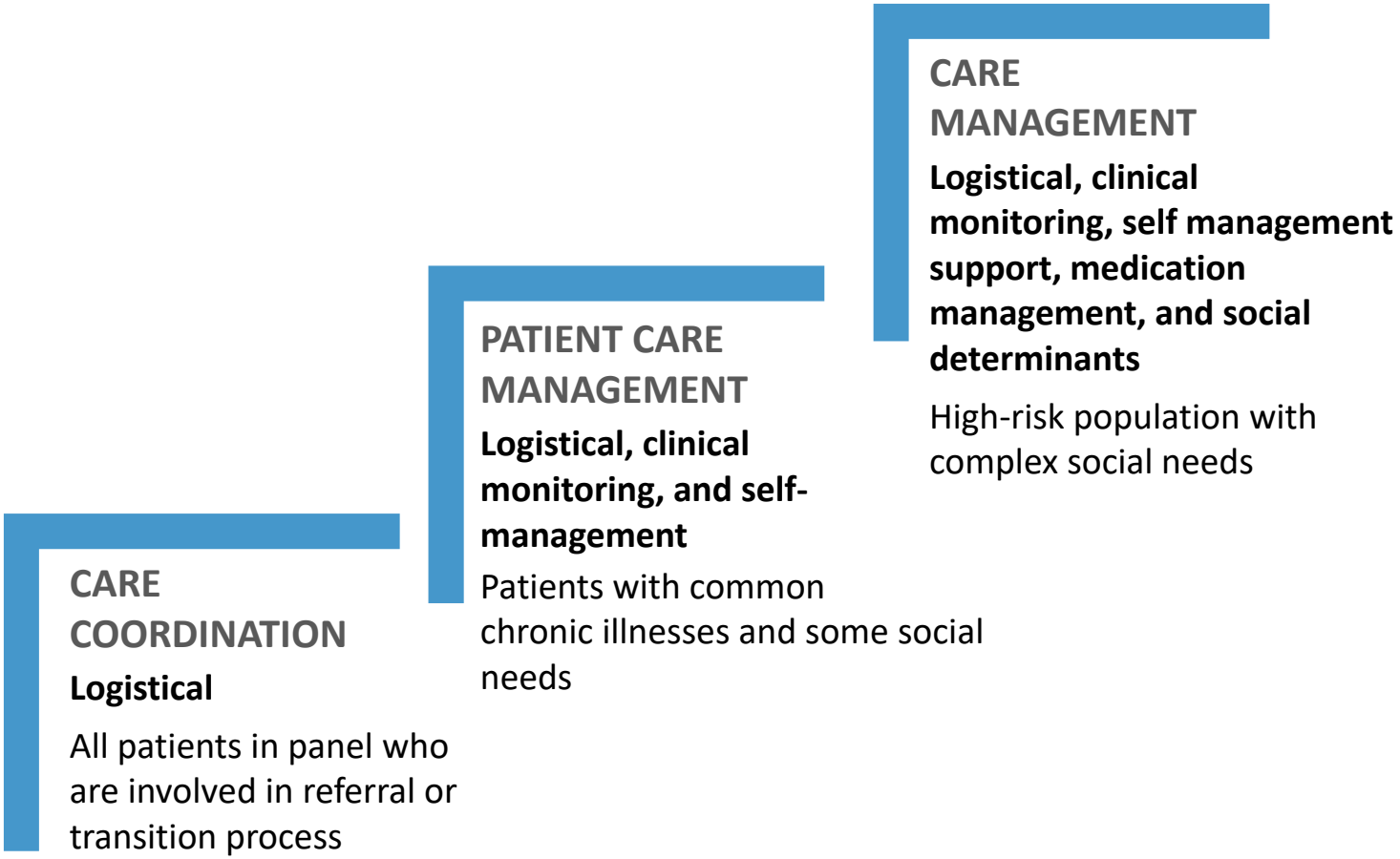
14. Do you offer any care management services (either directly or through a relationship with a health home) at your behavioral health agency?	61%
If partial/yes, how many FTEs on staff do you have dedicated to care management activities? How many individuals act as care management (e.g. 1 FTE could be comprised of two people at .5 FTE)?	
In general, have your care managers received formal specialized training and/or have more than 3 years' experience in the role?	54%
Are care management services integrated into the care team?	69%
How are clients referred to care management services?	
Direct service staff referral	100%
ED alerts	38%
Super-utilizer list	31%
Contracted member list	23%
Other (e.g. chronic condition)	15%
Do care managers use protocols and/or standing orders?	15%
15. Does your behavioral health agency use a care plan as a source for the management of care?	78%

