NYC HEALTH+ HOSPITALS | BREAKTHROUGH

Using Lean to Integrate DSRIP, Managed Care and Community Based Services (HCBS) Into a Strategic Planning at NYC Health + Hospitals/Kings County

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Disclosures

- No potential conflicts of interest to disclose

Kings County Behavioral Health Services

The Behavioral Health Service at Kings County snapshot:

- 235 Certified Beds (Adult = 160; Pediatrics = 45; Chemical Dependency = 30)
- Philosophy of Care is Patient Centered and Recovery Oriented
- Adult Inpatient Admissions = 2,481; Discharges = 2,617
- Adolescent & Child Inpatient Admissions = 662; Discharges = 690
- Comprehensive Psychiatric Emergency Program (CPEP):

  Treat & Release visits = 7,479

  Extended Observation Beds (6) Admissions = 566; Discharges = 443
- Detox Admissions = 756; Discharges = 748
- Outpatient Visits = 158,807
- Total BH visits (CPEP & OPD) = 166,286

Box 1: Reason For Action

BH has done a great deal of pre-work to ready itself for the restructuring of both its financial operations and care delivery yet there remain significant gaps that will negatively impact our ability to realize our goals:

- Numerous initiatives from HHC corporate in response to new healthcare landscape.
- The heart of ambulatory care (AOPD) is unable to meet the current demand flowing from CPEP and Inpatient into AOPD and the anticipated future demand from our medical ambulatory services.
- AOPD remains largely a private practice model.
- Financial and business operations supporting clinicians and clinics is fractured and inadequate for new managed care landscape.
- Connections between CPEP, INPT & Ambulatory services are not tight.

We are unsure given the changing landscape if we have 1) the right disciplines, in the right roles, at the right times; 2) to deliver safe and evidenced based care; 3) when and where are patients and managed care companies need them; 4) for us to build a financially stable system; 5) that can grow with our community needs.

Box 1: Reason For Action (scope)

Scope: Behavioral Health has 3 major challenges for the next 12 months:

1) Sustain gains made through DOJ process for CPEP & Inpatient services (child/adult).
2) Build financial & operations infrastructure around CPEP, INPT & Ambulatory care.
3) Restructure how we deliver care in our adult ambulatory care services.

The focus of this VSA/VVSM is to develop a plan of action for integrating traditional mental health, medical health and chemical dependency services using the corporate initiatives for Managed Care, Access & DSRIP as our guide in redesigning BH ambulatory care – AOPD, CIU, PCC, PHP, CHEM DEP with our customers and suppliers.

Aim: Create a care delivery model that is evidence-based & financially sustainable throughout the continuum of care.
Trigger: CPEP, AIP or CIU identify adult ambulatory need.
Done: Patient seen by appropriate service within 5 days.

Box 2: Current State (pre-work)

- Not all initiatives aligned and prioritized with strategic goals in an effective manner.
- CPEP not used appropriately. There are patients that could be assessed elsewhere in our system.
- AIP must move from current 19 day stay to 12 days over the next 2 years.
- 33 days to next available AOPD appointment.
- Financially, when revenue, non-revenue & grants reviewed finds that BHS expenses exceed revenue by 1/3.

True North	Metric	Baseline & Sample Dates	Data Source & methodology
HD	• Turnover & Retention rates • Certifications by service (beyond what must do for licensure)	Analyzing data	HR files
Q/S	• HBIPS: 1) Psych Continued Care Plan created 2)Plan transmitted to next provider (INPT-OPD)	94.6% /78.8%	Average of Q32014-Q22015 HBIPS
	• AOPD: Quality Indicators 1) Is there a PE in last year for off site? 2) Positive SBIRT reflected in Tx plan?	62.5%/79%	Quality report Q2
	• Reportable cases ratio (soc met/not met)	57/10	SIRC report 1-6/15
A	• CIU: % seen • CPEP: Briefs • AIP: LOS 1) <15 days 2) >15 days • AOPD: Next available apt (TNAA)	75.5% 23.7% 8.5/34 26.87	2-8/2015 9/14-8/15 9/14-8/15 Soarian 6-8/15 avg
F	• OPDS Productivity by day • Cost/Revenue: AdultMH/PA/PHP • Denials: AIP • Overtime: AIP, CPEP & AOPD • Temp usage: AIP, CPEP & AOPD • Over 11 days AIP	272 $384,797 17 monthly avg 3,588 1,697 $268,030	FY15 Finance report
G	• Managed Care members (out of network)	1147	FY15 Finance report

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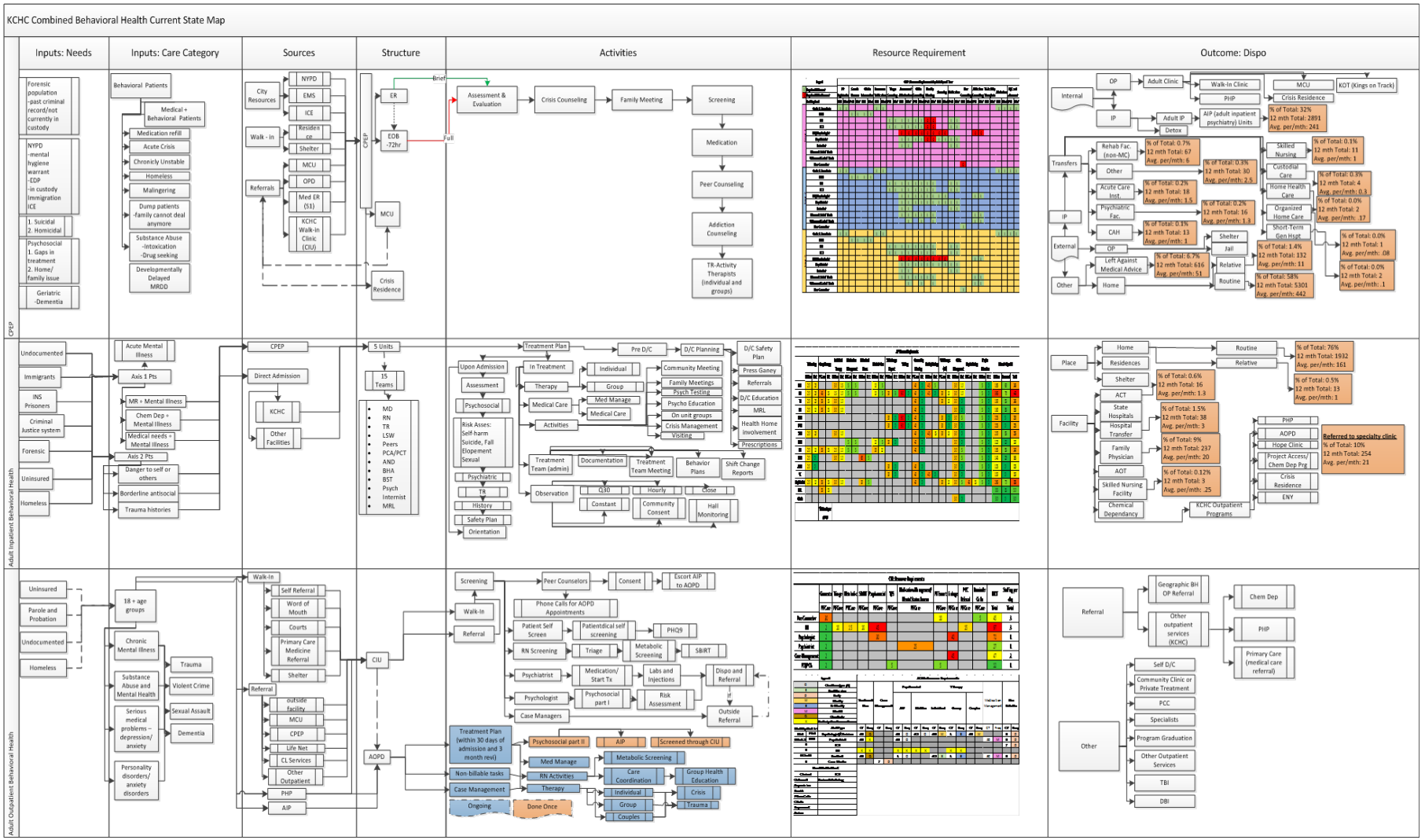
Box 2: Current State (pre-work)



