A Path to Value: Strategies for Developing Care Pathways

December 13, 2018

National Council for Behavioral Health
Montefiore Medical Center
Northwell Health
New York State Office of Mental Health
Netsmart Technologies

Care Transitions Network
for People with Serious Mental Illness

Today's Presenters

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Goals for Today

- ✓Define care pathways and their key components;
- ✓Explain how care pathways fit into population health management;
- ✓Identify roles of care team members in operationalizing care pathways; and,
- ✓Apply the care pathway development steps in their own provider setting.
- ✓Discuss next steps

CMS Change Package: Roadmap for Transformation	
Patient and Family-Centered Care Design	1.1 Patient & family engagement **1.2 Team-based relationships** 1.3 Population management 1.4 Practice as a community partner **1.5 Coordinated care delivery** **1.6 Organized, evidence-based care** 1.7 Enhanced access
Continuous, Data-Driven Quality Improvement	2.1 Engaged and committed leadership 2.2 QI strategy supporting a culture of quality and safety 2.3 Transparent measurement and monitoring 2.4 Optimal use of HIT
Sustainable Business Operations	3.1 Strategic use of practice revenue 3.2 Staff vitality and joy in work 3.3 Capability to analyze and document value 3.4 Efficiency of operation

Value-based Purchasing
An Old Term Getting New Life

"The concept of value-based health care purchasing is that buyers should hold providers of health care accountable for both cost and quality of care. Value-based purchasing brings together information on the quality of health care, including patient outcomes and health status, with data on the dollar outlays going towards health. It focuses on managing the use of the health care system to reduce inappropriate care and to identify and reward the best-performing providers. This strategy can be contrasted with more limited efforts to negotiate price discounts, which reduce costs but do little to ensure that quality of care is improved."

Source: Theory & Reality of Value-Based Purchasing: Lessons from the Pioneer. November 1997. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/meyer/index.html

The Value Equation

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Value Based Model Risk

Utilization Risk –

- The estimate of the amount of service that the covered population will **use/require** (e.g., average lengths of stay, average visits per case, & use of levels of care) is wrong.

- Utilization risk is the possibility that you and the provider organization you contract with will **use/require** significantly more care than you estimated.

- **Right Care, At the Right Time, For the Right Consumer**

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Care Pathway

Screening & Assessment	Level of Engagement	Level of Service Criteria/Cost	Service Bundle	Length of Care/ Time to Tx	Target Parameters
Adult Male, 25yrs old Substance Addicted (nicotine) Depressed High Blood Pressure Unemployed Homeless	Maintenance/ Relapse Prevention	Low Intensity/$	Medication Cog. Beh. Therapy Smoking Cessation Care Management Supported Employment Assistance Housing Assistance	Low Intensity 0-9 Months	Smoking Cessation or Reduction BP w/in Normal Range PHQ-9 Score <10 Appt's Kept No Hosp. & ED Use Employment Housing Satisfaction
	Action	Moderate Intensity/$$		Moderate Intensity 9-18 Months	
	Preparation				
	Precontemplation & Contemplation	High Intensity/$$$		High Intensity 18 -28 Months	

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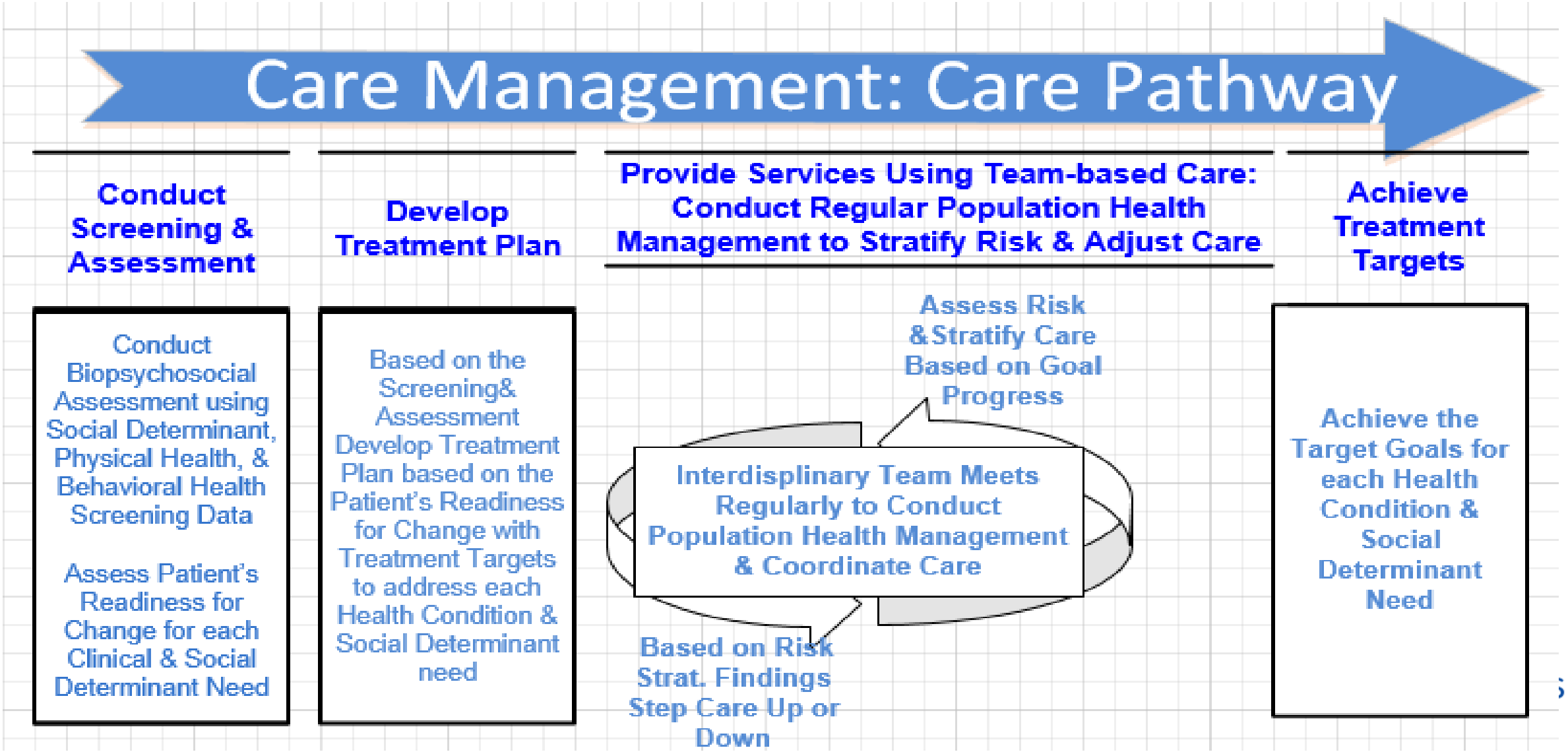
Where do Care Transitions Occur in the Day-to-Day Work of the Clinic?



