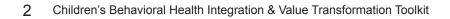# Children's Behavioral Health Integration & Value Transformation Toolkit

Washington State Pediatric TCPi

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WCAAP
The Washington Chapter of the
AMERICAN ACADEMY OF PEDIATRICS

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As integrated managed care continues to be implemented across Washington State by integrating Medicaid health care payors, contracts, and payments upstream, initiatives such as Washington's Medicaid Demonstration Project and Pediatric Transforming Clinical Practices Initiative (P-TCPi) work to innovate transformations within the service delivery system downstream. As this innovation presses forward, funding is moving to better reward value over volume, incentivize advancements in population health strategies, reduce unnecessary costs, and improve both the quality of health care and consumer experience with our health care system.

Most behavioral health agencies enrolled in P-TCPi do not embed their services within primary care settings and many have no intention of co-locating primary care providers within their behavioral health setting. This underlines the need for a transformation model uniquely tailored to behavioral health agencies that offers specific tools that can be adopted and adapted as these agencies take steps toward more robust and measured approaches to integrated care and value transformation. To date, P-TCPi has embraced the Center for Medicare and Medicaid Services' five-phase model of transformation but has not provided sufficient application of this model relevant to behavioral health agencies for adequately assessing and progressing in practice transformation.

With these realities in mind, the Washington Chapter of the American Academy of Pediatrics, under P-TCPi, is helping Behavioral Health Champions from across Washington State support progress on transformation efforts in preparing for a new system of value-based payment (VBP) during the final year of the initiative. In turn, the Washington State Department of Health and P-TCPi Practice Facilitators will spread the Behavioral Health Champions' learnings to behavioral health agencies and providers enrolled in P-TCPi statewide. Behavioral Health Champions will support behavioral health agencies with peer technical assistance (limited to their capacity at 10% effort on the initiative).

The specific structure and components of VBP for behavioral health agencies in a future, transformed system are insufficiently clear, yet Washington State has committed to transition at least 90% of Medicaid contracts statewide to contracts with a VBP component by 2021. At least four models of VBP have already been tested in Washington State: the Accountable Care Program, which provides reimbursement based on performance across financial guarantees and Washington State Common Measures; Multi-Payer, which leverages existing data and tools to support providers in coordinating and managing care and shared risk across multiple payers; Physical and Behavioral Health Integration, which accelerates delivery of whole-person care by making use of co-located services and care coordination between physical and behavioral health settings; and Encounter-based to Value-based, which has tested increased financial flexibility in Medicaid for Federally Qualified Health Centers, Rural Health Clinics, and Critical Access Hospitals to support expanded care delivery options like telemedicine.

Washington State VBP leaders have described possible future VBP contract elements that increase implementation of evidence-based practices, reward engagement in innovative integrated care practices, incentivize achievement of standardized population health metrics, reduce unnecessary costs, and improve patient experience of health care. Behavioral health agencies willing to engage collaboratively with primary care clinics will be an asset to those primary care clinics. At the very least, this collaboration may have its own benefits, as one vision for an integrated system places primary care in the center of an interlocking community network of care, and the patient at the center of primary care. The dominant model for this now is the patient-centered medical home.

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However, a patient-centered medical home could be located with the primary care provider or the behavioral health agency, depending on the needs of the patient. For individuals with more complex behavioral health disorders, there are tremendous barriers to accessing effective primary care, and they need services not available in primary care. There are opportunities to strengthen and bring to scale a model for integrating whole person care in behavioral health settings to meet these needs.

We are now striving to integrate all aspects of a given person's health care, even addressing factors which contribute to health and well-being in many forms— social determinants of health that include housing, transportation, and education. Many behavioral health agencies embrace the term "person-centered," supporting a vision of health care systems with the person at the center, engendering principles which are aspirational, and nearly Rogerian in spirit – empowerment, participation, equity, and integration. These systemic principles for a transformed system stand on the shoulders of giants like Carl Rogers, pioneer and champion of an increasingly humanistic paradigm for mental health services, who emphasized the necessity of person-centeredness, rather than expert-centeredness, model-centeredness, or systems-centeredness, in the provision of care. This is a bold and daunting vision.

