COLORADO

Most proud

★ Persisting through delays and state leadership changes on APM2, and continuing to support the CHCs on the team based care part of our payment reform (even with the delays).

Top 3 learnings

1. CCHN's long-term and deliberate efforts to partner with the state MK office has allowed for shared problem solving and innovation.
2. It has been hard to partner with our CMHC counterparts due to different priorities and continuous change in the MK landscape.

Change made possible

➔ Funding helped us convene our first Social Determinants of Health Learning Community in October 2018.

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COLORADO

It speaks for itself.

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IOWA

Most proud

- ★ 2-day Behavioral Health Strategy session and creating a strategic and collective vision for integrated care and prioritized parity for telehealth services
- ★ APM plan development with all members.

Top 3 learnings

1. Each State and Organization has a unique set of strengths and challenges, hence there is no cookie-cutter approach to succeed in the evolving value-based care environment.
2. It takes collective persistent efforts between the state and local organizations to create system wide change in policy, payment and practice.
3. It is challenging to develop joint goals with partners due to differing resources, organizational priorities, and the unique barriers and challenges faced by the various provider types.

Change made possible

- ➔ Practice: All members prioritized BH integration and expanded integrated workforce
- ➔ Policy: FQHCs listed as eligible distant site by Medicaid for Telehealth.
- ➔ System: Developed a capitated APM

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IOWA

Photo by Ethan Forsgren

Breaking Down the Silos

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MAINE

Most proud

★ Bringing Delta Center to Maine; our organizations' collaboration and leadership; stronger relationship and joint training with the State; members' progress toward understanding/engagement with VBP/C.

Top 3 learnings

1. Members need time to understand the importance of engaging in collaboration across primary care/behavioral health.
2. Members are in different places in understanding the importance of moving into value-based paradigms, in part because this plays out differently in primary care vs. behavioral health (different metrics) and in rural vs. urban.
3. Other states' experiences offer lessons and models that could be adapted to Maine, as well as validation that it's a journey.

Change made possible

➔ Our Delta Center work has laid groundwork and brought members/providers along to where they can make changes – and we helped align and inform State decisions about movement to VBP.

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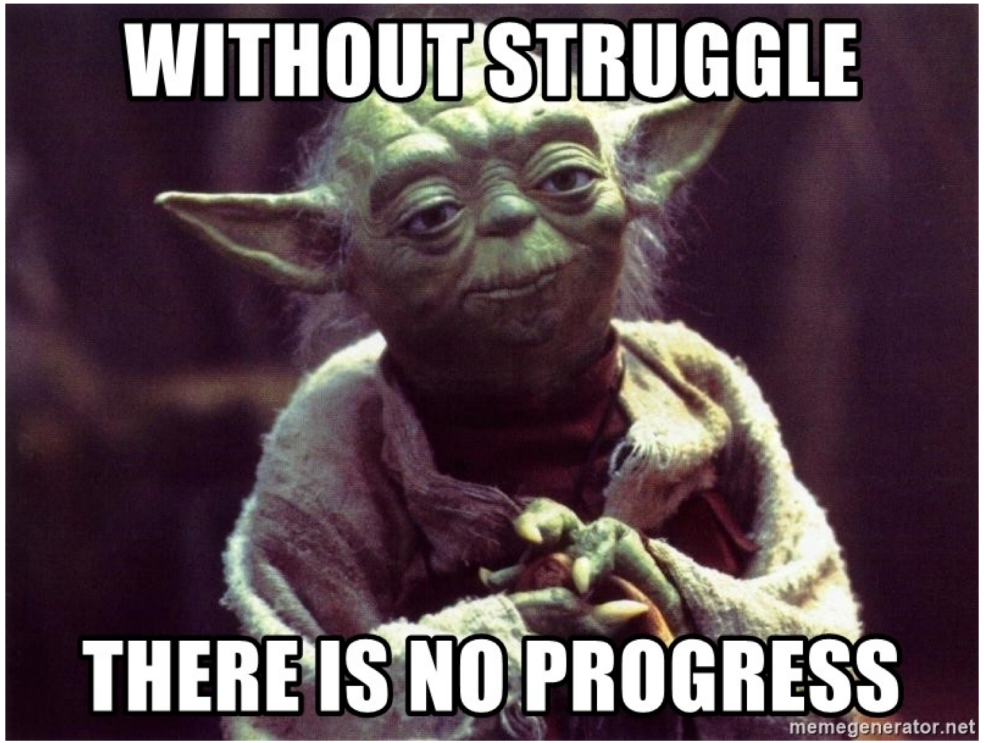
MAINE