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.

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What is a Care Pathway?

A defined path to health comprised of both clinical & administrative steps/workflows, including:

- Consumer engagement
- Screening, assessment & stepped evidence-based treatment with clearly defined treat-to-target parameters
- Interdisciplinary team-based care which employs population health management techniques
- Ongoing quality improvement to assess effectiveness & efficiency of the pathway

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The Care Pathway in Context

Two critical components of care pathway development and execution are:

- Team-based Care
- Population Health Management

5 Components of Effective Interdisciplinary Teams

1. Defining appropriate team goals.
2. Clear role expectations for team members.
3. A flexible decision-making process.
4. The establishment of open, safe, communication patterns.
5. The ability of the team to "treat" itself.

Source: Leipzig, Hyer et al. (2002). Attitudes Toward Working on Interdisciplinary Healthcare Teams: A Comparison by Discipline J Am Geriatr Soc 50:1141–1148.

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HUDDLE & TEAM MEETING: WHERE PHM & RS GET DONE!

Huddles & Team Meetings are an important practice change tool!

Although there are elements of successful and effective meetings, each clinic needs to determine, the form, shape, and process for their meetings.

CORE ELEMENTS

- Set agenda
- All members of the team attend
- Regular schedule
- Data Driven

EXAMPLE OF A HUDDLE AGENDA

- ✓Review unfinished follow-ups from previous day
- ✓Review status of clinic operations—staffing today, equipment or computer problems, any special events or meetings happening, any cancellations and open appointments
- ✓Review schedule for the day and highlight any new cases in which BH needs to be involved
- ✓Review any updates on patients with recent emergency or inpatient care and transition needs
- ✓Identify patients for BHP intervention or rescreening with PHQ-9 or other tool.
- ✓Discuss workflow challenges that need to be addressed.
- ✓Review of registry for patients on the schedule and identification of follow-up needed that day
- ✓Diagnostic or clinical updates for patients scheduled that day
- ✓Celebrate!

EXAMPLE OF A TEAM AGENDA

- ✓Celebrate!
- ✓Review Population Level Data for all SDOH & clinical Conditions
- ✓Case presentations
- ✓Identify team process concerns that need to be discussed in team meeting.
- ✓Review Care Pathway Elements/Processes that need Improvement/Change

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Population Health Management Requires

1. Knowing what to ask about your consumer/population
2. Data registry with dashboards to describe/risk stratify your consumer/populations
3. Teams able (e.g., huddles/team meetings, supervision, analytically capable, etc.) to respond to the findings for a consumers/populations
4. Continuous quality improvement policies/procedures to change the care pathway when populations are not improving or cost/time is not on target/within specification

Care Pathway Assessment

The Successful Care Pathway:

- Standardized with protocols/procedures based in policy
- Supervisors are responsible for monitoring pathway fidelity
- For each step in the path the data collected, the time required to complete the step and the cost/billing source is identified
- Risk stratification determinations are clearly described in protocols to allow for stepping consumers up to more intensive services
- Clinical and administrative data dashboards are used to aggregate and easily convey risk, progress/lack of progress toward targets…lack of efficiency and effectiveness.

What are the steps to create a care pathway?

1. Choose a clinical condition or social determinant need
2. Define the patient population
3. Convene an inter-disciplinary team
4. Define the target outcome(s)
5. Review the evidence base
6. Map the care pathway
7. Develop clinical & administrative protocols
8. Pilot the care pathway
9. Evaluate the efficiency & effectiveness of the care pathway
10. Ongoing monitoring of the care pathway metric specifications

Source: Adapted from Panella M et al. Reducing clinical variation with clinical pathways: do pathways work? International Journal of Quality in Health Care. 2003. 15(6): 509-521.