How will we pay for an increasingly progressive, person-centered, and integrated system of care? Managed care organizations are still largely in the process of designing value-based payment models for behavioral health agencies. Alternative payment models (APM) are payment approaches that reward providers for delivering high-quality and cost-efficient care; advanced APMs take it even further, letting practices earn more rewards in exchange for taking on risk related to patient outcomes. In Washington State, integrated managed care leadership has indicated that VBP design may, in some cases, adapt to reward as-of-yet undefined innovations in integrated care that are demonstrating beneficial

results. The end game for the behavioral health system is to see the implementation of integrative and client-/patient-centered practices that enhance clinical quality, reduce unnecessary costs, and result in increases in the achievement of standardized population health measures.

We can be certain that in the coming years, to some extent, behavioral health agencies will be paid based on health outcomes, or measures, rather than either strictly through fee-for-service or no-risk capitated payment arrangements. VBP is shaping up along a continuum, with statewide efforts enabling providers to move along that continuum. This involves risk sharing and incentives to reward providers for achieving quality. So, how can behavioral health agencies make a positive impact on the quality and effectiveness of physical health care, on achievement of standardized population health measures, on improving client/patient experience, and on reducing unnecessary costs of care? Here is a set of suggestions for implementation of integrated care practices and value transformation efforts, providing behavioral health agencies with specific tools for making changes.

Where to Begin

1. Identify a transformation champion within the behavioral health agency. This individual's role will be to become very familiar with transformation initiatives, integrated care practices, population health, and value-based payment; be a leader for the development and implementation of the behavioral health agency's plan for implementing integrated, client-centered practices which embody the vision for transformation; and to communicate to all levels of staff about the culture change related to this new integrated practice paradigm. The transformation champion will guide the behavioral health agency in establishing measurable targets for transformation (e.g. relating to collaboration with partners, improving health by achieving specific standardized health measures).

2. Identify, or hire if necessary, someone within the behavioral health practice to act in a "whole person care" or "integrated care" coordination role. A credentialed medical assistant may be a good option; one practice extended hours of a part-time telepsychiatry program coordinator to full-time to cover this role. Implementation of integrated care practices will require consistent coordinative support within your practice and someone to liaise with external partners.

3. Generate a report to identify which primary care clinics provide primary care to your behavioral health agency's clients, as well as to identify your clients who still have no assigned PCP. Ensure that all clients are asked for their assigned PCP at intake.

4. Convene a meeting including P-TCPi point-of-contact (POC), transformation champion, and possibly others with a local pediatric primary practice that sees your clients and establish an agreement on referral POCs and pathways. Repeat this with each primary care practice until, ideally, you have partnership agreements with all the practices that provide primary care to your clients. (Reference WCAAP's Pediatric Provider Toolkit for Primary Care and Behavioral Health ((https://bit.ly/2x8lWje)) for more information.)

   Rationale: Robust, beneficial integrated care practices start with constructive communication between behavioral health and pediatric providers. Until you know who each other are, what you each do, what you each need, in terms of referral and collaboration, and what barriers exist to integrating care, you won't know how to engage or what success together may entail.

   Recommended steps:
   a. Distill down what you, as a behavioral health agency, want from primary care in a referral, and identify what you as a behavioral health provider can offer a primary care clinic (e.g. convenient location, ease of access to care, wide array of services).
   b. At intake assessment, behavioral health provider should educate client/parent about the value of integrated care and encourage them to complete the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) medical appointment.
   c. Enhance follow-up process to EPSDT to ensure robust, meaningful follow-up that includes ping back from primary care practice with confirmation of completed first appointment with primary care physician.
   d. Develop plan for identifying clients with no primary care provider and for referring those clients in a robust referral process including a "warm hand-off" component that results in confirmation from the

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primary care clinic that the first appointment with a pediatric provider has successfully occurred, thus demonstrating a process that improves access to primary care.

e. See P-TCPi referral template in the Pediatric Provider Toolkit (https://bit.ly/2x8lWje), which PCPs can use for making referrals to behavioral health agencies, and behavioral health agencies can then use to loop back with follow-up feedback. Note that you can and should revise and amend this template and any other form you may need to be pertinent to your agreed pathways and practices, but they give you a place to start and help to standardize the referral process. Also provide your agency's Release of Information form.

f. Review specific programs and services provided by both practices and discuss reasons for which one practice might refer a patient/client to the other practice.

g. Assess barriers to access related to your clients accessing primary care or their patients accessing behavioral health services.

h. Brainstorm possible ways to improve access to care as partners in integration efforts.

i. Implement a plan to communicate about clinical visits or encounters with PCPs.

