THE KNOWLEDGE, SKILLS AND ATTITUDES FOR THE AFFORDABLE CARE ACT AND HEALTHCARE REFORM

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PRESENTATION

OVERVIEW

The KSA’s to leverage agency/practitioner strengths and improve revenue within evolving behavioral health landscape
Sections Overview

• Knowledge of the important sections of the Affordable Care Act

• Skills for understanding and engaging third party payers

• Attitudes that are essential for successful navigation of the healthcare landscape

• A template to help with strategic planning and understanding important components needed to leverage and prioritize tasks
KNOWLEDGE

Important sections of the Affordable Care Act for Behavioral Health Practitioners
Three key points to start…

1. For the next 1.5 hours you can ask any question about managed care or the business of behavioral health but may have been afraid to ask…maximize our time together!

2. The complexity of the healthcare delivery system and payer system in the US is staggering which leads to two realities right now: First, you can help shape the behavioral health components right now—perhaps like never before AND don’t feel bad if you don’t understand much of it and feel overwhelmed…you are not alone!

3. Much of the system does not make sense…however, the ACA has helped make it (potentially anyway) much more cohesive and sensible.
The Patient Protection and Affordable Care Act
Consumer Protections: Coverage

- **Ends Pre-Existing Condition**: Health plans can no longer limit or deny benefits to due to a pre-existing condition.

- **Keeps Young Adults Covered**: under 26 eligible to be covered under parent’s health plan.

- **Ends Arbitrary Withdrawals of Insurance Coverage**: Insurers can no longer cancel your coverage because of an honest mistake.

- **Guarantees Right to Appeal**: Assures right to ask plan reconsider its denial of payment
Consumer Protections: Costs

• **Ends Lifetime Limits on Coverage:** Lifetime limits on most benefits are banned for all new health insurance plans.

• **Reviews Premium Increases:** Insurance companies must now publicly justify any unreasonable rate hikes.

• **Helps Get the Most from Your Premium Dollars:** premium dollars must be spent primarily on health care – not administrative costs.
Consumer Protections: Care

- **Covers Preventive Care at No Cost**: Most eligible for recommended preventive health services. No copayment.

- **Protects Choice of Doctors**: Choose the primary care doctor wanted from your plan’s network.

- **Removes Insurance Company Barriers to Emergency Services**: Options for emergency care at a hospital outside of your health plan’s network.
Additional Important Features of ACA

- Expanding the marketplace.
- Increased access to Medicaid.
- Providing new coverage options for young adults.
- Making prescription drugs affordable for seniors.
- Preventive services with no cost or co-pay.
- 80/20 rule.
- Scrutinizing unreasonable premium increases.
- Removing lifetime limits on health benefits.
- New coverage options for individuals with pre-existing conditions.
- Uninsured 49.9 million over 16% of the population—ER and LT Costs
- October 2013 open enrollment coverage started on Jan.1, 2014
Triple Aim of Healthcare Reform

• Improving the patient experience of care (including quality and satisfaction);
• Improving the health of populations; and
• Reducing the per capita cost of health care.
Achieving the Triple Aim
Improved healthcare, improved health, reduced costs

These are the fundamental avenues of focus for improving care and outcomes, and enhancing employee health

<table>
<thead>
<tr>
<th>Payment Reform</th>
<th>Member Responsibility/Incentives</th>
<th>Population Analysis</th>
</tr>
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<tbody>
<tr>
<td>Performance-based contracting and other more sophisticated reimbursement approaches as providers’ sophistication matures <strong>Facilitates provider quality and accountability</strong></td>
<td>Consumer Tools/Transparency Centers of Excellence Benefit tiering/high performing networks <strong>Helps members make informed choices</strong></td>
<td>Sophisticated Analytics Intra-provider incentives Electronic Health Records that allow Provider Interoperability Consumer support tools <strong>Facilitates total population management</strong></td>
</tr>
</tbody>
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2014 Coverage Expansion

Below 133% FPL
($29,500 family)

Medicaid Expansion To Childless Adults
- Coverage for essential MH/SA at parity for benchmark plan
- Feds pay 100% for 3 years, then down 90%
- Simplified enrollment, express apps: web too
- Integrated data with State exchanges: one application
- Foster kids up to age 26

133 – 400% FPL
($88,000 family)

State Exchanges
- Coverage for essential MH/SA at parity & prevention @ no co-pays
- Helps individuals and small employers with purchasing health insurance
- Assist by voucher to pay premiums or cost sharing
- Develops consumer friendly tools & plain language on insurance
- One application to both exchanges or Medicaid; can do on the web
2010 Health Reform Timeline