Care Pathway Development Example

1. Choose a clinical condition or social determinant need

   Let's look at Depression

2. Convene an inter-disciplinary team

   You are here today w/ your team!

3. Define the target outcome(s)

   Clinically significant PHQ 9 Score dropping 10 pts w/in 3 months; No suicidal ideation

4. Define the patient population

   Adults with Serious Mental Illness

5. Review the evidence base

   PHQ9 & Columbia Guidelines; Depression Medication Algorithm; Individual & Group CBT; Case Management; Peer Coaching; Primary Care Coordination; Family Psychoeducation (as indicated)

Step 5. Review the Evidence Base/Depression Treat to Target Metrics

Number of Clients Screened: Screen all patients (some agencies will exclude people with bipolar disorder but must make sure have replacement screener) at least quarterly if not at every visit using PHQ 2 or 4.

Numerator: # clients screened
Denominator: all clients served – excluded clients

Clients that Screen Positive Receive Follow-up Care: Those that screen positive (e.g., PHQ 9 score >= to 10) receive treatment.

Numerator: Number of clients with depression treatment plan
Denominator: # clients screening positive

Clients with Positive Score on PHQ-9 Improve: For those that screen positive, have they improved over a three-month period?

Numerator: # clients with score improvement after three months
Denominator: # clients screening positive w/ a treatment plan

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Depression Dashboard

TRACKING PROGRESS AND ADJUSTING TREATMENT APPROACH

			Treatment Status				PHQ-9				GAD-7				Psychiatric Consultation	
			! Indicates that the most recent contact was over 2 months (60 days) ago				✓ Indicates that the last available PHQ-9 score is at target (less than 5 or 50% decrease from initial score) ! Indicates that the last available PHQ-9 score is more than 30 days old				✓ Indicates that the last available GAD-7 score is at target (less than 10 or 50% decrease from initial score) ! Indicates that the last available GAD-7 score is more than 30 days old					
View Record	Treatment Status	Name	Date of Initial Assessment	Date of Most Recent Contact	Number of Follow-up Contacts	Weeks in Treatment	Initial PHQ-9 Score	Last Available PHQ-9 Score	% Change in PHQ-9 Score	Date of Last PHQ-9 Score	Initial GAD-7 Score	Last Available GAD-7 Score	% Change in GAD-7 Score	Date of Last GAD-7 Score	Flag	Most Recent Psychiatric Consultant Note
View	Active	Susan Test	9/5/2015	2/23/2016	10	26	22	14	-36%	2/23/2016	18	17	-6%	! 1/23/2016	Flag for discussion & safety risk	1/27/2016
View	Active	Albert Smith	8/13/2015	! 12/2/2015	7	29	18	17	-6%	! 12/2/2015	14	10	-29%	! 12/2/2015	Flag for discussion	
View	Active	Joe Smith	11/30/2015	2/28/2016	6	14	14	10	-29%	2/28/2016	10	✓ 6	-40%	2/28/2016	Flag for discussion	2/26/2016
View	Active	Bob Dolittle	1/5/2016	3/1/2016	3	9	21	19	-10%	3/1/2016	12	10	-17%	3/1/2016	Flag as safety risk	2/18/2016
View	Active	Nancy Fake	2/4/2016	2/4/2016	0	4	.	No Score			.	No Score				
View	RP	John Doe	9/15/2015	3/6/2016	10	25	20	✓ 2	✓ -90%	3/6/2016	14	✓ 3	✓ -79%	3/6/2016		2/20/2016

FREE UW AIMS Excel® Registry (https://aims.uw.edu/resource-library/patient-tracking-spreadsheet-example-data)

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Metrics that are used in all Care Pathways

- Care Coordination
- Services use
- Risk Score
- Treatment Plan Goal Progress or Completion
- Cost
- Others?

What is meant by "Transitions of Care"?

The movement of patients between health care locations, providers, or different levels of care within the same location, as their conditions and care needs change

- **Across health states**: e.g., palliative care to hospice, or personal residence to assisted living
- **Between providers**: e.g., PCP to a psychiatrist, or acute care provider to a palliative care specialist
- **Within settings**: e.g., primary care to specialty care team, or intensive care unit (ICU) to ward/department
- **Between settings**: e.g., inpatient hospital to outpatient care, or ambulatory clinic to senior center

Source: NTOCC

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Elements of Transitions of Care

Seven Essential Elements:

1. Medication Management
2. Transition Planning
3. Client and Family Engagement
4. Information Transfer
5. Follow-Up Care
6. Healthcare Provider Engagement
7. Shared Accountability Across Providers and Organizations

Source: NTOCC's Seven Essential Elements of Transitions of Care

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Care Transition (CT) Elements and Associated Metrics

Elements

1. Medication Management
2. Transition Planning
3. Client and Family Engagement
4. Information Transfer
5. Follow-Up Care
6. Healthcare Provider Engagement
7. Shared Accountability across Providers and Organizations

Metric Examples

1. Prescriptions filled by client
2. Number of CT meetings between CMH/hospital
3. Number of CT meetings with client/family/CMH/Hospital staff
4. CCD shared between providers
5. Appt scheduled within 7 days of hospitalization
6. Number of no-shows
7. Metrics defined in BAA

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Care Transition Target Metrics

Follow-up within 7 days of hospital discharge: All clients admitted to the hospital will be seen by a BH professional within seven days of discharge from the hospital

Numerator: # clients seen within 7 days
Denominator: all clients admitted to the hospital

Clients admitted to the hospital will have at least one care transition meeting: All clients admitted to the hospital will have at least one Care Transitions meeting attended by ABC Hospital and XYZ staff

Numerator: # clients admitted to hospital how at least one CT meeting
Denominator: all clients admitted to the hospital

Other metrics could be created based on what you and your transition of care partner decide!