Maine fixed Yoda's syntax - VBP/C easy is!

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MASSACHUSETTS

Most proud

★ The relationship between our associations has advanced significantly. During the pandemic, with rapid telehealth expansion, we share best practices and identify areas for coordinated advocacy.

Top 3 learnings

1. Innovation requires jumping in feet first. Once hesitant about risks and costs, COVID-19 forced members to jump into telehealth and learn as they go.
2. Education and information are essential. We had to show our vision in stages: intro training on telehealth, explore internal use of telehealth, then look at how telehealth creates opportunities to connect across the health care ecosystem.
3. Data is King. As Massachusetts moves to VBP/C we need data analytics that show value in both total cost of care and health outcomes.

Change made possible

➔ The preparation our members had through our early telehealth work undoubtedly enhanced their ability to shift in a matter of weeks to offering care via telehealth--for some now 100% of their services.

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MASSACHUSETTS

Telehealth is going viral! (or is it anti-viral?)

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MICHIGAN

Most proud

- ★ Shaping official re-design of state BH system to include expanded focus on integrated care, funded through APM approaches
- ★ Success of our PTA, with 28 members developing real-world APM approaches.

Top 3 learnings

1. It is critical to be “real” with members about VBP and APM approaches and the changes required, and to not to get too far ahead of them.
2. The importance of including providers and payers in Michigan’s Practice Transformation Academy (PTA). This allowed teams to focus on real-world “stretch projects” and work together on solutions.
3. Having Oakland CHN (a peer) on the PTA faculty presenting actual APM approaches in use allowed participants to focus and not get overwhelmed.

Change made possible

- ➔ CMHA and MPCA have been key advocates/resources for MDHHS as it prepares to expand BH and Opioid Health Homes and to become a CCBHC state with the aim of ensuring an advanced APB/VBP structure.

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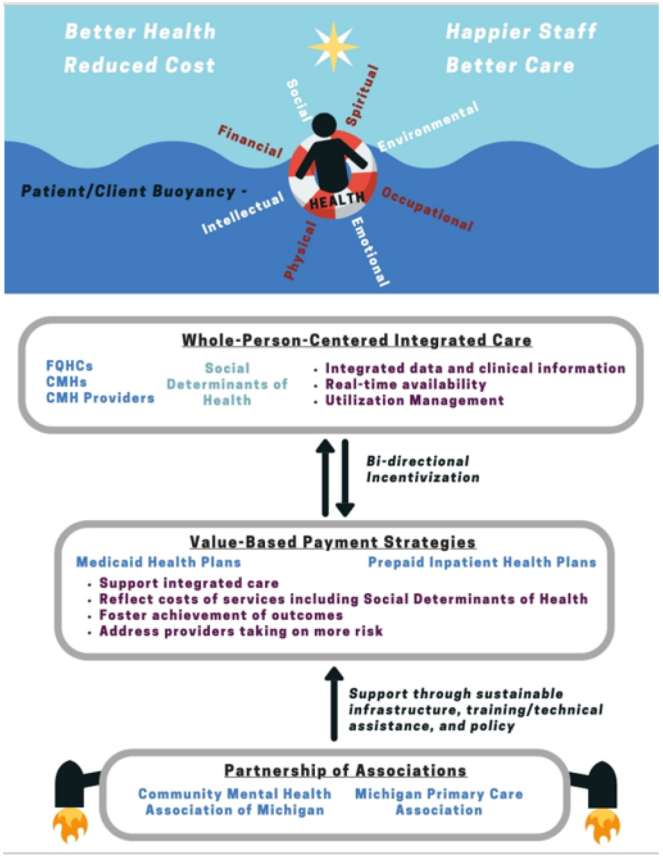
MICHIGAN



