FINAL WORKING DRAFT:

VALUE-BASED PAYMENT PRACTICE TRANSFORMATION PLANNING GUIDE

NOTE: This working draft is for use by Value-Based Payment Practice Transformation Academy participants only. The original version of the guide was designed by the National Council for Behavioral Health for organizations enrolled in the New York State Care Transitions Network for People with Serious Mental Illness. This version is being updated to align with the goals of the Washington State Healthier Washington Initiative.

VALUE-BASED PAYMENT PLANNING GUIDE

Washington State has embarked upon an ambitious health system transformation that is outlined in the Plan for a Healthier Washington. Paying for value is a primary Healthier Washington strategy to achieving the triple aim of better health, better care, and lower costs. Meeting this goal will require shifting healthcare reimbursement strategies away from a system that pays for volume of service to one that rewards quality and outcomes. To that end, Washington will drive 90% of state-financed healthcare to value-based payment (VBP) by 2021.

In January 2017, Washington State and the Centers for Medicare and Medicaid Services (CMS) reached agreement on a groundbreaking five-year Medicaid Transformation Demonstration that allows the State to invest in comprehensive Medicaid delivery and payment reform efforts through a Delivery System Reform Incentive Payment (DSRIP) program.

VBP strategies are built into the fabric of the Demonstration by their inclusion as a foundational element of delivery system reform activities. Within Medicaid, the Health Care Authority (HCA) has changed Apple Health Managed Care Organization contracts in ways that align with the Demonstration's goals. The Health Care Payment & Learning Action Network (HCP-LAN) Framework will be used for the implementation of VBP in Washington by defining payment models subject to incentives and penalties, aligned with Healthier Washington's broader delivery system goals. The Medicaid Transformation Project Toolkit specifies metrics that will be assessed for performance to ensure a consistent focus on value. The shift from fee-for-service (FFS) to VBP requires delivery system changes. Time-limited DSRIP funds allow providers to make these changes through initial investment in the health system transformation process, and build provider capability as it relates to VBP.

As Behavioral Health Agencies begin the organizational transformation to tie value to payment, internal leadership and operational teams will require a vision and strategic plan to shape the process.

This VBP Planning Guide is designed initially to support and be shaped by the behavioral health agencies participating in the 2017 – 2018 Practice Transformation Support Hub's Value-Based Payment Practice Transformation Academy. However, once finalized, it will be a valuable tool for behavioral health agencies across the state. This Planning Guide is offered as an example for structuring your action plan and provides one possible framework for your strategic plan. It is designed to help you and your team outline, prioritize, and determine an agreed-upon roadmap and timeline to prepare for VBPs. However, transformation is not a one-size-fits-all process. Given the complexity of this type of transformation, paired with the accelerated timeline for state payment changes under Medicaid and federal changes to Medicare, your organization will need to identify and implement a change process that suits your organizational needs and culture. This tool is designed to help your organization identify the manageable objectives and tasks that will build toward the long-term goal of preparedness for VBPs.

The Planning Guide is designed to assist your organization in pacing the needed changes, gaining buy-in and building needed infrastructure in order to promote a systematic approach toward transformation. The Planning Guide aims to support your organization in:

1. Mobilizing personnel needed to guide and support practice transformation;
2. Identifying key performance measures, establishing baselines, and collecting data to track progress over time; and
3. Creating a work plan to set aims, benchmark progress, sustain change, and demonstrate value to payers.

The tasks outlined in the work plan below are flexible and only recommendations. You can adapt this Planning Guide to suit the infrastructure of your organization. Your Value-Based Payment Practice Transformation Academy faculty coach can serve as resource to your organization as you are prioritizing goals and developing an implementation plan.

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SECTION 1: ASSEMBLE YOUR TEAM

Organizational transformation requires considerable resource allocation and, therefore, careful planning. One the most important first steps in a transformation initiative is securing buy-in from organization leadership and assembling a team. According to a 2013 Strategy&/Katzenbach Center survey of global senior executives on culture and change management, the success rate of major change initiatives is only 54%. Organizations across industries often attribute transformation initiative failure to the incubation of the change process within the C-suite.