5. Assess all clients for medical needs, and systematically track efforts at coordination with PCPs for all clients.

6. Design and implement a process to educate clients/families on benefits of integrated/whole person care practices at appropriate points of entry (e.g. intake), treatment planning, and/or referral.

7. Develop a plan for transitional care coordination upon client utilization of an emergency department and other acute care settings related to a mental health condition.

Rationale: Children who are hospitalized are more likely to be re-hospitalized if they have a mental health disorder, and in some cases, comorbidities exacerbate symptoms and increase the likelihood of utilization of varying forms of acute care. It is possible for behavioral health providers to engage in collaborative practices with physical health providers which provide opportunities for diversion from acute care, such as emergency department (ED) utilization, through better coordinated care.

Recommended steps:

a. Gain access to an interoperable HIT/HIE health data system (e.g. Premanage/EDIE) to facilitate ease of access to primary care and emergency department health data. This will require either agency investment of a large sum of money, or sponsorship by a MCO.

b. Ensure your practice is being notified when clients utilize the emergency department (ED) or any other acute care setting related to a mental health condition.

c. Ensure transitional care through your behavioral health practice is provided within ten days of discharge from ED or any other acute care setting.

d. Behavioral health provider will provide post-discharge assessment for increase/change in symptoms of previously diagnosed behavioral health conditions that may be exacerbated by the ED incident and for onset of any new symptoms/condition which may have developed as a consequence of the ED incident (e.g. anxiety, trauma).

8. Develop, implement, and track effectiveness of 24/7 on-call procedures.

9. Plan and implement a way to measure outcomes. Track and aggregate data sets related to all integrated care practices that are implemented. Ideally, use an electronic health record for data collection and organization. Ensure managers receive data reports with regularity.

    Rationale: Behavioral health agencies will be reporting progress on integrated care practices that promote bidirectional integration of physical and behavioral health through their regional Accountable Community of Health (ACH), as this transformation project is required under Washington State's Medicaid Demonstration Project for all nine regions of the state.

    Recommendation: Take time to review the list of "Performance Measures" available within the Healthier Washington Medicaid Transformation Project Toolkit (https://bit.ly/2MqtenL).

10. Develop plans and implement practices for improving specific Value Transformation Assessment (VTA) item ratings. Choose specific targets that are realistic, meaningful, and achievable for your behavioral health practice. **Note:** The Value Transformation Assessment was developed by the Value-based Payment Transformation Academy, led by the Washington Council for Behavioral Health. Value Transformation Assessment: (http://bit.ly/2DgJojD)

11. If your behavioral health agency provides psychiatric medication management services, request a self-assessment of partnering pediatric primary care providers' comfortability and confidence with transitioning behavioral health clients stable on a psychotropic medication regimen to their primary care practice for ongoing medication management.

    Rationale: When pediatric primary care practices refer their patients to a behavioral health agency for mental health therapy and psychiatric medication management, once the patient is stable on a psychotropic medication regimen, the medication regimen can be managed well from that point by the child's primary care provider. However, in many cases, pediatricians do not feel comfortable or confident in managing these medications.

    Recommended steps:
    a. Ask pediatric primary care practice to identify comfort and confidence in managing psychotropic medications.
    b. Ask pediatric primary care practice to identify barriers and needs related to managing psychotropic medications.
    c. Request detailed feedback related to specific medications.
    d. Identify medications and conditions for which to consider protocols (e.g. stimulants, ADHD).
    e. Develop protocols for returning clients to care of pediatric provider upon successful achievement of behavioral health treatment plan goals and medication stabilization, offering ongoing consults, as needed, with psychiatric provider.
    f. Ensure pediatric primary care practice is familiar with and encouraged to utilize Seattle Children's Partnership Access Line (PAL): https://bit.ly/2p1MC19, a child psychiatric consultation resource program for pediatric primary care providers.

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g. Help facilitate a relevant training in identified areas of psychotropic medication management for pediatric providers. P-TCPi is one resource for such trainings.

12. Identify targeted conditions for your behavioral health agency to provide partnerships, pathways, and protocols in the provision of integrated care.

13. Improve the ability, as a behavioral health agency, to respond to conditions or concerns in the local community or region by systematically monitoring news and maintaining key information-gathering networks. One example would be monitoring for an increase in adolescent suicides. In a concerted effort to respond well to trends or events, coordinate services with other providers, as feasible.