- Prohibition of pre-existing conditions exclusions for kids under 19
- Extension of dependent coverage to
- Prevention Services at no cost to beneficiary
- MLR Ratio Requirement (2011)
2014 Health Reform Timetable

• Wellness Incentives to 30% of plan costs
• Individual Mandate
• Employer Mandate (pushed back to 2015)
• Prohibition of annual limits
• Guaranteed issue & renewability
• Exchange coverage begins
ACA by the Numbers

• **49.9 million** -- The number of uninsured Americans. That's 16.3% of the total population.
• **18.4%** -- Percentage of uninsured Americans younger than 65.
• **28.4%** -- The percentage of Americans 25 to 34 without insurance.
ACA by the Numbers

• **26.9%** -- Percentage of people earning less than $25,000 a year who are also uninsured.

• **256.2 million** -- The number of Americans who were insured in 2010.

• **195.9 million** -- The number of Americans with private health insurance in 2010, 64% of the total population.
ACA by the Numbers

- **169.3 million** -- The number of Americans who get their insurance through the workplace.
- **95 million** -- Number of people in the United States covered by government health insurance, 31% of the population.
- **48.6 million** -- The number of Americans covered by Medicaid in 2010.
- **$940 billion** -- The amount of money the Congressional Budget Office estimates it will cost to provide the expanded insurance coverage over 10 years.
ACA by the Numbers

• The tax rate high-income individuals would pay into Medicare, up from 1.45%. High-income is defined as individuals making more than $200,000 ($250,000 for couples filing jointly).

• **2014** -- The year that people who don't buy insurance will be penalized $95 or up to 1% in income.

• **19.1%** - Percentage of people living in the South who are uninsured, the highest percentage of any region.

• **24.6%** - The percentage of uninsured people in Texas, the highest of any state.

• **5.6%** - The percentage of uninsured people in Massachusetts, the lowest of any state.
Essential Health Benefits

The Affordable Care Act ensures Americans have access to quality, affordable health insurance. To achieve this goal, the law ensures health plans offered in the individual and small group markets, both inside and outside of the Affordable Insurance Exchanges (Exchanges), offer a comprehensive package of items and services, known as “essential health benefits.” Essential health benefits must include items and services within at least the following 10 categories:
Essential Health Benefits

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management, and
- Pediatric services, including oral and vision care
Parity Act

- In October 2008, President Bush signed into law the Paul Wellstone-Pete Domenici Mental Health Parity and Addiction Equity Act.

- This historic law requires most insurance plans to provide the same level of benefits for mental health and substance use disorder services that they provide for other health care conditions.

- The final rule that was issued on November 8th, 2013 through the Departments of Treasury, Labor and Health and Human Services. These rules govern the implementation of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA).
Unfolding Opportunities within Parity and Essential Health Benefits

- Prior authorization and utilization management
- Business cases to reduce costs of individuals and populations with chronic health conditions
- Peer supports, health navigation and care management
- ROSC
- SBIRT
- Integrated Care Models
- Many others (slide 74)
SKILLS

The nuts and bolts of partnering with third party payers
Integrated Care: From Silos....
A Good and Modern System

A modern mental health and addiction service system provides a continuum of effective treatment and support services that span healthcare, employment, housing and educational sectors. Integration of primary care and behavioral health are essential. As a core component of public health service provision, a modern addictions and mental health service system is accountable, organized, controls costs and improves quality, is accessible, equitable, and effective. It is a public health asset that improves the lives of Americans and lengthens their lifespan.
Integration

The integration of primary care, mental health and addiction services must be an integral part of the vision. Mental health and addiction services need to be integrated into health centers and primary care practice settings where most individuals seek health care. In addition, primary care should be available within organizations that provide mental health and addiction services, especially for those individuals with significant behavioral health issues who tend to view these organizations as their health homes. Providing integrated primary care and behavioral health services will allow for cost effective management of co-morbid conditions.
To Systems of Recovery
2.87 Trillion Dollar Healthcare Spend

Exhibit 3. Health Spending by Category, December 2012

- Hospital care: 32%
- Physician & clinical services: 19%
- Prescription drugs: 10%
- Dental services: 4%
- Nursing home: 5%
- Home health care: 3%
- Remaining personal health care: 11%
- Other health spending: 16%