TIMING PRIORITY

RISK STRATIFICATION – DRIVING LEVELS OF CARE MANAGEMENT



STEP LADDER OF CARE



CLIENT-CENTERED CARE

23. Do you collect client satisfaction data through a survey tool?	83%
24. For any/all client feedback you receive, what are consistently the top issues mentioned?	
Difficulty accessing appointments when needed/desired	22%
Wait times to see direct service staff for appointment	22%
Courtesy/respect from direct service and other staff	22%
Lack of understanding of what to do to manage care/follow up	11%
Other	17%
25. Do you provide use of an electronic client portal for client access? Client Portal: secure online website that gives clients convenient 24-hour access to personal health information and other related services from anywhere with an Internet connection	11%
If yes, does it provide access to:	
Client records	50%
Appointments	50%
Clinical questions	50%
Other	0%
If yes, do more than 50% of clients use it for any reason?	0%
26. Do you use any client-centered tools such as shared decision making, decision support tools?	22%
27. Do you track client visit cycle time (i.e. the amount of time it takes a client from the time they enter the door to exit with a completed visit?)	6%

ENHANCED ACCESS

28. Does your behavioral health agency operate or have an agreement in place for a 24/7 telephonic crisis response service?	67%
Does your behavioral health agency offer phone nurse triage at the following times:	
Operating hours	89%
After hours	39%
29. Do you use a standard unit of time (e.g., 15 minutes) for appointment blocks for all of your appointments?	61%
30. To what extent do you have evening hours?	
1-2 Days	28%
3-4 Days	33%
All M-F	6%
To what extent do you have weekend hours?	
1-2x/month	17%
Every weekend	28%
31. Do you offer same-day appointments for urgent and non-urgent care?	50%

TIMING PRIORITY

LINGUISTIC AND CULTURAL COMPETENCY

35. Has your behavioral health agency assessed the linguistic/cultural needs of the population in the service area within the last three years?	61%
36. Are adequate language translation/interpretation services available for clients?	67%
37. How often does your behavioral health agency train direct service and other staff on cultural competency?	
No training is provided	6%
During orientation	61%
Annually	72%
Other	11%
38. Are direct service staff cultural/linguistic demographics and/or experience fully reflective of the community in the service area?	28%
39. Has your behavioral health agency developed client education materials, information on evaluation and assessments in multiple languages and at appropriate health literacy levels?	33%

BEHAVIORAL HEALTH/PRIMARY CARE INTEGRATION OF SERVICES

40. Are primary care services available to your clients in the same physical facility as behavioral health services?	22%
41. Is a medically trained staff member part of the clinical care team, located on-site and available to confer with the team throughout the day?	61%
If yes, are they available 100% of the time?	20%
42. If a behavioral health provider refers a client for medical services (non-urgent), how often can the client be seen the same day for their medical needs?	17%
43. Do primary care and behavioral health staff document in a shared medical record?	28%
If partial/no, do they have at minimum viewing access in each other's records?	0%

TIMING PRIORITY

THE CASE FOR INTEGRATION

- ROI of $6.50 for every $1 spent
- 70+ randomized controlled trials demonstrate it is both more effective and more cost-effective
  - Across practice settings
  - Across patient populations
  - For a wide range of the most common BH disorders
- Better medical outcomes for common chronic medical diseases
- Greater provider satisfaction

Source: Unützer J, Harbin H, Schoenbaum M, Druss B. The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes, Health Home Information Resource Center Brief, May 2013.
Unützer J, Harbin H, Schoenbaum M, Druss B, (2013). The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes, Health Home Information Resource Center, Brief May 2013.
Unützer J, Harbin H, Schoenbaum M, Druss B, (2013). The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes, Health Home Information Resource Center, Brief May 2013.
Hwang W, Chang J, LaClair M, Paz H (2013), Effects of Integrated Delivery System on Cost and Quality. Am J Manag Care. 2013;19(5):e175-e184.
Katon WJ, Russo JE, Von Korff M, Lin EH, Ludman E, Ciechanowski PS. "Long-term Effects on Medical Costs of Improving Depression Outcomes in Patients with Depression and Diabetes." Diabetes Care. June 2008;31(6):1155-1159.
Levine S, Unützer J, Yip JY, et al. "Physicians' Satisfaction with a Collaborative Disease Management Program for Late-life Depression in Primary Care." General Hospital Psychiatry. November-December 2005;27(6):383-391.

FOUR CORE PRINCIPLES OF INTEGRATED CARE

Based on a summit held at UW in 2011, four principles were identified that should be incorporated into workflows

- Team-based care
- Evidence-based care
- Measurement-based care
- Population-based care

Source: aims.uw.edu

FINANCIAL/OPERATIONAL

1. Does your behavioral health agency train direct service staff on proper coding and documentation practices?	94%
If yes, do you provide training to new direct service staff during orientation?	88%
Do you train direct service staff on coding and documentation on a regular basis, at least annually?	88%
2. Does your behavioral health agency have coders on staff?	28%
3. Please provide the following information for 2014:	
Number of FTEs on staff - direct service staff	
Number of FTEs on staff – coders	
Number of FTEs on staff - billing staff (excluding coders and front desk)	
4. Does your behavioral health agency review the coding of direct service staff on a regular basis?	78%

FINANCIAL/OPERATIONAL

6. Does your behavioral health agency monitor direct service staff productivity?	72%
If yes, do you monitor visits?	92%
Do you monitor RVUs?	31%
Are the direct service staff productivity reports reviewed with clinical leadership and the direct service staff themselves?	100%
If yes, do you do this at least monthly?	
Daily	0%
At least monthly	62%
7. Does your behavioral health agency monitor the productivity (panel size) of non-direct service staff?	22%
8. Does your behavioral health agency analyze cost per visit on a regular basis to identify cost efficiencies?	33%