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Depression Dashboard with Care Transition Data

TRACKING PROGRESS AND ADJUSTING TREATMENT APPROACH

Click here for Patient Tracking Spreadsheet Template resources

1) EVERY time this worksheet is used, ensure all other versions of the template are CLOSED, and press "Ctrl+J" to refresh the page.
2) Do NOT use the Caseload Overview if fewer than 2 ACTIVE patients are entered on the Patient Tracking worksheet.
3) Do NOT change the number of rows or columns. If you need to make a[illegible]hanges to th[illegible]ble wha[illegible]ver (othe[illegible]n sort and filter), use the de-identified template provided at the link to the left.
4) Be aware that at least one PHQ-9 score must be entered for a given re[illegible] in order fo[illegible]t recor[illegible]AD-7 sco[illegible]o display properly in the Caseload Overview.

			Treatment Status					Trans[illegible]s of Care[illegible]us				PHQ-9				GAD-7				Psychiatric Case Review	
			! The most recent contact was over 1 month (30 days) ago The next follow-up contact is past due					✓ [illegible]g Occurre[illegible]ded w[illegible] ! C[illegible]ing didn't happ[illegible] seen wi[illegible]				✓ The last available PHQ-9 score is at target (<5 or 50% decrease from initial score) ! The last available PHQ-9 score is more than 30 days old				✓ The last available GAD-7 score is at target (<10 or 50% decrease from initial score) ! The last available GAD-7 score is more than 30 days old					
View Record	Treatment Status	Name	Date of Initial Assessment	Date of Most Recent Contact	Date Next Follow-up Du[illegible]	Number of Follow-up Contac[illegible]	Weeks in Treatment	Date of Admit to ABC Hosp	Date of D/c from ABC Hosp	CT Meeting	7 day f/u appt	Initial PHQ-9 Score	Last Available PHQ-9 Score	% Change in PHQ-9 Score	Date of Last PHQ-9 Score	Initial GAD-7 Score	Last Available GAD-7 Score	% Change in GAD-7 Score	Date of Last GAD-7 Score	Flag	Most Recent Psychiatric Case Review Note
#N/A	Active	Beverly B	11/1/2016	11/12/2017	11/25/2017	0	3	11/15/2017	11/22/2017	11/20/2017	yes				No Score	-100		4274300%	10/24/2016	0	
View	RP	John Doe	1/15/2016	! 11/16/2016	⚑ 12/16/2016	12	53					20	✓ 0	✓ -100%	! 11/16/2016	14	✓ 1	✓ -93%	! 11/16/2016		11/1/2016
View	Active	Susan Test	5/20/2016	! 1/2/2017	⚑ 1/16/2017	10	35					22	15	-32%	! 1/2/2017	18	14	-22%	! 1/2/2017	Flag for discussion & safety	9/15/2016
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FREE UW AIMS Excel® Registry (https://aims.uw.edu/resource-library/patient-tracking-spreadsheet-example-data)

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Step 6. Map the Care Pathway

A. A care pathway **workflow** is a **sequence** of connected clinical and administrative process steps diagramed/flowcharted to explain the movement of materials, information, or people through a process that has clearly defined start and stop points.

   Did you get all the clinical & administrative steps diagramed?

B. Promotes understanding of each team member's role(s).

   Did you identify what members of the team do what in the workflow?