Box 3: Target State (pre-work)

- All initiatives funneled through Breakthrough.
- Data driving behavior and unit/team based decisions
- CPEP work flows and staff patterns adjusted to meet projected demand.
- AIP workflows made nimble so that they can adjust to managed care changes.
- 5 day appointment availability in all ambulatory services.
- Financial acumen of staff and leaders improved and infrastructure built to deliver on and monitor financial success monthly to radically reduce current and projected deficits.

True North	Metric	Baseline & Sample Dates	Target
HD	• Turnover & Retention rates • Certifications by service (beyond what must do for licensure)	TBD	TBD
Q/S	• HBIPS: 1) Psych Continued Care Plan created 2)Plan transmitted to next provider (INPT-OPD)	94.6% /78.8%	↑ 99% / 95%
	• AOPD: Quality Indicators 1) Is there a PE in last year for off site? 2) Positive SBIRT reflected in Tx plan?	62.5%/79%	↑ 90% / 95%
	• Reportable cases ratio (soc met/not met)	57/10	Trends analyzed monthly and soc not met reduced.
A	• CIU: % seen • CPEP: Briefs • AIP: LOS 1) <15 days 2) >15 days • AOPD: Next available apt (TNAA)	75.5% 23.7% 8.5/34 26.87	↑ 95% ↓ 10% ↓ 5/12 ↓ 14 = good, 9 = very good, 5 = excellent
F	• OPDS Productivity by day • Cost/Revenue: AdultMH/PA/PHP • Denials: AIP • Overtime: AIP, CPEP & AOPD • Temp usage: AIP, CPEP & AOPD • Over 11 days AIP	272 $384,797 17 monthly avg 3,588 1,697 $268,030	↑ 20%=good, 30%=very good, 40% = excellent ↑ 20%=good, 30%=very good, 40% = excellent Less than 34 monthly (allow ↑ due to payment) ↓ 20%=good, 30%=very good, 40% = excellent ↓ 20%=good, 30%=very good, 40% = excellent $161,700
G	• Managed Care members (out of network)	1147	Reduction by month of 10%

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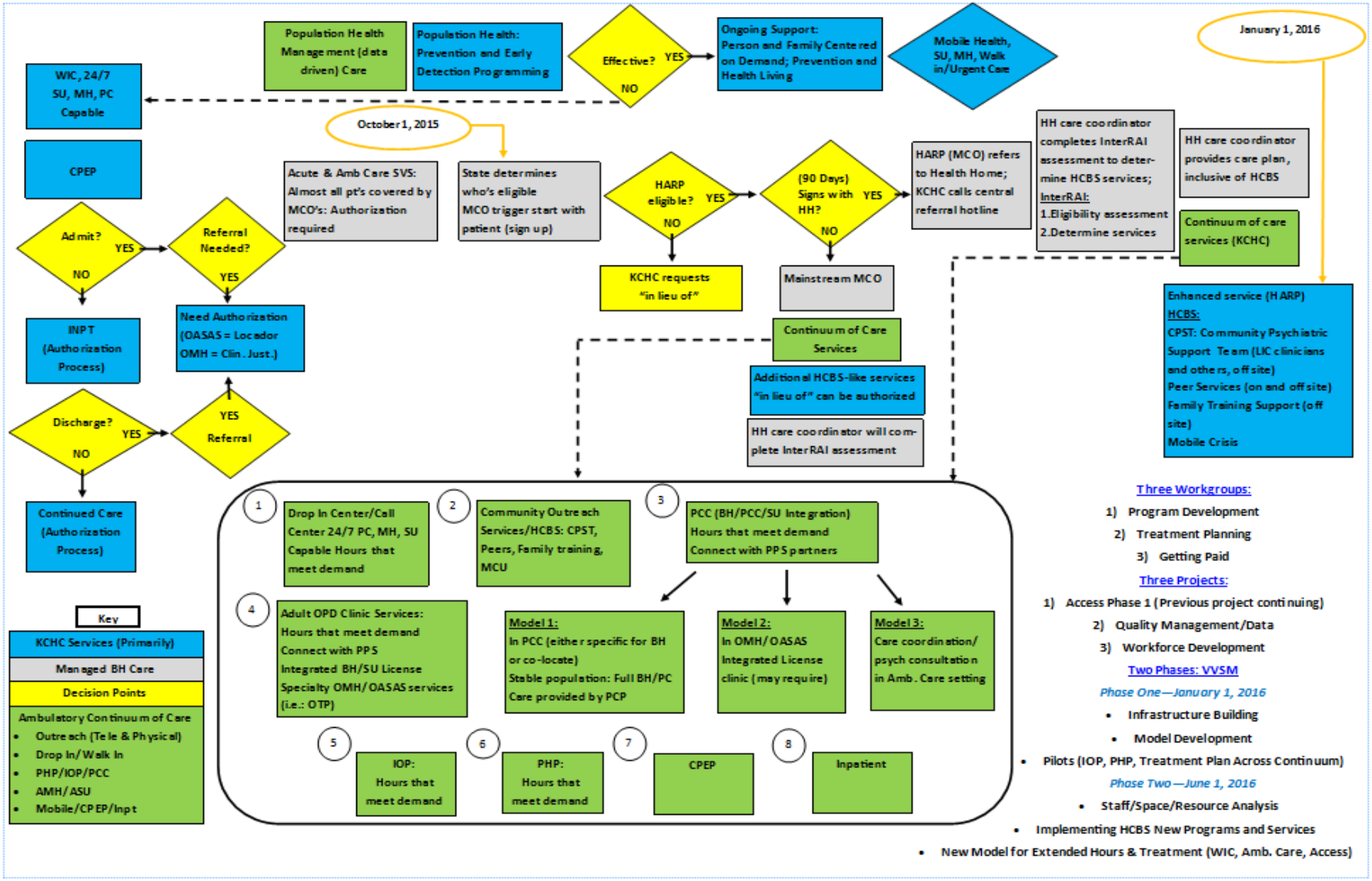
Box 3: Target State (pre-work)