14. Provide training to staff on values of whole-person care and integration, process of transformation for the agency, and specific changes in the role and focus for staff, with modified performance outcomes and expectations. Also consider prioritizing recruitment and retention of staff who demonstrate a commitment to integrated, whole-person care. These efforts will likely be best led by the agency's identified Transformation Champion.

15. Use an organized approach to identify and act on opportunities for quality improvement. Include opportunities for participation in QI across all positions, and empower staff to participate fully.

16. Increase implementation of practices that are based on or informed by best practice evidence.

    Recommended steps:
    a. Assess all evidence-based practices (EBP) which your BH provider staff are certified to provide.
    b. Invest the time and funds necessary to equip provider staff in relevant EBPs.
    c. Explore whether there is any research indicating a benefit between specific EBPs and comorbid, targeted physical health conditions, as one path toward integrating care.

17. Facilitate a training for partnering pediatric providers on childhood trauma and trauma-informed care or co-facilitate this training together for other providers in the community with the incorporation of a multidisciplinary panel discussion.

    Rationale: Concern that pediatric providers sometimes inaccurately diagnose mental health conditions (e.g. ADHD) when symptomology is better explained by past childhood trauma.

    Recommended steps:
    a. Review literature/resources:
        i. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4939592/.
        ii. https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/resilience/Pages/Becoming-a-Trauma-Informed-Practice.aspx
    b. Show behavioral health and/or primary care providers TED Talk by Nadine Burke Harris, "How childhood trauma affects health across a lifetime." https://bit.ly/1w1DJW5

18. Develop and implement a process to report to staff and, when possible and appropriate, other stakeholders, on performance relative to transformation goals.

19. Develop and implement strategies and activities within your behavioral health agency to cultivate joy in work (e.g. staff recognition, social activities). Be sure to measure, document, and learn from results related to staff work satisfaction, changing course as beneficial.

20. Ensure that financial data is well-organized and shared transparently within the behavioral health agency as appropriate, as part of efforts to innovate business tools and practices to analyze and document the value the organization brings to various types of alternative payment models.

21. Engage in formal planning at the level of leaders and managers to ensure readiness for migration into alternative-based payment arrangements.

22. Use a formal approach to understand the agency's work processes, eliminate waste in the processes, enhance processes and services through identifying and reducing inefficiencies, and increase efficiencies and the value of all processing steps.

23. Maximize billing for all types of treatment, ensure providers are operating at the top of their credentials to maximize resources for and impact on positive treatment outcomes, and be flexible in your use of staffing and resources in ways that maximize value and treatment effectiveness.

Additional Suggested Integrated Care Practices

24. Integrate care coordination for shared clients/patients with uncontrolled asthma.

    Rationale: Integrated care coordination related to uncontrolled asthma constitutes not only bidirectional integration of physical and behavioral health care, but also chronic disease intervention (i.e. asthma targets are represented in two NCQA HEDIS measures and a priority condition for improved population health management in Washington State). This is therefore an area that can result in: enhancement of both transitional care from acute care settings and diversion intervention from acute care settings; improvement in access to needed primary care (with the addition of screenings within behavioral health practices); and an area in which engagement with social determinants of health can be demonstrated, when screens such as PRAPARE are used (i.e., child living in poor home environmental conditions may receive social service assistance that improves environmental air quality).

    Recommended steps:
    a. Ensure proper consents to release information are signed and in the client record for each client of a particular primary care practice.
    b. Provide the primary care practice a list of shared clients/patients and ask them to identify any on the list who have been diagnosed with asthma.
    c. For those targeted clients, provide informed consent related to opportunity for integrated care coordination.
    d. Implement behavioral health services which support effective management of asthma (e.g. breathing exercises, mindfulness interventions, asthma diary, refill tracking log).

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e. Ensure primary care practice is collecting and aggregating relevant data through their EMR.

f. In the behavioral health agency, implement asthma screener into intake assessment process. It may be best to include the screener in a pre-session "lobby packet."

Asthma screener questions should include—

    i. Do you have asthma symptoms?

    ii. How many times a week do you have symptoms?

    iii. How often do you wake up at night with symptoms?

    iv. Are you limited from doing normal activities due to your asthma?

    v. How often do you use your short-acting inhaler?