Source: Altarum monthly NHE estimates
Note: See Exhibit 5 for complete list of NHE categories
Profit, Admin & Medical Loss

**Medical Loss (2012)**
- Aetna $23.7 Billion (73%)
- United $80.2 Billion (76%)
- Wellpoint $48.2 Billion (79%)

**Administration**
- Aetna $6.8 Billion (11%)
- United $17.3 Billion (10%)
- Wellpoint $8.7 Billion (6%)

**Profit**
- Aetna $1.6 Billion (5%)
- United $5.5 Billion (6%)
- Wellpoint $2.6 Billion (5%)
Healthcare Spend (Billions)

- Hospitals $927
- Physician Services $555
- Prescription Drugs $280
- Other Prof Services $79
  - SA ~22 Billion
- Social Security $730
- National Defense Budget
  - 650 Billion
  - 4,950 Hospitals in U.S.
Percentages of Adults with Mental Disorders and/or Medical Conditions

People with mental disorders: 25% of adult population

People with medical conditions: 58% of adult population

68% of adults with mental disorders have medical conditions

29% of adults with medical conditions have mental disorders

National Comorbidity Survey Replication, 2001-2003
### U.S. Adults with a Mental Disorder in Any One Year

<table>
<thead>
<tr>
<th>Type of Mental Disorder</th>
<th>% Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety disorder</td>
<td>18.1</td>
</tr>
<tr>
<td>Major depressive disorder</td>
<td>6.7</td>
</tr>
<tr>
<td>Substance use disorder</td>
<td>7.0</td>
</tr>
<tr>
<td>Bipolar disorder</td>
<td>2.6</td>
</tr>
<tr>
<td>Eating disorders</td>
<td>2.1</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>.44</td>
</tr>
<tr>
<td><strong>Any mental disorder</strong></td>
<td><strong>26.2</strong></td>
</tr>
</tbody>
</table>
Median Age of Onset

One-half of all lifetime cases of mental illness begin by age 14, three-quarters by age 24

- Anxiety Disorders – Age 11
- Eating Disorders – Age 15
- Substance Use Disorders – Age 20
- Schizophrenia – Age 23
- Bipolar – Age 25
- Depression – Age 32
Trauma—Adverse Childhood Experience Study

- 17,000 Kaiser Permanente Members & Partnership with CDC
- 63% at least one category of trauma
- 20% at least 3 categories of trauma
- 11% emotional abuse
- 28% physical abuse
- 21% sexual abuse
- 19% grew up with someone in the household with MI
- 10% physical neglect
- 13% saw mother being treated violently
- 27% grew up w/someone using Alcohol and/or drugs
Trauma—Adverse Childhood Experience Study
Funding Sources

Federal, State, Local and Foundation Funding

ESI

Medicaid/CHIP

Healthcare Exchanges
The CBO Projects ESI Steady Through 2022

Expected Sources of Coverage (in Millions), 2012, 2017, and 2022

- **2012**: Non-Group 50, Medicare 53, ESI 34, Exchanges 29, Medicaid and CHIP 25, Uninsured 155
- **2017**: Non-Group 58, Medicare 42, ESI 25, Exchanges 29, Medicaid and CHIP 25, Uninsured 155
- **2022**: Non-Group 66, Medicare 43, ESI 25, Exchanges 30, Medicaid and CHIP 25, Uninsured 157

Source: Congressional Budget Office, Estimates for the Insurance Coverage Provisions of the Affordable Care Act, Updated for the Recent Supreme Court Decision, July 2012; Congressional Budget Office, March 2012 Medicare Baseline, March 2012 ESI = Employer-Sponsored Insurance

www.TheNationalCouncil.org
The Medicaid Client: A Reintroduction

The new Medicaid member may not be what you’re used to:

- 60% will have a diagnosable mental health disorder
- 83% have 3 or more chronic health conditions
- Dual eligibles are highly complex; they have unique needs that require special expertise
- Half of disabled Medicaid enrollees with psychiatric conditions have claims for diabetes, pulmonary, or cardiovascular disease – significantly higher than those without psychiatric conditions
- Health improvement and cost reduction will not occur without the successful treatment of behavioral and emotional health issues.
- Traditional systems of care must be supported by community services and programs that offer appropriate alternatives based on Recovery and Wellness.
Direction from Health and Human Services/Center for Medicare/Medicaid Services

- **HHS** and **CMS** are facilitating the following strategies as a major focus of Health care reform:
  - **Public Reporting**: engaging consumers and others stakeholders
  - **Health Information Technology**: enabling improvement
  - **Value-Based Payment**: rewarding achievement
  - **Clinically-Integrated Delivery Systems**: achieving patient-centered, coordinated care

- The Department of Health and Human Services in setting the stage for health care reform has commissioned the National Quality Forum to aid in the development of a national measurement strategy.