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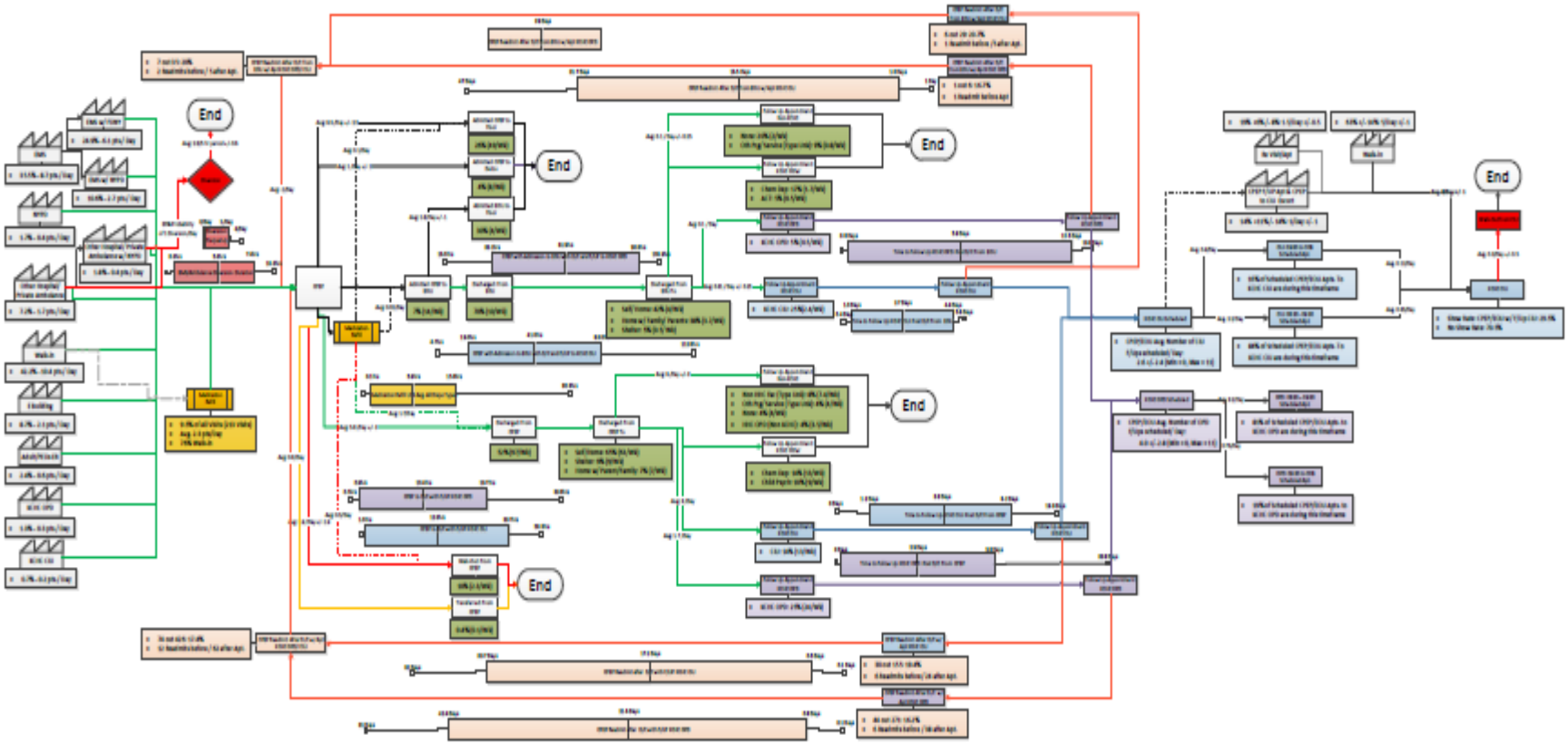
Box 3: Target State (pre-work)



- Process map of demand flowing from CPEP-WIC-AIP-AOPD.
- Utilized to revise Workgroup activity and develop RIE & Rapid Experimentation plans.

Box 4: Gap Analysis SWOT (pre-work)

Gaps: Managed Care/Access			
Strength	**Weakness**	**Opportunity**	**Threat**
• Learned a lot in pre-work & demonstration phase pilots • Range of services • Peer program in place • MRL's • Interdisciplinary teams on AIP and AOPD • IP and Recovery Center (early stages) • BH has a financial department	• Inpatient focused • 24% CPEP volume are briefs • Staff and management in early stages of understanding changes (Access, DSRIP, Managed Care) • No clearly identified "implementation team" • Pre-work is limited in scope and in early stages • Peer role needs to change • Unknown takt, resource allocation, infrastructure, and work flow needed for managed care	• IOT/IOP • WIC/Recovery Center • Expand hours in PCC, WIC & AOPD • Learn about and expand community relationships (DSRIP partners) • Group work • HCBS – capitalize • Initiative integration • Financial and clinical partnerships within KCHC BH • Coordination of HH care coordinator with providers	• Integration challenges • Aligned challenges • Financial risk/viability • Loss of market share • Recreating work and doing too much at KCHC BH • Evidenced based practice expansion while changing • Health Home capacity • Patient concerns regarding Health Home enrollment • OPD infrastructure • OPD flow between levels of care • Soarian functioning (system shifts after EPIC) • Addressing Managed Care, Access, DSRIP & AOPD structure while maintaining DOJ compliance in AIP and CPEP