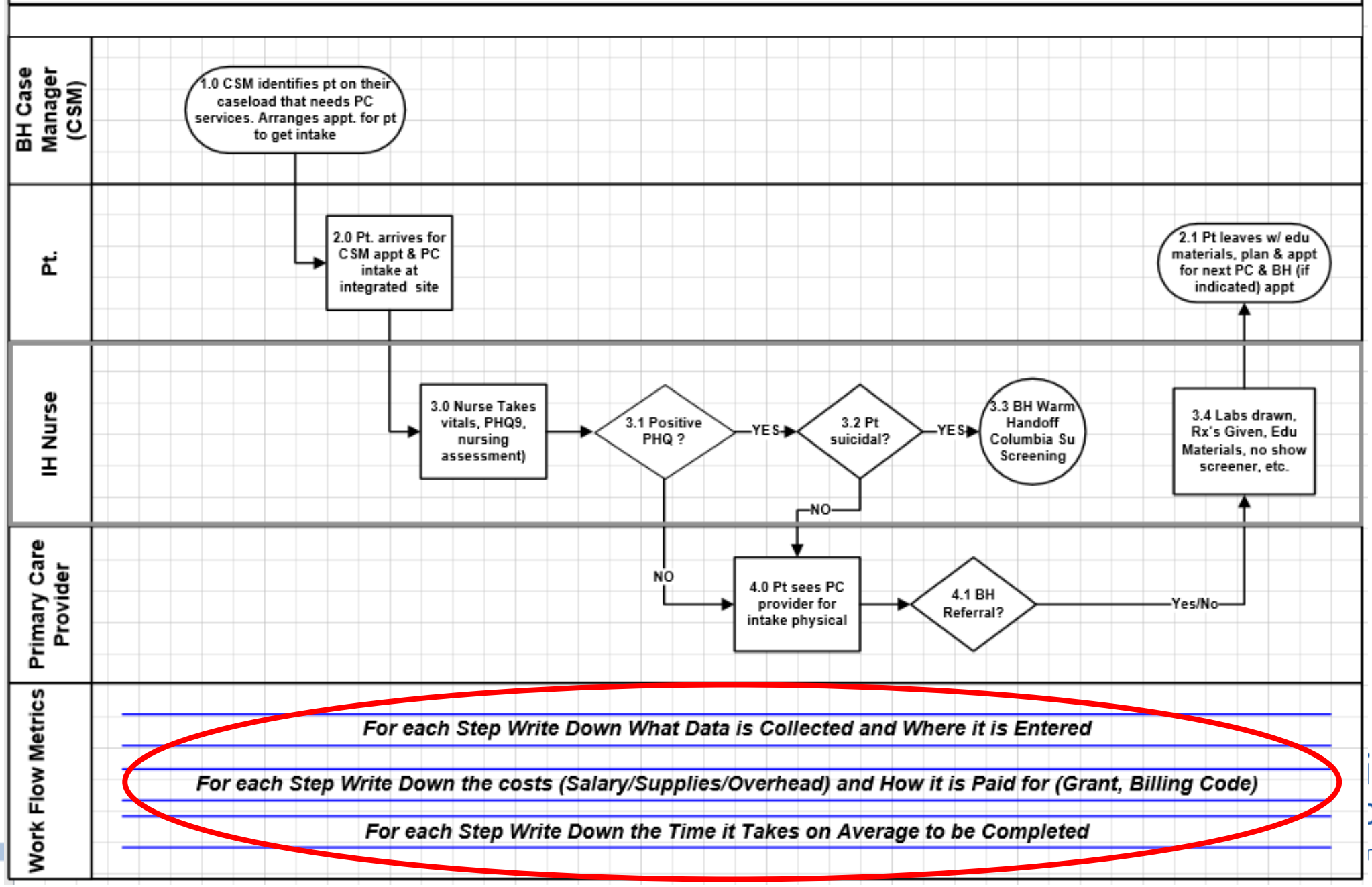
C. Clarifies the process and outcome measures being used to collect data and report findings as part of a population health management and risk stratification approach?

   Did you define the measurement tools and data to be collected? Did you explain how it will be collected, analyzed, and shared?

D. Estimates the cost associated with providing the service.

   Does the workflow indicated what is billable and what is not so a cost estimate can be obtained?

XYZ CMHC: Depression Care Pathway



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Critical for Effective Billing

4.0 REGISTRATION FOR PRIMARY CARE: Train consumer on getting

- Demographics
- HIPAA Release
- Patient Rights
- Insurance/Income
- Consent to Treatment
- Medical History

Makes an appointment for the next day if PAR not in or takes paperwork to PAR who makes appointment

CPT Code	Diagnosis Code	Credential	Who/Rate/Service
CPST – 51% in community	Behavioral Health Diagnosis	LMHP, MD, APRN CNS	$20.28/15 minutes
Community Support Service Under Rehab Option – PSR – Skill Building	Behavioral Health Diagnosis	LMHP, MHP or MHS under supervision of LMHP	$12.50/15 minutes

TIME NEEDED: 20 minutes

DOCUMENTED IN: MH/MR Clinical Record – Note must show rehab

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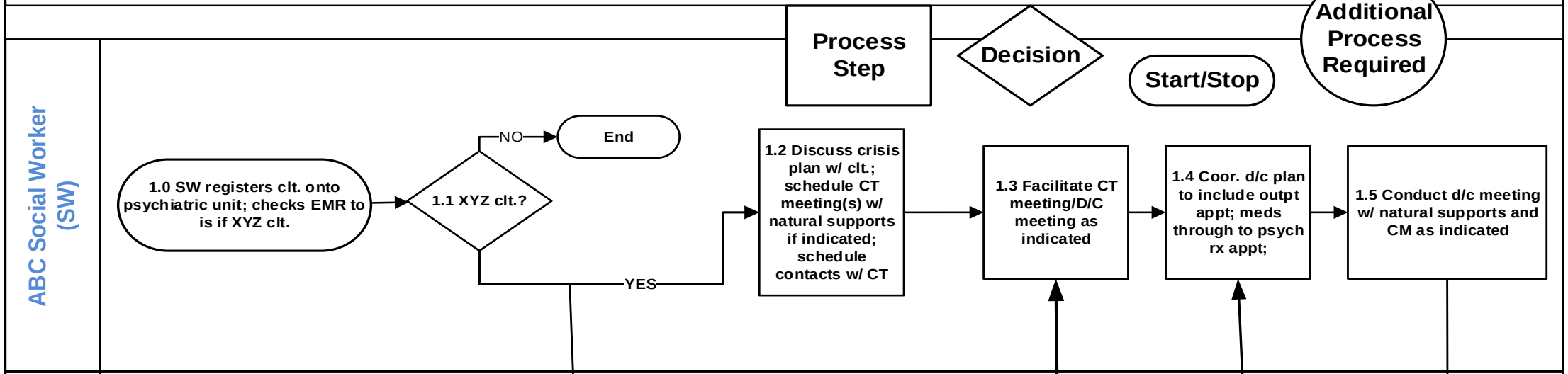
XYZ CMHC & ABC Hosp: Transitions of Care Pathway