Client buoyed by our Delta Center work!

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MISSOURI

Most proud

★ Enhanced collaboration and communication between the Associations, Members, and two clinically integrated Independent Practice Associations (IPAs)

Top 3 learnings

1. New training methodologies have been useful for movement from in-person to virtual training
2. Resources and opportunity to work with peers across the country for new ideas/process/resources
3. Importance of foundational partnership, training, and advocacy to assist practices thrive in the ever changing health care landscape which became more critical when COVID-19 hit the state.

Change made possible

➔ MO was nearing some policy, practice, system changes when COVID-19 struck. The timing of COVID impacted ability to move advocacy, in person training, data, partnership/collaboration IPAs forward.

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MISSOURI

Missouri's Pursuit of Value-Based Care: The Journey Continues

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NEW MEXICO

Most proud

- ★ New Mexico is very proud of the relationship that has developed, and continues to develop, between the Primary Care Association and the Behavioral Health Providers' Association.

Top 3 learnings

1. Integration is not equal to co-location.
2. Behavioral health care must be included in primary care value-based payment models.
3. It is beneficial to bring varied groups together to collaborate and learn from.

Change made possible

- ➔ Building relationships with state policy makers, state agencies, payers, and providers while bridging the gaps in knowledge and learning related to integration and VBP at statewide convenings.

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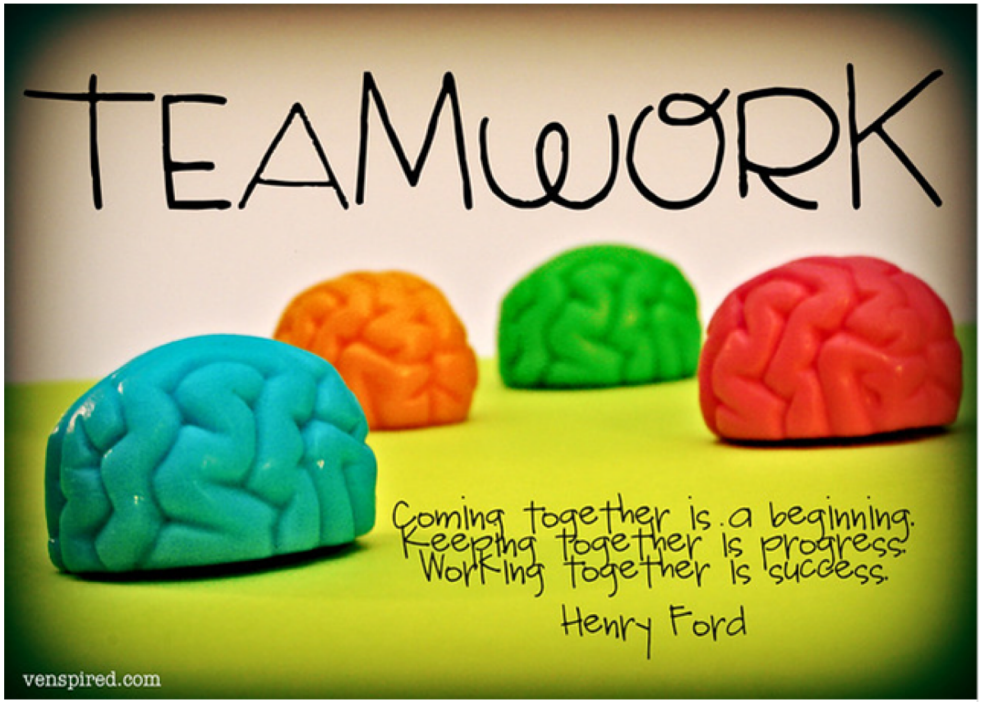
NEW MEXICO