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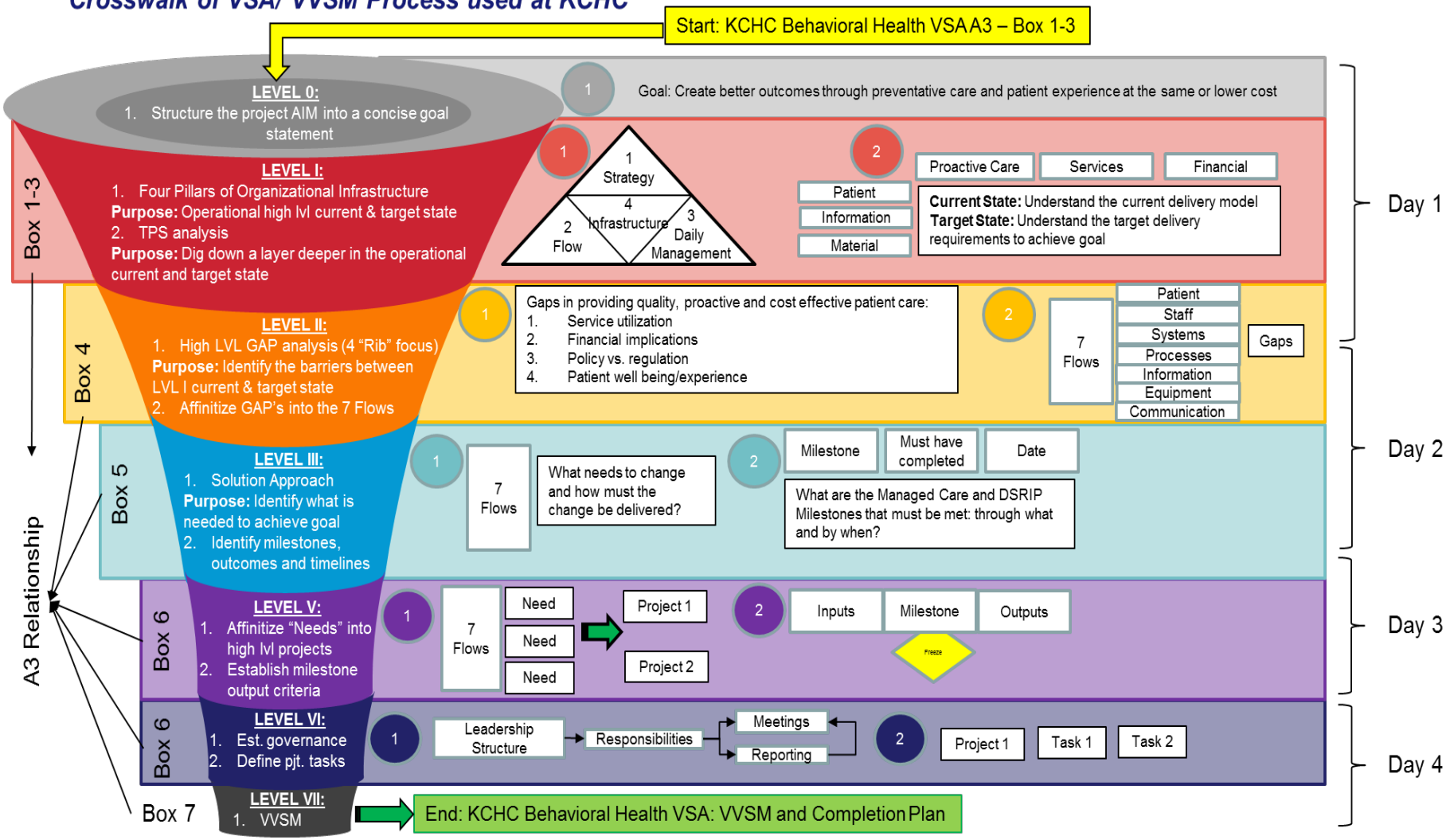
Boxes: 1-7 Event Structure

Behavioral Health Transformation

Crosswalk of VSA/ VVSM Process used at KCHC



Four Pillars of Operational Infrastructure

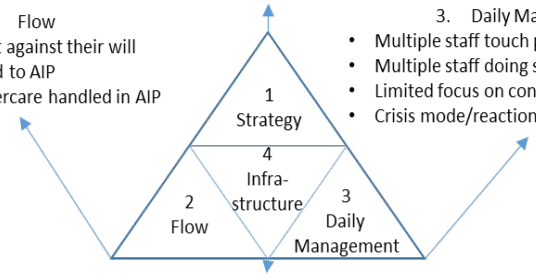
Goal: Create better outcomes through preventative care and patient experience at the same or lower cost

1 Current

1. Strategy
- Sit and wait for people to show up
- Focused on sick: services build on ER
- Model on crisis management
- Integrating medical & mental health

2. Flow
- Patients brought against their will
- Services directed to AIP
- Gaps in OPD aftercare handled in AIP

3. Daily Management
- Multiple staff touch points per patient
- Multiple staff doing same work
- Limited focus on continuum of care
- Crisis mode/reactionary



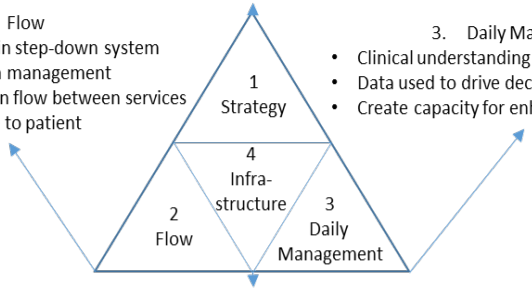
4. Infrastructure
- Fear of liability
- Treatment delayed until it is severe/Community mental health biases
- DOJ-mandated services/structure
- Community-based services not yet built/Unknown needs to support our services

2 Target

1. Strategy
- Remove silos, enhanced communication/Staff utilized effectively
- Preventative care, financially driven/True continuum of care for alignment of treatment
- Patient-centered, treatment plan follows patient

2. Flow
- Continue treatment in step-down system
- Patient-driven health management
- Improved information flow between services
- Services accountable to patient

3. Daily Management
- Clinical understanding of patient needs
- Data used to drive decisions and changes
- Create capacity for enhanced care



4. Infrastructure
- Staffing model based on demand/Care linked through EMR
- Monitoring/reporting structure in place
- Clear linkages/partnerships with external partners/Enhancing access/other specialty services
- Cross-clinical flexing of resources/Care allocated based on population health/demographics
- Employee satisfaction and retention