25. Integrate care coordination for shared vulnerable, high-risk, or co-occurring clients/patients.

Recommended steps:

a. Ensure proper consents to release information are signed and in the client record for each client of a particular primary care practice.

b. Provide the primary care practice a list of shared clients/patients and collaboratively identify any on the list who are to be considered vulnerable, high risk, co-occurring clients/patients.

c. For those targeted clients, provide informed consent related to opportunity for integrated care coordination.

d. Implement behavioral health services which support effective management of collaborative care and treatment measures.

e. Ensure primary care practice is collecting, aggregating, and when possible and appropriate, sharing relevant physical health data.

f. Ensure compliance with 42 CFR Part 2 federal regulation regarding privacy of substance use disorder treatment related records.

26. Per HEDIS measure, ensure in routine medication monitoring that no client is on more than one antipsychotic medication. If discovered, provide immediate integrated care coordination.

Rationale: See NCQA rationale at http://www.ncqa.org/hedis-quality-measurement/hedis-measures/antipsychotics-children-measures:

a. "Antipsychotic medications are among the most expensive, highest in risk, and fastest growing of therapeutic classes for children with mental disorders. For example, the frequency of prescribing antipsychotics increased from 8.6 per 1,000 children in 1996 to 39.4 per 1,000 in 2002.

b. Although evidence supports use of antipsychotics in youth for certain narrowly defined conditions, the majority of children on antipsychotics do not have one of these conditions.

c. Antipsychotics have serious, common side effects, including weight gain, hyperprolactinemia, and metabolic disturbance."

27. Implement screening protocols and integrated care coordination for clients at risk for developing diabetes.

Recommended steps:

a. Blood pressure screening.

b. Clients who are identified as having a BMI greater than 30-35 will be invited by the behavioral health provider to consider referral to a PCP for appropriate assessment.

   c. Order metabolic lab for clients on antipsychotics (if employing a medical assistant with the necessary training in phlebotomy), due to increased risk of developing diabetes.

   d. Review diabetes management guidelines from the American Diabetes Association (https://bit. ly/2NBLIGJ).

   e. Note: This is a particularly good area for integrated care coordination between a behavioral health agency's psychiatrist(s) and/or psychiatric ARNP. Additionally, some integrated care coordination can be carried out independently by a credentialed medical assistant.

   f. Caution: Take care to guard against "weight shaming," including ensuring staff are trained in effective diabetes intervention. Linking to credentialed dieticians and certified diabetes educators may be useful.

28. Implement social determinants of health screening at intake (e.g. PRAPARE, Social Needs Screening Tool), referring to appropriate social service agencies and resources, as indicated.

29. Integrate care coordination related to shared clients/patients identified as engaging in frequent or inappropriate use of emergency department (ED) services.

30. Administer screenings in your behavioral health agency which are also being utilized within partnering primary care practice when possible and not duplicative, which promotes shared understanding and rating system for collaborative care.

   Recommended measures:

   a. PHQ-A, or CDI

   b. GAD-7, or SCARED

   c. CATS

   d. ACE Questionnaire

   e. SNAP

   f. Vanderbilt

   Recommended steps:

   g. Identify shared screeners.

   h. Clarify strategies for treatment targets.

   i. Incorporate baseline measures into referral process.

   j. Establish collaborative treatment goals for shared clients/patients ("treat to target").

   k. Share measures between practices, with regularity (e.g. quarterly).

Suggestions for Engaging in Beneficial Education and Advocacy

31. Ask questions of contracted managed care organizations, your regional Accountable Community of Health leadership, and Health Care Authority leadership about the future of collaborative care coding (e.g. CoCM), alternative payment models (APM), and value-based payment in Washington State. Advocate for better access to data and interoperable HIE systems as well as consideration and inclusion of your own promising integrated care practices in the value-based payment framework.

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32. Educate MCO representatives and ACH staff about the unique aspects of specialty behavioral health agencies.

    Rationale: Too often, those involved in health care delivery system transformation efforts conflate behavioral health programs integrated within primary care practices and specialty behavioral health programs operating independently of primary care practices.

33. Educate MCO representatives and ACH staff about promising integrated care practices within children's health care.

    Rationale: Too often, those involved in health care delivery system transformation efforts conflate adult treatment considerations and pediatric treatment considerations, and we have heard critiques of insufficient inclusion of unique child/pediatric voice and interests in statewide delivery system transformation efforts.

34. Engage in conversations and consideration of scope of practice concerns for behavioral health agencies involved in integrated care (i.e. we treat identified behavioral health diagnoses within scope of education, training, and experience, yet integrated care demands incorporation of components of physical health care into treatment planning and service provision).