BETTER TOGETHER

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NEW YORK

Most proud

- ★ Stronger working relationship between Associations.
- ★ New member relationships and partnerships forming.
- ★ BHCCs and PC IPAs meetings – groundbreaking initiative that we plan to continue.

Top 3 learnings

1. The path to achieve integrated care is complicated. But we need to have partners to achieve progress.
2. The resistance by our providers equally to give up space for each other is significant. But working together helps break down the barriers.
3. This work takes time and at times we might have felt frustrated recognizing that it does take time. There is still more work to do that we plan to continue.

Change made possible

- ➔ We reach out and focus on each other's issues and concerns more now.
- ➔ Joint advocacy on DSRIP legislation and a telehealth paper.
- ➔ Policymakers see us as partners working together on issues.

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NEW YORK

CRAIN'S NEW YORK BUSINESS

CRAIN'S HEALTH PULSE NEW YORK

Crain's Health Pulse, 7/9/2020

Primary care, behavioral health providers urge measures to sustain telehealth access post-pandemic

The Community Health Care Association of New York State and the New York State Council for Community Behavioral Healthcare are calling on policymakers to make permanent telehealth measures that have been implemented during the Covid-19 crisis.

The advocacy groups say doing so will help to address health disparities and barriers to care, aid in preventing avoidable conditions as well as higher costs, and ensure the financial stability of safety-net providers.

The groups recommend that, post-pandemic, the state should continue to support a full range of telehealth modalities, including reimbursement for telephone visits and expanded Wi-Fi and cellular service in urban areas. They also urge keeping telehealth's use at the discretion of clinicians in collaboration with clients, based on individual patient needs and capacity.

Additionally, the groups are calling on elected officials to maximize regulatory flexibility. That includes continuing to expand the list of licensed practitioners allowed to provide such care, not requiring in-person visits before remote visits, and investing in workforce training and research to establish where telehealth is most impactful. It also includes reconsidering certificate-of-need requirements and whether certain safety-net providers need separate applications for extension sites when telehealth is a significant component of their service delivery model.

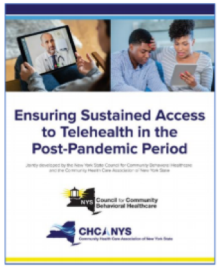
Finally, the groups stress that telehealth visits should be reimbursed on par with in-person visits, and a capitated alternative payment model could eliminate the need for the state to count and pay for each different visit type and care delivery modality.

"It is important to think about how telehealth can promote integration of behavioral health and primary care, and how that's really been important during the pandemic," said Rose Duhan, president and CEO of the Community Health Care Association of New York State.

As New York moves ahead in its phased reopening, continued support for virtual care is critical, Duhan said.

"We think it can be really effective in managing chronic conditions," she said. "As we go into flu season, it can also be a way to help reduce the spread of other types of contagious infections."

Initial outcomes have proved promising, the advocacy groups say. Expanded regulatory relief and measures for telehealth have resulted in immediate improvements in access to care.



The Community Health Care Association of New York State reports that 88% of the state's federally qualified health centers now deliver care remotely, up from just 35% in 2018. And a recent survey by the New York State Council for Community Behavioral Healthcare found that telehealth comprised 90% of visits and 86% of revenue for behavioral health providers.

Early data indicate fewer no-shows for appointments as a result of virtual care and high patient satisfaction, particularly when it comes to telephone visits, the groups said. And telehealth visits have been a financial lifeline for providers that reported staggering declines in in-person care as a result of the pandemic and tens of millions of dollars in losses a week in some cases.