Understand the current delivery model

	Proactive Care	Services	Finance
Patient	• Safety net care • No model: proactive care • Same community outreach • Some patients don't want to utilize services	• Lack of community violence programs • Services driven by DOJ • Lack linked track to continue care • MCU/MRL in place	• Undocumented/uninsured • Lack finance infrastructure/ knowledge • Systems do not talk • Financial clearance
Information	• Extensive assess: poor knowledge pt history • Community & facility: different definition of stability • Qmed not in all service	• BH and Med cannot see others systems • Poor system to track, analyze/understand data • Understanding CPEP census in real time	• Do not understand changes to care plan if patient goes to a different facility • Co treat with other hospitals without talking • IP insurance different than OP
Material/ Resources	• Not utilizing or have in place the appropriate staff • Not a sophisticated management system in residence and community OP services • Community liaison • RN's in OPD to act as care managers		

Understand the target delivery requirements to achieve goal

	Proactive Care	Services	Finance
Patient	• Scheduling aligned with patient needs/ ease of access • Services based on community services • Create pull for OP services	• CBT, DBT, Schizophrenia, Trauma • Kings on Track • Medication, Geriatric track • Psychosis and Mood disorder	• Insurance information • Proactive care tracking & resource coordination • Partnership between patient, managed care & KCHC
Information	• Strength based assessment & treatment • Understand goal: quality vs. quantity • Collaborate IP&OP: case closing • Patient understands value of treatment plan	• Data analytic/reporting structure • Create the right expectations and measure and assess on this	• ID patients before CPEP: direct to non IP • Denial tracking and proactive problem solving • A standardized system in place ready for Managed Care and HSBC to start
Material/ Resources	• Clear understanding of coordination and guidance expectations from HARP etc.	• Leverage support services to free up capacity for other services • Pre- auth process standardized and staffed to not increase LOS	• UM resources in CPEP to ID patients • Build and standardize the financial support structure in CPEP, IP & OP

Box 3: Target State (event) using Four Pillars of Operational Infrastructure

Strategy:

1. Deliver consistent/ standardized, individual continuum of care
2. Deliver patient centered care through integrated services, staffed effectively and linked through strong communication that provides services when, where and how a patient desires.
3. Provide financially sound care that utilizes all types of Behavioral Health services to develop a treatment plan that is carried throughout the patients journey

Flow:

1. Patient driven integrated health management

Daily Management:

1. Data used to drive decisions and changes
2. Clinical understanding of patient mix and resources to provide tailored patient care

Infrastructure:

1. Care allocated by population health
2. Clear linkages and partnership with all internal and external partners
3. Cross clinical flexing of resources

Critical Elements:

1. Integrated systems that deliver whole person care
2. Coordinated care and transitions
3. Value-based payment within a strong sustainable network
4. Activated patients, consumers and clients who are equipped to fully participate in managing their health
5. Optimal access to appropriate services
6. Standardized performance measurement with accountability for improved outcomes

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Box 4: Gap Analysis 7 Flows (event)

7 Flows		Gaps
Patient		• Patient education & buy-in: how do we truly put the patient in the center of care • Patients required to interact with many providers to get Tx • Patients are not consulted on needs/desires prior to Tx • What do our patients want? Deliver services they want • Do we understand community need • Low census: Access, Hours, Language
Staff	**Resources**	• Staff resistant to change • Clinical staff at high burn out if tasked with pre-auth – attrition risk • Increased staff stress/dissatisfaction = poor patient experience • Lack flexibility • No system for staff accountability within many departments or processes • Do Union contracts all enough flexibility in staffing?
	Training/ Communication	• Clinical staff not familiar with billing codes and vice versa • Staff training not complex care capable • Clinicians not well suited/trained for changes in type of care needed • Providers not trained in IDDT • Lack clarity about insurance and impact on service
Systems		• Treatment trajectory tends to be long-term and not recovery oriented • Acute services over utilized • Have not built all needed levels of care • Medical/ psychiatric/ substance abuse not integrated in the same floor or clinic • Access to care is a challenge • Ambulatory services are not offering alternatives to acute care • Remove license barriers: patient should access service no matter where • State agencies have different regulations for different services • Multiple regulations: OMH, OASAS, DOH

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Box 4: Gap Analysis 7 Flows (event)

7 Flows			Gaps
Process	Finance	Resources	• Resource intensive UM demands • # of staff assigned for pre-auth may be outnumber by needs
		Process	• Not prepared for ICD-10 • Lack of clarity around billing and managed care • Who will get prior authorization?
	Clinical		• No/few clinical outcome measures that can be quickly acted upon • Concrete barriers: housing, transportation, child care • Are care plans truly patient centered • No best practice guidelines for the patient common/prevalent diagnosis • Seems to be a low threshold for our AOPD and outside OPDS to close cases due to risk • Community's unmet needs (Geri, TBI) are rule-out for our AOPD • High level regulations/processes not yet operationalized • Prevention model & clinical programming not or underdeveloped
Information			• Lack of clear outcomes data in OPD • Absence of actionable real-time data • EMR across services desperately needed • No clear way of tracking patient/ patient information across/between services