Aiming for Value-based Transformation

Through August 2018, P-TCPi has primarily utilized a practice transformation assessment called the TCPi Practice Assessment Tool (PAT); for assessing behavioral health agencies, we have utilized a slightly modified version of that tool, the TCPi Specialist PAT. With our experience to date, it has become clear that the Specialist PAT has proved insufficient in capturing meaningful progress toward supporting population health and making a successful transition to value-based payment strategies. Many behavioral health agencies around the state have also utilized the Maine Health Access Foundation (MeHAF) Site Self-Assessment tool for assessing progress in integrating care, which has proved beneficial yet also fails to capture the necessary elements for practice transformation we are aiming for through P-TCPi.

Recently Qualis Health and the Washington Council for Behavioral Health released a new hybrid tool adapted from blending elements of the Specialist PAT and the MeHAF Site Self-Assessment. This new tool, the Value Transformation Assessment (VTA) has been selected by Washington State P-TCPi to serve as the primary measure for behavioral health practice transformation during the final year of our state's four-year grant initiative (October 1, 2018 through September 30, 2019).

The VTA measures key areas demanding transformation by behavioral health agencies to ensure preparedness for value-based payment systems. These key areas include: sustainability, patient and family engagement, team-based relationships, population health management, coordinated care delivery, enhanced access, engaged and committed leadership, quality improvement strategy, transparent measurement and monitoring, optimal use of HIT, staff vitality and joy in work, capability to analyze and document value, efficiency of operations, and strategic use of practice revenue.

Specifically, in these areas of assessment, at the highest level of "value transformation," a behavioral health agency will reach the following goals:

- Meet at least 75% of its targets and sustained improvements in practice-identified metrics for at least one year;
- Follow evidence-based guidelines for treatment and practices, while supported through provider education and reminders, applied appropriately and consistently;
- Elicit client/family involvement in care planning and communicate directly with clients/families about integrated care practices as an integral part of the system of care, engaging in collaboration between the client/family and team members and considering family, work, or community barriers and resources;
- Set clear, documented expectations for each team member's functions and responsibilities to optimize flexibility, outcomes, and accountability, ensuring team members work to the maximum of their skill set and credentials to optimize efficiency and outcomes;
- Track vulnerable client groups that require additional monitoring and intervention through client lists (registries) with specified criteria and outreach protocols monitored on a regular basis, with outreach performed consistently with information flowing back to the care team;
- Ensure systems are in place to support continuity of care between primary care and behavioral/mental health providers, ensure all clients are screened, assessed for treatment as needed, treatment scheduled, and follow-up maintained;
- Collaborate with primary care practices in their medical neighborhood and jointly develop and implement criteria for episodic care, co-management, and transfer of care/return to primary care, processes for care transition, including communication with clients and families;
- Identify the primary care providers or care teams of each client and where they are seen for primary care, communicating to the primary care team about each visit or encounter;
- Have a clinician available from the practice or on a contract basis who can speak to clients after hours while being able to access the client's record;
- Develop and share broadly a vision and detailed plan that addresses goals of transformation with specific clinical outcomes and utilization aims that are aligned with national TCPi aims, along with the detail on how each of the aims will be addressed;
- Fully incorporate regular improvement methodology (e.g. PDSA, Model for Improvement, Lean, FMEA, Six Sigma) to execute change ideas and improvement opportunities in the practice setting;
- Build quality improvement capability in the behavioral health practice and empower staff to innovate and improve by allowing staff/providers to participate in QI activities by allocating time for QI activities, including QI within defined job duties, recognizing and rewarding innovation and improvement;
- Regularly produce and share reports on provider and/or care team performance at both the organization and provider/care team levels, including progress over time and how performance compares to quality goals, with an effective system for following-up to address needs and opportunities for improvement;
- Implement a robust electronic health record (EHR) accessible to all providers, with service delivery team using a registry or EHR to routinely track indicators of client outcomes and integration outcomes and with indicators reported regularly to management, using data to support a continuous QI process;
- Implement strategies to support joy in work and demonstrate the results through metrics such as staff survey results, high retention rates, or low turnover rates;
- Share financial data in a transparent manner within the practice and develop the business capabilities to use business practices and tools to analyze and document the value the organization brings to various

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types of alternative payment models;

- Achieve a state of readiness for migration into alternative payment arrangements;
- Use an organized approach (e.g. lean process mapping) to review work processes, eliminate waste in the process, and understand the value of each process step to the clients and families served; and
- Fully integrate funding, with resources shared across providers, maximizing billing for all types of treatment, using resources and staffing flexibly.