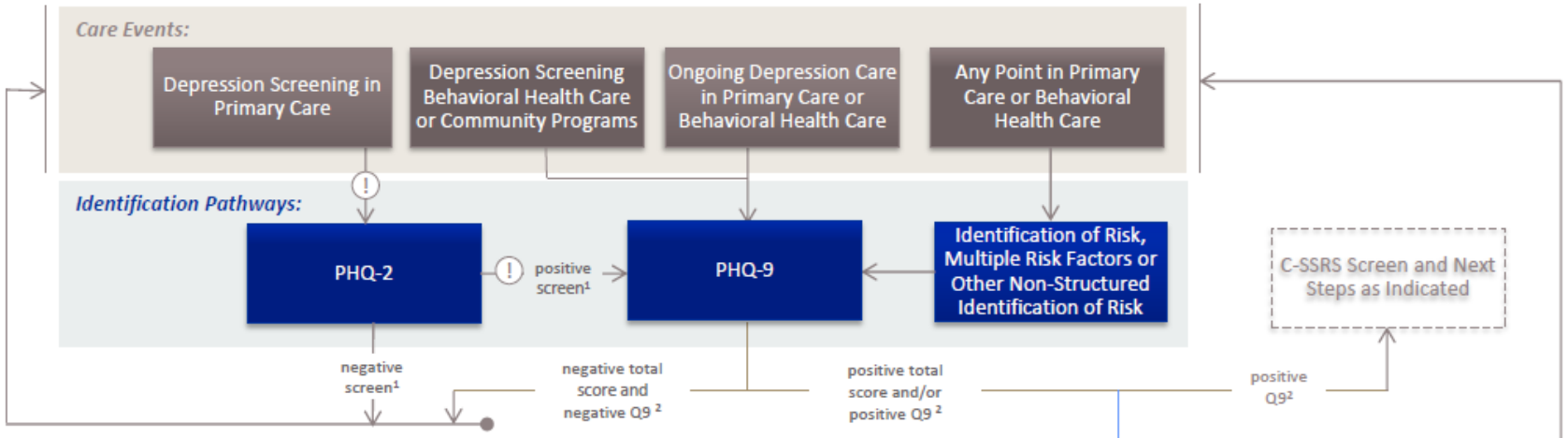


Work Flow Metrics

For each Step Write Down What Data is Collected and Where it is Entered

For each Step Write Down the costs (Salary/Supplies/Overhead) and How it is Paid for (Grant, Billing Code)

For each Step Write Down the Time it Takes on Average to be Completed



Managing Depression: Clinical Pathways in Primary and Behavioral Health Care

THE INSTITUTE FOR FAMILY HEALTH

Foundational Performance Metrics:

- ✓ Screening Rate

<u>90 Days following first PHQ-9 Administration:</u>

- ✓ Percent of Patients with At Least Two PHQ-9s in Initial 90 Days Following First Out of Patients with At Least One PHQ-9
- ✓ Percent of Standard Met in Initial 90 Days out Of Patients with At Least 2 PHQ-9 Scores

<u>90 Days preceding Last Administration of the PHQ-9:</u>

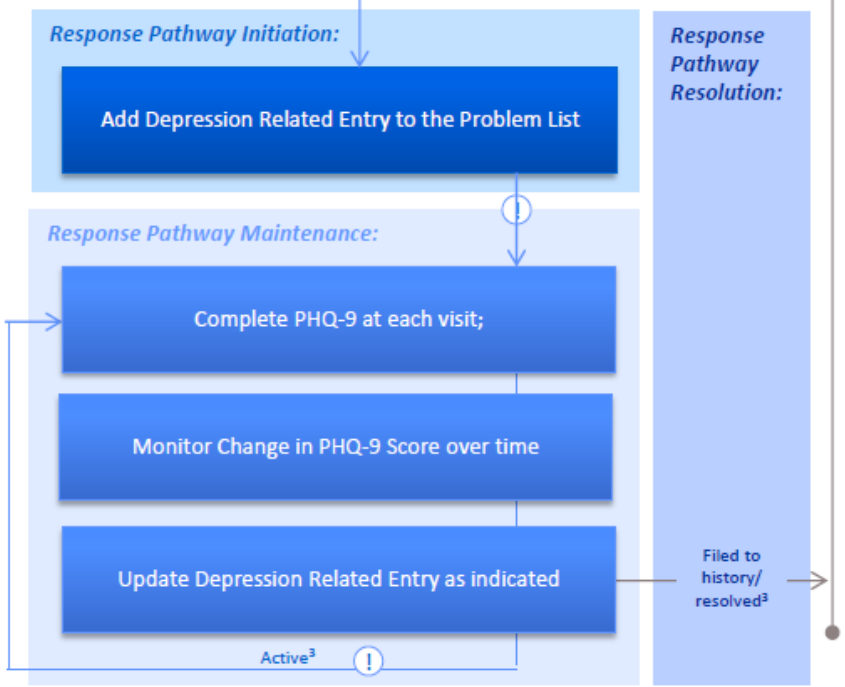
- ✓ Percent of Patients with At Least Two PHQ-9s in 90 Days Prior to Last Out of Patients with At Least One PHQ-9
- ✓ Percent of Standard Met in 90 Days Prior to Last Out Of Patients with At Least 2 PHQ-9 Scores

Icon Key:

ⓘ Indicates that Clinical Decision Support is in place to support movement along pathway.