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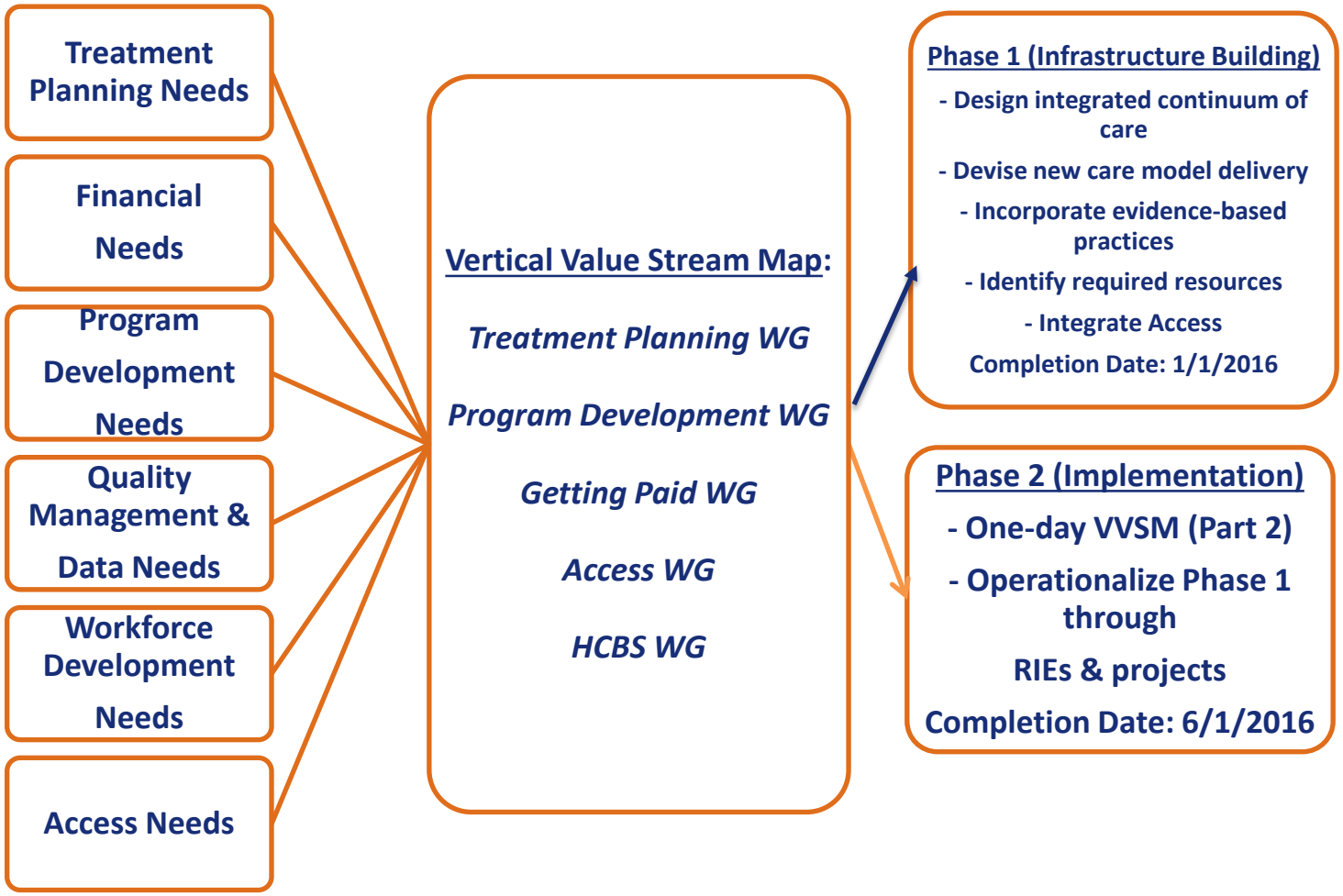
Box 5: Solution Approach

7 Flows			Needs
Patient			• Better first patient contact • Better initial assessment process that addresses wants, needs regulations, family and community involvement • HARP plan of care
Staff	**Resources**		• Needs effective structure for supervision and monitoring functions • Staffing on demand (match hours/locations with patient need) • Address case load/staffing ratio • Staff engagement strategy • Support staff development and training • Use DSRIP to advocate scope of licenses • Union workforce contracts
	Training/ Communication		
Systems			• Plan for effective licensing and ID regulatory barrier • System for monitoring and moving patients through the continuum (PCOMS?) • Services designed to match need and provide continuum of care • Understanding/ incorporate community services • Design effective billing system • Integration of care between services/clinics
Process	**Finance**	**Resource**	• Implementation of new billing system (appropriate staffing and process) • Align existing services with managed care initiative • COCUS system to ID patient level of care • Package services based on needs/ presentation • HCBS: Community Psych support team, peer services, family training/ support, mobile crisis • DSRIP compliance through evidence based practice • System for monitoring Tx effectiveness • Revising current services and incorporating HCBS/ community/ family involvement
		Process	
	Clinical		

Box 5: Solution Approach (cont.)



Box 6: Rapid Experiment (VVSM)

Project Due Date	Project Type and phase	Core Team						
		Lenic	Monuka	Roumen	Donna	Candance	Susan	Kristen
5-Oct-15	S1.a		SALT - Develop an effective structure for supervision & monitoring functions of management					
	P01.a					Prg Dvlp- Community Partners Project (MF & SC) Review list of community partners, identify gaps		Check in with each wo mgrs up (Octvian) Build data needs that address - population management, quality management, local data and financial data
12-Oct-15	P02.a					Prg Dvlp - HCBS: 1. Research/ understand community needs 2. build off Health Home pilot (review what was done and plan next steps)		
	P05.a						Prg Dvlp- AOPD Tx model: 1. Research models and evidence based practices 2. Understand community/ patient needs for AOPD care	
19-Oct-15	PM1.a		Getting Paid: (MR) ID workflow for clinical interaction with financial systems					
	TX1.a			Tx Plan: Revise Tx plan assessment tool for use in Ambcare				
	P04.a						Prg Dvlp - Urgent Care Entry Portal: Research/understand community needs	
26-Oct-15	PM1.b		Getting Paid:(UD) 1. ID workflow for finance 2. ID payors and authorization					
	TX1.b			Tx Plan: Integrate Tx plan across AIP & OPD - revisit UCA & UIRP - portability of data across services and with outside partners - Tx & care plan				
2-Nov-15	PM1.c		Getting Paid: (MR/UD) Integrate the clinical/ UM workflow that reflects the timeline of pilot (OPEP/Inpt/Opd)					
	P05&4.b						Prg Dvlp:(TR) Build OPD Processes	
9-Nov-15	P01.b					Prg Dvlp- Community Partners project: Stand and work for partnership process		
	P05.c						Prg Dvlp - AOPD Tx Model: Determine measurement process	
16-Nov-15	PM1.d		Getting Paid: (LD/KQ) Staffing resource model to support and train					
23-Nov-15								
30-Nov-15	TX1.c			Tx Plan/Train the trainers on Tx plan				
	P02.b					Prg Dvlp- HCBS: Choose services to deliver		
7- Dec-15	PM1.e		Getting Paid: (Tom: Amb/Eddie: Acute) Develop scenario and that reflects quality of clinical integration and inform supervisors of "health" of clinical business					
14-Dec-15								
21-Dec-15								
28-Dec-15	TX1.d			Tx Plan: Test Tx plan across AIP and OPD				
	P05.d				Prg Dvlp - AOPD Tx Model: Select AOPD Model			
	P04.c				Prg Dvlp - Urgent Care/Entry Portal: Select Entry Model Design			
1- Jan-16	M1		Milestone 1 : HCBS Service Start					
			0 Freeze Point	Outputs 1. Automated Sorian report AOPD (completed) 2. Reauthorization complete for 1900 patients (completed) 3. Experimental area specific dashboard/data record (Draft completed) 4. Current Service Functioning structure to bring in new patients and refer to next level of care (Plan and timeline completed) 5. Authorization process and staffing in OPEP and AOPR (Plan and staffing model completed) 6. Caseload/staffing ratio and staffing on demand (Plan created) 7. Authorization and reauthorization demand (Plan created) 8. UM Integration (Plan created) 9. Community outreach and coordination (Plan created) 10. PHP/IOP licenses (Needs Identified) 11. Treatment plan that reflects (justifies) acute need for continued services (Model created and tested) 12. HCBS: Develop CPST, Peer services, Family training,MDU, MRL(Plan and focus for phase 2 identified) 13. Site Engagement strategy 14. FTI Rate: 85% (Evidence of progress towards goal and plan) 15. TNAA: 5 days (Evidence of progress towards goal and plan) 16. No Show: 20% (Evidence of progress towards goal and plan)			