- NQF will be convening a behavioral health workgroup to examine and assimilate measures.
## Integrated Service Delivery Core Principles

<table>
<thead>
<tr>
<th>Principle</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td><strong>Whole Person Orientation</strong></td>
<td>Focus on integrated consumer direct mental and physical health wellness goals, offering programs and services that are aligned with and supportive of the individual.</td>
</tr>
<tr>
<td><strong>Coordinated Team Based Integrated Care</strong></td>
<td>Personalized care across acute and chronic problems, to include prevention and focus on the physical, social, environmental, emotional, behavioral and cognitive aspects of care.</td>
</tr>
<tr>
<td><strong>Enhanced Access</strong></td>
<td>Improved access in accordance with consumer preferences for the type of care and provider preference.</td>
</tr>
<tr>
<td><strong>Alignment of Incentives</strong></td>
<td>Enhance evidence-based screening, assessment and intervention that promotes health behavior changes that improve member outcomes, increase consumer and provider satisfaction, and prevents/decreases hospitalization.</td>
</tr>
<tr>
<td><strong>Recovery and Resiliency</strong></td>
<td>Empowering individuals with tools, services and resources that focus on personal recovery goals. Engaging peers as coaches, educators and supporters. Embracing unique community based services to strengthen consumer choice.</td>
</tr>
<tr>
<td><strong>Accountable Model/Outcomes</strong></td>
<td>Measurement and management of population health delivered by the entire care team with a focus on achieving the triple aim: better care for individuals, better health outcomes for population and reduced costs of care.</td>
</tr>
</tbody>
</table>
WORKING WITH THIRD PARTY PAYERS

Doing the Managed Care Dance
Stereotypes of MCOs

Managed Care/Insurance companies

- Overeducated
- Money grubbing, greedy, profit driven
- Don’t have real world experience…don’t “get it”
- Not interested in provider’s expertise, ideas
- Lazy, move too slow
- Bog providers down in regulation & details
- They don’t know what they are doing
- They are too big to be concerned about one client or one provider
Stereotypes of SA Providers

Substance Abuse Treatment Providers

- Undereducated
- Rigid, “one way to recover”
- Re-traumatize clients
- Confrontive, shaming of clients
- Black and white, right versus wrong thinking
- Don’t work well with other treatment modalities/professionals
- Poor documentation & outcome data
- Unfamiliar or indifferent to research/ EBPs
Understanding MCOs

- Both mission and margin driven—Medical Loss Ratio
- Significant numbers of employees former providers and in recovery
- Work to make system changes that can effect many people
- Are very familiar with laws, regulations and statutes from the source documents
- UR staff characteristics
# Behavioral Health Managed Care: A Reintroduction

## Partnership
- Relationship-centric
- Holistic health and wellness focus
- Federal, state and local Network Development and Management
- Innovative service and reimbursement models
- Person-centered focus and Recovery and Resiliency

## Integration
- Integration of behavioral and physical health including pharmacy
- Integration of health records
- Coordination of available benefits
- Chronic Disease management
- Pharmacy Management

## Innovation
- Provider partnerships and pay for performance programs
- Single Member Health Record
- Analytics/Outcomes
- Coordination of funding streams
- Telehealth
- Systems capable IT
Decision Making: How Managed Care Works

“The goal is equitable, efficient, effective and life enhancing systems at all levels.”

Decision Making:

1) Source Documents
2) Research and Professional Literature
3) Professional Experience
4) Cognitive analysis and Intuitive Reflection
Components of Most Behavioral Health Organizations and Partnering with Each

“Knowing the structure and purpose of each department and individual contacts within each make effective partnerships easier to attain.”