"This type of innovation in health care was due," said Lauri Cole, executive director of the New York State Council for Community Behavioral Healthcare. "Now the challenge is, how can we ensure that all the providers that want it have the means, financial and otherwise, to capitalize on it?"

Cole said that holds especially true for behavioral health providers, which already operated on slim margins and now are tending to three pandemics at once: the opioid crisis, increased rates of suicide and Covid-19.

"We need every tool at our disposal," she said. "Telehealth doesn't replace anything. It simply enhances the toolbox of a clinician or staff person to be able to reach out and provide service needs."

The goal is to influence and inform decision makers to not be afraid of telehealth as the current crisis winds down, she said. — *Jennifer Henderson*

One example of our joint advocacy work.

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NORTH CAROLINA

Most proud

★ We are most proud of the foundational relationship that we've established between our two organizations. Better understanding of our individual, collective strengths, gaps and priorities.

Top 3 learnings

1. Adaptive Leadership model and how we can use it in NC
2. The MAHP 2.0 framework
3. i2i learned more about FQHCs scope of services and how critical they are to BH safety net and NCCHCA learned a lot from i2i's experience in BH managed care as we await physical health moving to managed care.

Change made possible

➔ VBC collaborative with NC DHHS, MCOs, BH providers and PCA to look at APM related to community support teams. Also planned for managed care Tailored Plan collaboration between same stakeholders.

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NORTH CAROLINA

We have had to do a lot of 'pivoting' to external and internal challenges - but have had fun and worked as a team. We look forward to accomplishing and 'pivoting' more together in the future!

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OREGON

Most proud

★ AOCMHP and OPCA partnering on joint safety net policy and practice initiatives; collaboration between CMHPs and CHCs; customized technical assistance for our members on integrating care and VBP.

Top 3 learnings

1. Changing payment structures requires early commitment from the payers and cannot be done by providers/local safety net alone;
2. In order to implement real change, there must be regulation/statutory revisions passed by state legislatures and contractual requirements promulgated by the state health authorities;
3. Without PACs, BH entities and CHCs must rely on unity of advocacy and on organizing structures such as IPAs to leverage any form of negotiating power with Medicaid managed care entities.

Change made possible

➔ This experience has “prepared the soil” for future work and helped us clarify what we can do together representing Oregon's safety net.

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OREGON

Partnering on an uphill battle

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TEXAS

Most proud

★ Achieving system-wide support for the implementation of the CCBHC model of care and standardized directed payment.

Top 3 learnings

1. Adoption of a new initiative is more successful when the process for moving forward acknowledges and builds on current achievements.
2. Providing organizational support and technical assistance throughout the process is essential to initiate and sustain change.
3. Hosting high profile meetings and training opportunities while facilitating discussions across program areas elevates the importance and significance of the work.

Change made possible

➔ CCBHC model and directed payment work served to inform the state agency as they moved to operationalize: VBP Roadmap; 1115 Waiver DSRIP Performance Measures and Transition Plan; and BH Strategic Plan.

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TEXAS

Together We Can

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WASHINGTON

Most proud

★ The complete reset of working relationships between our associations will further beneficial collaborations and foster cooperative instead of competitive provider relationships.

Top 3 learnings

1. It is virtually impossible to effect practice change at the provider level without supporting alignment in the policy, regulatory & financing context.
2. There are few comprehensive models in the country of collaborative, bi-directional integration that effectively address the primary care needs of patients with SMI or addiction disorders.
3. Cross-sector policy change related to the needs of any sub-population or minority group is difficult and slow due to systemic barriers and blind spots.

Change made possible

➔ We checked in about key bills & budget issues during 2018 to 2020 legislative sessions, including the use/overuse of telehealth, MH-SUD specialist credential & improving BH payment in both settings.

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WASHINGTON

The bewilderment before the storm.

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