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Box 7: Completion Plan

WG	WHAT	WHEN
X	Create work standard for VSST and for workgroups: ▪ DMS coaching (M. McKenzie) & Workgroup coaching (Jenna & Jason)	*10/7/15*
X	Verify dates and roles defined on VVSM map	*10/9/15*
X	Launch each workgroup: ▪ Team selected; Meeting schedule set & Boxes 1-3 & 7 ready for VSST.	*10/27/15*
X	Reach out to workgroup teams and schedule first meeting: ▪ Getting Paid Workgroup ▪ Program Development ▪ Treatment Planning	*10/13/15*
X	Align BHS table of organization to workgroup governance from VSA/VVSM	*11/18/15*
X	Finalize AOPD leadership structure	*11/18/15*
X	Communicate clear plan to staff via Town Hall meetings, BH newsletter & updated and simplified Mission Control Board: ▪ Finalized VSA/VVSM A3 ▪ Finalized EXCEL visual of VVSM project map ▪ Finalized Target State map ▪ Town Hall & Mission Control Board A3's POSTED	*10/30/15* *TH scheduled 12/9/15*
X	Schedule one-day VVSM session for Phase 2 (1/15/16)	*11/15/15*
X	Streamline data/analysis across DOJ, QC, SIRC, and Breakthrough: ▪ Investigation training ▪ SIRC & QUALITY sub-committee coaching support	*3/1/16*

Box 7: Completion Plan (cont.)

WG	RIE/WS	WHAT	WHEN
x		▪ Update workgroup completion plan to reflect VVSM specifics	*1/20/16*
x		▪ Double book pilot	*1/19/16*
x		▪ New encounter form pilot	*1/19/16*
x		▪ Update Access completion plan to reflect VVSM specifics	*1/20/16*
x		▪ OPD appointment scheduling process clarification – integration of finance, clinical, and schedulers	*2/17/16*
x		▪ OPD encounter form and Activity Guide roll out	*1/26/16*
x		▪ Soarian clean up and maintenance system	*2/5/16*
	x	▪ Centralized Scheduling Workshop: ▪ Double booking intake slots on centralized Soarian intake template ▪ Guide for how to find existing providers/last visit in QMed ▪ AIP intakes booked directly from AIP ▪ Can CPEP book directly into OPD (clear referral criteria)	*2/24/16*
x		▪ Update workgroup completion plan to reflect VVSM specifics	*1/20/16*

Box 7: Completion Plan (cont.)

WG	RIE/WS	WHAT	WHEN
x		Inform Dr. E that Recovery Center transition plan (from RIE) will be rolled into PC Integration workgroup and reported on monthly at VSST	*1/20/16*
x		Update workgroup completion plan to reflect VVSM specifics -regarding IOT development	*3/31/16*
x		Provide regular updates in AOPD staff meetings	*1/20/16*
x		Finance meetings and scorecard roll out Supervisory and leadership structure to support: Clinical, Finance Soarian (template availability, intakes)	*3/31/16*
	x	CPEP RIE: • Restructure WIC workflow, Briefs, CPEP team approach to care	*3/28/16*
	x	Restructuring AOPD work flow RIE: • Staffing pattern/afterhours calls for patients • Teams & Case management • SOW training for all staff • Training of Best Practices template & sequenced	*~~5/23/16~~* *~~6/27/2016~~* *7/18/2016*
	x	Restructuring WIC work flow RIE: Changes based on needs post prior RIE's listed above.	*~~6/27/16~~* *7/25/16*
		Child VSA: OUT OF SCOPE FOR THIS VSA – Notes here to be used for future VSA's. • Soarian/Workflows for end to end care in child services • Next Steps: need to set date & establish team for March 2017 VSA due to managed care rollout for child moved to July 2017	*~~8/1/16~~* *1/1/17*

Box 7: Completion Plan (cont.)

WG	RIE/ WS	WHAT	WHEN
		Find mechanism for how to imbed workgroup products into supervisory product/competency models 5/1/16: Drill down show gaps in SOW & use of PCB's Next Steps: Build into 2 upcoming RIE's and all VSA'a AND for areas that are not a focus of VSA – do in Monthly A3 mtg.	~~*5/1/16*~~ *6/27/16*
		Meeting to integrate workgroup products Getting Paid/Best Practices/Treatment Planning	*5/1/16*
		Identify coaches w/ Lean experience to guide workshops and future RIE's/Child VSA: 5/1/16: Exploring Training with K Q, A P, R B & T R & development of internal Learn training program Next Steps: Rethink how Quality & Training shops are structured to make room for this kind of work – new A3 for Quality started!	~~*5/1/16*~~ *10/1/16*
		Outpatient/Inpatient Best Practice Integration scheduled meeting	~~*6/27/2016*~~ *8/15/2016*

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BOX 7: BHS VALUE STREAM COMPLETION PLAN
GAPS & COUNTERMEASURES FOR REVIEW BEFORE CLOSING ADULT OPD VSA