Five Phases of Transformation for Behavioral Health Agencies

According to the outcome of value transformation assessment, utilizing the VTA, P-TCPi Department of Health Practice Facilitators will rate behavioral health agencies along a continuum of five phases of transformation. Here is a bird's eye view of the five phases of transformation for behavioral health:

1 No or minimal movement toward VBP

- Aims are set
- Identify practice transformation champion
- Train staff on integrated care practices
- Select practices for implementation

Phase #1 – At this level, aims for necessary practice transformation have been set. To move through phase one, a behavioral health agency must, at a minimum, identify a Practice Transformation Champion for vision-setting and driving implementation, engage in vision-setting and training with behavioral health staff on integrated care practices, and select preliminary integrated care practices for implementation. Phase one represents no or minimal steps toward integration or readiness for VBP.

2 Clear steps toward VBP

- Use data to drive care
- Identify integrated care coordinator
- Implement one or more integrated care practices
- Establish baseline data
- Track progress
- Provide regular quality review

Phase #2 – At this level, data is being used to drive care. To move through phase two, a behavioral health agency will likely need to identify or hire someone to serve in an "integrated care coordinator," or "whole person care coordinator" role in order to manage the work required in developing and maintaining client registries (note: many agencies do not have sufficient registry capability within their EHR and have found success using Microsoft Excel workbooks) to track measures. A behavioral health agency in phase two is typically implementing at least one integrated care practice, actively tracking and monitoring progress on

relevant aims and measures, establishing baseline data, providing regular quality review, and adapting treatment strategies as indicated. Additionally, phase two represents some movement toward early milestones on a host of value transformation measures. Phase two represents clear and meaningful steps being taken toward bidirectional integration of care and preparation for VBP.

3   Measured progress on VBP

- Track and monitor progress on aims
- Implement "treat to target" at least one standardized population health measure
- Perform systematic quality review
- Incorporate QI feedback
- Demonstrate progress on standardized population health measure

Phase #3 – At this level, progress on aims is being achieved. To move through phase three, a behavioral health agency is actively tracking and monitoring progress on aims and measures, "treating to target" for at least one standardized population health measure, engaging in systematic quality review, incorporating QI feedback into a feedback loop that makes its way not only into systems-wide process improvement but also back to active case consultation process, and demonstrating progress in at least one standardized measure related to an integrated care practice. Phase three represents measured movement toward milestones on a host of value transformation measures and preparedness for VPB.

4   Significant progress on VBP

- Achieve goal benchmarks in multiple areas of value transformation
- Implement "treat to target" on multiple standardized population health measures
- Demonstrate collaborative care partnership with at least one PCP
- Demonstrate achievement of benchmarks

Phase #4 – At this level, goal benchmarks are being achieved in multiple areas of transformation. To move through phase four, a behavioral health agency is "treating to target" for multiple standardized population health measures, actively and effectively collaborating with at least one primary care practice, and demonstrating achievement of an identified, targeted measure benchmark for which the behavioral health agency is providing integrated care. Phase four represents significant movement toward milestones on a host of value transformation measures and preparedness for VPB.

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- Thorough assessment of value transformation
- Robust integrated care
- High degree of transformation
- Confident in options and preparation for VBP contracting

Phase #5 – At this level, the behavioral health agency is thriving as a business via pay-for-value approaches. To move through this level, a behavioral health agency has engaged in thorough assessment of value transformation, is engaging in robust integrated care, has achieved high degrees of transformation along a host of value transformation measures, and is confident in options and preparedness for contracting in an alternative payment methodology that qualifies as VBP.

Conclusion

This sort of work represents fundamental challenges and opportunities in the new frontiers of a pediatric healthcare delivery system which will be built on foundations of accurate empanelment; data-driven goal-setting based on standardized population health metrics; interoperable health information technology; organizations committed to improving client/patient experience at every turn; healthcare communities replete with enhanced, bidirectional relationships between primary care and behavioral health providers; care that better engages and treats the whole person; and health care economies driven by cutting-edge systems of value-based payment. As behavioral health agencies enrolled in P-TCPi forge paths toward value transformation, P-TCPi will continue to provide technical support and network resources through September 2019 as we work together to transform the system of care for health care consumers across the state of Washington.