Notes:

1. Negative on PHQ-2 is defined as a score of 0; Positive on PHQ-2 is defined as a score of 1-2.
2. Negative Response to PHQ-9 is defined as a score of 0-9; Positive Response to PHQ9 is defined as a score of 10-27.
3. Active or File to History/Resolved is determined in accordance with guidelines included in Appendix A: Problem List Entry Guidance



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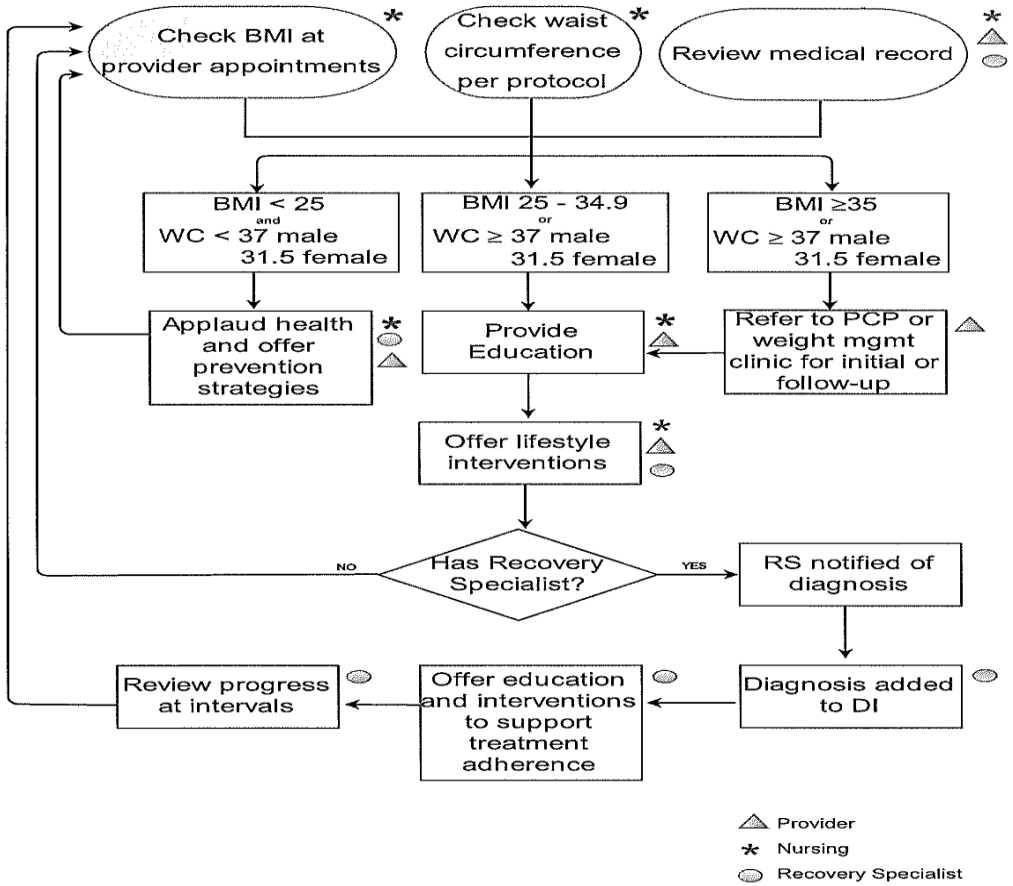
HSC
Partners In Healthcare

Obesity



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Conducting a Data Tracer to Help Map Your Care Pathway

Purpose of the Data Tracer exercise is to trace data from granular level/first collection through to aggregation/use.

1. What data point is collected?
2. Why is it collected?
3. When is it collected?
4. When is it reviewed, how & by whom?
5. How is it used by the consumer, consumer's natural supports, care provider(s), administrator(s), funder(s) & accrediting bodies?

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Data Tracer Example

- **What is collected?:** PHQ-9
- **Why is it collected?:** To screen & assess for depression & suicide; Required by state; Evidence-based practice/treatment
- **When is collected?:** Collected at intake & every visit thereafter if consumer scores positive otherwise given annually
- **When is it reviewed, how & by whom?:** Each session the clinician shows the consumer their score; At least wkly clinicians review scores to identify outliers; Supervisor reviews scores for caseloads at least monthly; Quarterly chart audits, Team huddles, Quarterly as part of team report to utilization review team & for upload to the state. Data are accessed by EMR data dashboard report
- **Where is it collected?:** Consumer fills out paper form in waiting room & form is reviewed by therapist. The score is entered into EMR
- **Who uses the data?:** Consumer uses it along with therapist & prescriber to chart progress in reduction of depression symptoms; Administration uses data to monitor strategic plan goal to achieve 80% of tx targets; State uses data to monitor CCBHC progress/effectiveness