WHAT
Close out AOPD VSA with plans for gaps and next steps (VSA/A3's)
BOX 7: **WORKGROUPS:** - GETTING PAID: Finance A3 1-2 day to address gaps in staffing plan of Getting Paid WG who/when - DATA TRACKING: Jordan Vanek will work on this with AOPD leadership when - HCBS: Pilot with H+H Health home & Healthfirst who/when - TREATMENT PLANNING: Monitored in Quality Council – explore UR process. who/when - ACCESS: A3 moved to monthly A3 meeting to address further spread and address no show rates and fill rates in AOPD. - PCC & BEST PRACTICES: A3 driven Training plan developed to ensure all training initiatives planned (Partner for Safety, Co-Occur, PCC & Best Practices) happen. who/when **RIE's:** - AOPD: Training in Partner for Safety & Mock Codes then PCC/BEST PRACTICES when/who - WIC: Staffing schedule, huddle, flow. 90 days post - SOW INCOMPLETE: AOPD Resource Guide: SW intern to complete quick and final drafts Susan Cameron/Nov 1
BOX 8: - First 5 metrics were out of scope of this VSA or RIE's scheduled at end of year so lack of progress not of concern. - Final 7 metrics measured things we worked on and showed progress and gaps. Below are gaps ideas to work on through a variety of mechanisms.
FUTURE VSA's: - Identify coaches with lean experience to assist A3, VSA and RIE needs. - AOPD: VSA or A3? - Substance Use: OCT? - Child OPD: March?
Monthly A3 meeting & Quality Councils: - A3's: First Wed 2-4 (monthly) all services present working A3's to ensure continuous improvement & sustainment outside of VSST – status update after 9/7/16 meeting - Quality Council: SOW when metrics red or not improving

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Box 8: Confirmed State

Alignment	Metric	Baseline (9/2015)	Target	Jan. 2016	Feb. 2016	Mar. 2016	Apr. 2016	May 2016	Jun. 2016	Jul. 2016
Quality/ Safety	CIU: % Seen	75.5%	95%						76%	80%
Access	AOPD: TNAA	26.87	14	20	5	4	8	8	6	7
Finance	OPDS Productivity (by day)	272	299	310	365	323	314	360	307	268
Finance	Cost/Revenue (Adult MH, PA, PHP)	350,819	385,901	314,812	342,552	413,577	539,148	480,806	393,508	453,899
Finance	AIP Denials (monthly average)	17	34	22	14	22	12	9	16	15
Finance	Over 15 Days AIP ($)	268,030	161,700	131,859	130,193	88,249	64,092	119,070	93,639	71,099

Box 9: Insights

- Prep work (current & target state mapping, demand data, SWOT) extremely helpful…allowed us to do deep and multiple gap analyses in event and create a detailed methodical action plan using the VVSM tool.
- Rapid Experiments from January 2015 Visioning & Managed Care Transformation Pilots instrumental in shaping plan of action.
- Behavioral Health now has clear vision going forward, following DOJ achievements.
- Team representation across services (both within KCHC and outside) allowed for true understanding of developing healthcare landscape.
- DSRIP, Health Home, & BHS Transformation representation on team allows for more effective collaboration going forward.
- Flexible use of Breakthrough models & tools allowed team to adapt and integrate complex processes in a meaningful way.

Appendix: Event Recipe Card

VSA/VVSM RECIPE CARD

PREP PHASE

1) **Breakthrough Prep sheet: 90 DAYS PRIOR**
    - Clearly identify Scope, Aim, Reason for Action, Current and Target State narrative and associated metrics with BT shop and BHS leadership.
    - Suggest focusing on adult services first as BH Transformation initiative & Managed care focus is adult this year and finances don't change for child until 2017 as a way to help scope activity.
    - Reason for action should include need for integration of corporate initiatives around Primary Care Access, BHS Transformation, DSRIP, Managed Care & Health homes.
    - Pull all metrics required by various initiatives and regulatory agencies to inform your high level metrics.
    - Identify date & VSA/VVSM team members including BH senior leaders, site financial team, DSRIP HUB ED, Health Home rep from CO, Primary Care & BH Transformation CO coaches and Managed Care reps to event 30-60 days out.
    - Identify dates and teams to complete 3 maps: CPEP, INPT & AMBCARE services. Teams should be made up of Medical Director, Service area nursing and admin plus inter-disciplinary staff members.
    - Get VVSM paper.
2) **Current State Mapping:**
    - Schedule **CPEP, INPT & AMBULATORY CARE services current state mapping sessions** independent of one another as you would for a VSA (ie: flow map with data boxes, demand data for each service and hi utilizer data attached to maps).
    - Review for completeness and amend VSA level metrics as demand data and data boxes inform the depth of your challenges.
3) **Matrix of Meeting structure, Table of Organization & list of all ongoing projects:**
    - All projects going on to date (Breakthrough and non-Breakthrough) so that this information can feed gap analysis and solution approach in event.
    - Also gives a fuller picture of resources needed for Target State.
4) **Target State Mapping:**
    - High level map that shows full continuum of clinical services and financial infrastructure required from CPEP-INPT- AOPD that integrates the MCO, HH, HARP & DSRIP connections.
    - This is a tool that helps team see how these all interconnect and then the Target State maps then helps your team start with a series of gap analysis for your event.
5) **Gap Analysis part one:**
    - Complete a SWOT analysis using current and target state maps to give your team on day one of event a high level understanding of gaps.

Appendix: Event Recipe Card

EVENT ACTIVITY:

Day One

1) Review Boxes 1-3 of prep sheet; current and target state maps; SWOT.
2) Use 4 pillars model (see A3) to do a current and target state view through an operational infrastructure.
3) Finish day with a brainstorming session of all potential gaps using 5 categories (see A3).

Day Two:

1) Attach potential root causes and possible solutions to gaps.
2) List out all milestone dates for DSRIP, Managed Care, & BH Transformation.
3) Use 7 flows tool to filter solutions into a vertical and horizontal integration matrix.
4) Further synthesize solutions into 4-6 main buckets of work.
5) Identify project/workgroups based on 4-6 buckets of work.

Day Three:

1) Begin VVSM mapping for next 2 days.
2) Start with identifying 1 or 2 major milestones and associated dates on your map and spell out the outputs needed for both.
3) Break team up into 4-6 groups (according to buckets of work) and have them identify tasks need to do to break this bucket of work into smaller steps; attach phases to this work and identify who needs to be involved and then finally outputs for their phases.
4) Review **Matrix of Meeting structure, Table of Organization & list of all ongoing projects** to table to inform buckets of work and governance structure for your integrated model going forward (ie: how can current meetings be eliminated or added to ensure all work managed through a single structure like your VSST rather than having your initiatives and project work managed in silo's; do some roles need to change to support your efforts'?)
5) Label VVSM map as tool indicates (ie: dates down left side and core team, suppliers, customers across top).
6) Bring team together and use the work the 4-6 teams did to start VVSM map for rest of day 3 and most of day 4.

Day Four:

1) Bring team together and use the work the 4-6 teams did to complete VVSM map for rest of day.
2) Develop your box 7 tasks to drive this project (VVSM). VVSM project map is your box 6.