- Administration
- Finance
- Medical/Clinical
- Provider Relations
- Network Operations
- IT/DMA
- Claims
- Recovery and Wellness
- Quality and Compliance
- Customer Service
Strategies for Partnering with BHMCOs

1) Become DSM and ASAM Experts
2) Know your state’s Medicaid Plan and service definitions
3) Develop professional relationships with clinicians doing authorization/utilization
4) Use the appeals process vigorously
5) Investigate “Preferred Provider” status
6) Develop relationships with different departments
7) Offer your expertise when possible/make presentations that are data driven
8) Utilize “Principles above Personalities”
9) Use “person first” language
10) Start with a “walk through”
11) Share your change projects and perhaps invite participation…share status and outcomes.
Preferred Provider Status

Characteristics

1. Use of EBPs and evidence of good clinical outcomes.
2. Evidence of accessibility.
3. Administrative efficiency including use of electronic claims submission.
4. Utilizations of customer satisfaction surveys.
5. Addresses cultural health disparities and works well within a system of care.

Benefits

1. Potential for increased referrals.
2. Free Continuing Education.
3. Training Discounts.
4. Access to many additional mental health resources, assessment tools, appointment and medication notification tools that can be shared with clients.
5. Ranges of options to do on-site utilization management.
The Credentialing Process

1. Go to the BHMCO website
2. Click on “Provider Home” or “Join Our Network”
3. Obtain Provider Handbook
4. Obtain Credentialing Checklist and Application
5. Call Provider Relations With Any Challenges or Questions
6. Thoroughly, Completely and Accurately Complete Application
7. Don’t take NO for an answer…here’s why…
You’re seeing our redesigned website!
You’ll still find useful tips and other valuable information here — just now with a fresh, new look!

Provider Services

ValueOptions® touches the lives of more than 30 million people. Integral to the services we offer are our more than 127,000 national network provider locations.

As a provider, your expertise furthers our company’s mission of helping people live their lives to the fullest potential. To help you assist others, ValueOptions® provides secure, reliable, online tools for your use.

Please browse through this list of some of our online tools.

- **ProviderConnect®** is a secure application created with your needs in mind. It allows you to submit and review claims, check eligibility, update your practice profile, and view correspondences. It’s available 24/7.

- Our **ProviderConnect® Helpful Resources** link connects you to a user’s guide, HIPAA information, software downloads, important forms and helpful phone numbers.

- Our **Provider Handbook** contains information about our policies and procedures. Handbook topics include administrative procedures, clinical criteria, and employee assistance programs (EAPs).
ABHW Member Organization Credentialing

Links

• Aetna Behavioral Health
• Beacon Health Strategies
• CBHNP PerformCare
• Cenpatico Behavioral Health
• MHN
• New Directions Behavioral Health
• Optum Behavioral Health
• ValueOptions
Credentialing

- Provider Credentialing Criteria Checklist
- Site Audit Tool
- Application Process (up to 180 days)
ATTITUDES

Creating environments of value and positive therapeutic outcomes
The Story Teller...
The Law of Floatation was not discovered by contemplating the sinking of things, but rather by contemplating the floating of things which floated naturally and intelligently asking why they did so.”

--Thomas Troward, English Philosopher, Judge
Attitude and Aptitude

- Train
- Promote Empower
- Transfer
- Coach
Addiction Professionals.
Strategies for Success.

1. Create massive value.
2. Apply for Managed Care Panels.
3. Assess eligibility (funding streams and benefit packages) for target population and do strategic business plan to capitalize.
4. Become a Medicaid provider.
5. Partner with Employee Assistance Professionals, local companies and governmental organizations.
6. Apply for grant notification services.
7. Partner with physical health groups, health homes, medical providers, ER and Urgent Care.
8. Understand SBIRT/ROSC.
9. Development and Sustainability Officer/Committee.
10. Diversify—services and funding streams i.e. recovery coaching, integrated funding streams, training etc.
11. Importance of Professional Trade Associations like NAADAC.
Effective Engagement and Accurate Assessment

“Unless people believe it is safe enough to be vulnerable around us, we can never really teach them anything, for they will never let us see themselves as they actually are.”

(Rudolph Dreykurs)
Essential Qualities for Positive Therapeutic Outcomes

1) Factors related to what the client brings to the situation (about 40%)
2) The therapeutic relationship (about 30%)
3) Expectancy and Hope (about 15%)
4) An explanatory system that guides the healing practices (about 15%)
“This means that 60% of what accounts for whether or not a person responds to treatment hinges on the people delivering the treatment. If they develop a positive, warm, supportive and empathic relationship, support the development of hope that progress can be made, have a clear rationale for what they are doing that outlines a therapeutic map of recovery, and empower the client to help themselves, there is likely to be improvement.” (Bloom 2009)
Steve Jobs & Mike Markkula

- The first principle of the Apple Marketing Philosophy is empathy, an intimate connection with the feelings of the customer: We will truly understand their needs better than any other company. (Mike Markkula)

- The companies that truly stand at the intersection of Information Technology and the Humanities will create the opportunities, indeed, the economies of the 21st Century. (Steve Jobs)
Howard Schultz

- Valuing personal connections at a time when so many people sit alone in front of screens; aspiring to build human relationships in an age when so many “people sit alone in front of screens; aspiring to build human relationships in an age when so many issues polarize so many; and acting ethically, even if it costs more, when corners are routinely cut—these are honorable pursuits, at the core of what we set out to be.