Step 7. Develop Clinical & Amin. Protocols

Clinical

- **Screening & Assessment (PHQ-9 & Columbia Suicide Screen; Clinical Interview)**
- **Level of Care Determination**
- **Person-center Plan w/ Treatment Targets (includes family involvement & crisis plan)**
- Clinical Practices:
  - Cognitive Beh. Therapy
  - Motivational Interviewing
  - Trauma Informed Care
  - Case Management
  - Medication Therapy
  - Family Psychoeducation

Administrative

- **PHQ & Columbia Data Entry**
- Biopsychosocial Documentation &/or Progress Note
- Care Coordination Data Entry (e.g., referral, scheduling, data sharing)
- **Team Huddle**
- Individual & Group Supervision
- **Billing & Revenue Cycle**

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Next steps:

8. Pilot the care pathway:

Develop a plan for piloting the Care Pathway

- Identify a small group (team/patients) who will try it out
- For how long?
- Who will lead?

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Finally:

9. Evaluate the efficiency & effectiveness of the care pathway

- How will you know if the pathway is effective?
- Have you built in your data points for reporting and for evaluating whether what you are doing is working?
- What other services/community supports etc. do you need to make this plan effective (e.g., care coordination)?

10. Ongoing monitoring of the care pathway metric specifications

- Once the Care Pathway is standard operating procedure make sure to use CQI tools to monitor it and insure it stays within specification.

This is all well & good…but now what… How do we start?

You can't know where you're going unless you first know where you stand and where you want to go!

1. Conduct a baseline assessment for care pathway development to know where you stand!
2. Take inventory of your resources:
   a. Who are you (i.e., CEO, Middle Manager, Frontline Staff Champion)?
   b. How many resources do you have (i.e., staff, time, etc.)?
   c. What is realistic to be accomplished knowing a & b?
3. Define the SMART goal(s) (i.e., by XX date we will have accomplished X)
4. Develop your work plan and get to work!

Care Pathway Worksheet/Assessment

Instructions: Each member of your team should fill out this worksheet on their own. Once all team members have completed the worksheet meet as a team and discuss your findings. Averaging the scores across team member can help target areas of Care Pathway strength and opportunity.	**Agree 3**	**Mixed 2**	**Disagree 1**
1.) Our organization has care pathway protocols describing the steps for how clinical conditions and social determinants of health needs are addressed through our services.			
2.) Our care pathway protocols include the collection, analysis, and monitoring of process and outcome measures specific to the clinical condition or social determinant need.			
3.) Our job descriptions describe the specific scope of practice for each member of the interdisciplinary team (i.e., clinical and administrative staff).			
4.) Our mental health, substance use disorder, and physical health care clinical pathway protocols are based on the latest evidence-based practice guidelines.			
5.) Our social determinants of health care pathway protocols are based on latest evidence-based practice guidelines.			
6.) Teams have access to service cost estimates for clients being served.			
7.) Teams have access to timeframe estimates for achieving clinical and social determinant need outcome metrics.			
8.) Our care pathways clarify the process and outcome measures being used to collect data and report findings as part of a population health management and risk stratification approach.			
9.) Teams have access to the process and outcome data collected in the care pathways.			
10.) A risk stratification process is clearly described in our care pathway protocol to help with decisions about stepping consumers up to more intensive services or down to less intensive services.			
11.) We are using clinical and administrative data dashboards to aggregate and easily convey data findings for individual clients and populations served.			
12.) Group and individual supervision include the monitoring of staff/team fidelity to the pathway protocols.			
13.) Our teams have regular huddle meetings to discuss clients who were just seen and about to be seen.			
14.) Our team has established open, safe, communication patterns.			

Questions?

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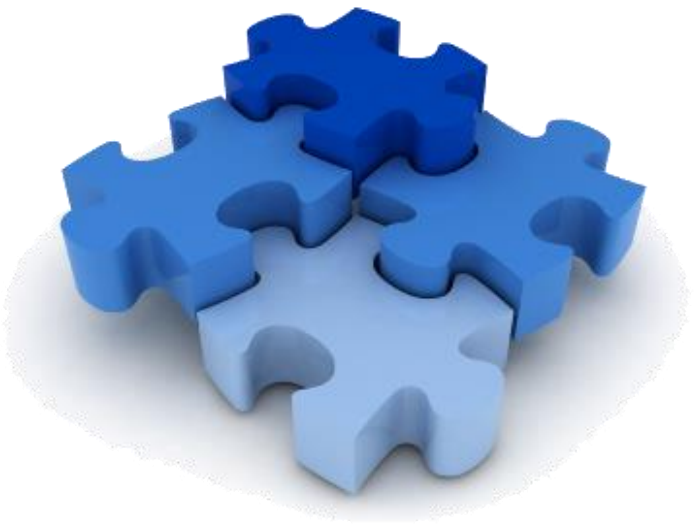
Sustainable Business Operations	3.1 Strategic use of practice revenue 3.2 Staff vitality and joy in work 3.3 Capability to analyze and document value 3.4 Efficiency of operation

Tying it Together



- Care Pathways Workshops
  - Identify the need
  - Mapping a care pathway
  - Discuss challenges to creation of care pathways
- Behavioral and Physical Health Co-Management Webinar Series
  - **1st Webinar:** Reducing Fragmentation Through Coordinated Care – Thursday, January 17, 12-1 p.m. ET (CEUs available)

Care Transitions Network
for People with Serious Mental Illness

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Thank you!

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