TIMING PRIORITY

FINANCIAL/OPERATIONAL

12. Does your behavioral health agency calculate/monitor the total, annual cost per patient for in-house services?	28%
13. Does your behavioral health agency monitor the utilization of specific services by patient for in-house services?	44%

ORGANIZATIONAL FINANCIAL STRENGTH

21. Does your behavioral health agency have more than 30 days of working capital? Days in Working Capital = (Current Assets – Current Liabilities)/(Total Annual Operating Expenses/365 days)	78%
22. Does your behavioral health agency have a positive unrestricted net asset position?	83%
24. Did your behavioral health agency generate a positive operating margin (operating revenue less expenses before depreciation and non-operating revenues and expenses) for the three most recent completed fiscal years?	50%
25. Does your behavioral health agency prepare monthly financial statements?	89%

TIMING PRIORITY

ORGANIZATIONAL FINANCIAL STRENGTH

28. Has your behavioral health agency developed a revenue model to budget the amount and timing of revenue and cash flow for potential VBP arrangements?	0%
Has the behavioral health agency evaluated the upfront costs of participating in the VBP arrangement and new skill sets/core competencies?	6%
Has the behavioral health agency evaluated reserve requirements and/or the opportunity to partner with other providers?	22%

TIMING PRIORITY

QUESTIONS

HEALTH MANAGEMENT ASSOCIATES

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HMA | HEALTH MANAGEMENT ASSOCIATES

Sub-Committee Progress Reports

CNY BHCC
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Clinical Integration

Committee Chair Lisa Mancini

- Continuing to work with statewide BHCCs, OMH and OASAS on the development of the universal consent
- Working to identify types of services, populations served and best practices throughout network.
- Working to develop ways to close gaps for any services/populations we are missing
- Working closely with Data & Quality groups to identify interventions to assist in improving outcomes of identified measures
- Data Sharing Agreements

CNY BHCC
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Quality Oversight and Data Analytics

Committee Chairs Kathleen Gaffney-Babb and Scott Ebner

- Collaboration of Committees
- Statewide BHCC quality group's working set of metrics
- Committee contribution to statewide discussion
- Recommendation and approval of an initial small set of 6 measures
- On-going work with Clinical Integration on "moving the needle" on the identified metrics
- Recommendations for the PSYCKES BHCC Access View
  - Either in collaboration with the PPS or solely the BHCC
- Review of several systems

CNY BHCC
All in for better health

Initial Identified Measures for CNY

- Adherence to Antipsychotic Medications for People with Schizophrenia
- Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using antipsychotic medication
- Engagement of alcohol and other drug dependence treatment (initiation and 2 visits within 44 days)
- Follow up after hospitalization for mental illness within 7 days
- Follow up after hospitalization for mental illness within 30 days
- Adherence to mood stabilizers for individuals with Bipolar 1 disorder
- Diabetes Monitoring- No HbA1c>1 year

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Where are we currently at?
IPA Formation

- The Independent Provider Association (IPA) is the #1 model that is being recommended by New York State DOH / OMH and OASAS
- The MCOs / insurance companies want Regional Provider Networks to provide a broad of range of services and geographic coverage
- However, BH IPAs at this juncture cannot contract directly with MCO insurance companies
- The primary issue is that BH providers do not have any primary care attribution
- As a result, BH IPA providers will have to link contractually to an IPA or an Accountable Care Organization (ACO) that does have Primary Care attribution

IPA Formation

Tania Anderson, Organizing Partner and Gerald Archibald, Consultant

- Operating Agreement finalized
- Member's ownership proportionate to capital contribution
- Class A Members currently Helio Health, Liberty Resources, Upstate Cerebral Palsy & Inclusive Alliance IPA
- Class B Members afforded lower capital contribution, may not face capital calls
- Board of Managers comprised of both Class A & Class B representatives
- Profits and losses allocated pursuant to ownership interest

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Project Plan

Katie Weldon, CNY BHCC Director

- Please see handout titled “Project Plan” in your folders

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Bringing it all together: Goals and Action Steps

CNY BHCC
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Goals

Katie Weldon, CNY BHCC Director and Organizing Partners

- Greater Access to Services- Right time, Right Service, Better Overall Health
- Continuing to make progress in our work plan and beyond
- A network of shared resources creating better value for everyone~ How do we leverage this?
- Identify and commit to core functions of the BHCC/IPA
- Moving beyond the state initiatives
- Creating a system of high quality care that addresses barriers to treatment~ Management, Quality Improvement, Accountability to ourselves and our patients
- The clients are what matter. How do we continue to serve them in the best way possible!

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Action Steps

Katie Weldon, CNY BHCC Director and Organizing Partners

- Give Feedback
- Engage in this process. This is everyone's initiative!
- What stand out resources could you provide to the network?
- Homework:
  - Measures
  - Do you already track these measures?
  - How are you tracking these measures?
  - What assistance from the BHCC might you need to begin tracking?

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Questions?