- Getting back in our customers’ shoes, provided an enlightening and for some emotional exercise that underscored just how critical it was that all of us place the customer at the center of every meeting and business decision. If we had any hope of reigniting their emotional attachment, we had to replace our profit at any cost mindset.
1. Understand and involve the customer

Understanding the customers' needs presents a challenge to the field of substance abuse treatment. With insurance issues and budget constraints treatment agencies face pressure to treat more patients with fewer resources.

Successful companies that are committed to understanding their customers typically:

• Assume they do not know what their customers need and actively involve the customer in the improvement process;
• Ensure that the customer sees the improvement as significant and that it meets the customers key needs;
• Survey customers on a regular basis; and
• Educate customers about new improvements.
Making Changes

- Start with a “walk through”
- Services Scan
- Third Party Payer Scan
- Purchaser Scan
- Regulatory Scan
- Strategic Change Plan

“One of the best ways to understand your customers is to walk through the process as they do”. NIATx
Plan the Walk Through

1. Ask the Change Leader and one other person to play the roles of "client" and "family member." They will need to be detail-oriented and committed to making the most of this exercise. To ensure that their experiences will be as realistic and informative as possible, have them present themselves as dealing with an addiction you are familiar with, and thus are able to consider the needs of people with that particular addiction issue.

2. Let the staff know in advance that you will be doing the walk-through exercise. Ask them to treat the team members as they would anyone else.
3. Have the Change Leader and one other person go through the experience just as a typical client and family member would. The walk-through should begin with a customer’s first contact with your agency: an addict or family member interested in obtaining treatment services making a first call for information.

4. Try to think and feel as a client or family member would. Observe your surroundings and consider what a client or family might be thinking or feeling at any given moment. Record your observations and feelings.

5. At each step, ask the staff to tell you what changes (other than hiring new staff) would improve the experience for the client, family member, and staff. Write down their ideas and feelings as well as your own.
Study the Results

6. Make a list of the areas that need improvement along with suggested changes to attempt. Include the perspectives of the client, family member, and staff. Sort the ideas into those that are directly linked with your team’s improvement project and those that are unrelated.

7. As a team, discuss what went well with the walk through, what didn’t go well or was confusing, and what you would do differently the next time around.
Act on the Results

8. Share the results internally and with your small group.
9. Discuss how to incorporate the relevant change ideas into your project.
10. Decide how to handle the ideas that are not directly related to your project.
11. Share your lessons learned about doing walk-throughs in your organization
Outcomes

• Notes from walk-through
• List of practices that seem to work well from walk-through
• List of practices that don’t work well/need to be changed
THE VIA POSITIVA TEMPLATE: GETTING STARTED

“Whatever you can do, or dream you can do, begin it. Boldness has genius, power, and magic in it. Begin it now.” — Goethe
Plenty of Opportunities Unfolding

- Integrated Partnerships
- Helping to shape parity & essential heath benefit package
- Chronic Disease Management
- Recovery Oriented Systems of Care
- Evidence based practices
- SBIRT
- Direct Relationships with Purchasers/Payers/ASOs/Health Plans
- Trauma Informed Care
- Co-occurring disorder treatment
- Gender Specific Services
- Culturally Honoring Services
- Technology including Telemedicine
- Nicotine Cessation
- Obesity Coaching
- Life Skills
- Peer Mentoring
- Adolescent & Young Adult Services
- Healthcare exchanges
- Recovery Coaching
Completed by:
Reviewed by:
Approved by:

Approval date:

Overarching Goal:
To achieve increased funding, diversification and sustainability while preparing for and responding to changing market realities and funding streams, including Medicaid Expansion and the Patient Protection and Affordable Care Act.

Action Areas:

- Diversification and Sustainability Strategies
- Claims, Billing & Insurance
- Integration, Partnerships, Marketing, Outreach, Research & Training
- Data & Outcome Measures
- Clinical/Operational
Final Quiz!

Thank You!
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