Your organization has a vested financial interest in the success of transformation efforts as the cost of change fatigue and transformational failure can take a toll on client satisfaction, quality clinical care, workplace culture, business efficiencies and, ultimately, financial viability.

Transformational failure is potentially even more toxic to a business' preparation for healthcare reform as quality care lives and breathes on the frontlines. To prepare your workforce to operate in harmony to achieve the organizational vision and to mitigate the risk of transformation failure, use the prompts below to develop a steering committee, transformation subcommittees, and a transformation lead.

ESTABLISH A VBP STEERING COMMITTEE

Identify a VBP steering committee comprised of both clinical and administrative leadership. The VBP Steering Committee will set the vision of the transformation strategy. Examples of potential committee members include:

- Chief Executive Officer
- Chief Program Officer
- Chief Operating Officer
- Chief Financial Officer
- Chief Medical Officer
- Administrative
- Leadership (Vice Presidents/Middle Management/Information Technology/Human Resources/Quality Improvement)

MY VBP STEERING COMMITTEE WILL INCLUDE THE FOLLOWING PEOPLE:

CREATE VBP SUBCOMMITTEES

Subcommittees will include representatives from the program targeted for change. When multiple programs are identified for change, multiple subcommittees can be created. This can, however, place a burden on staff that support multiple programs as they could be required to participate in multiple subcommittees. Your organization should use its best judgement

regarding the creation of subcommittees and the level of effort required of staff. A subcommittee will be comprised of frontline staff, clinical team members, and administrators. Examples of team members include:

- Director
- Practice Manager (i.e., clinic or site manager)
- Billing
- Front Office
- Nursing
- Medical
- Therapists
- Utilization Review

SUBCOMMITTEE MEMBERS WILL INCLUDE:

THE SUBCOMMITTEE WILL MEET EVERY TWO WEEKS ON THE FOLLOWING DATE AND TIME:

IDENTIFY YOUR TRANSFORMATION LEAD

Choose one person who is accountable for transformation within your organization. The Transformation Lead will possess both quality improvement and project management skills. He or she will be responsible for ensuring deliverables are met within pre-determined timelines. This person will be present at all committee meetings and will be driving the transformation process. The Transformation Lead should have enough authority and influence within your organization to ignite change.

THE TRANSFORMATION LEAD FOR MY ORGANIZATION IS:

SECTION 2: PRIORITIZE BASELINE DATA COLLECTION

Over the course of the next year and beyond, you will want to have indicators that your transformation initiatives have been effective. For this reason, it is imperative to establish a baseline as you improve clinical work and operational efficiencies. Implementation of the Risk Stratification and Chronic Conditions Financial Calculator tools will assist your organization to embrace a population health management approach to both clinical care and business operations. The User Guide provides more information on how to use these tools. The tools shed

light on the populations that you are serving with chronic behavioral health conditions and will begin to answer the questions:

- *What does my organization do best?*
- *Who should I consider partnering with in my community?*

Your steering committee will use this data as the foundation for decision-making around workforce development and community partnership as well as articulating value to payers.

Data to consider should align with the state's common measures, as outlined in the Healthier Washington Medicaid Transformation Project Toolkit and the Statewide Common Measure Set. By selecting and tracking these measures, the VBP Practice Transformation Academy projects will be collecting data on measures Washington State has already deemed important. Some examples include the following metrics:

- Antidepressant Medication Management
- Plan All-Cause Readmission Rates (30 days)
- Mental Health Treatment Penetration
- Outpatient ED Visits per 1000 Member Months
- Follow-up After Discharge from ED for Mental Health or SUD

SECTION 3: VBP WORK PLAN

The work plan below is aligned with the timelines and goals set forth by the federal and state governments as they prepare to have 90% of Medicare and Medicaid payments tied to value by 2021. In Washington State, the Health Care Authority's Value-Based Payment Roadmap establishes the following milestones along the path to 90% in 2021:

- 2016: 20% in VBP
- 2017: 30%
- 2018: 50%
- 2019: 80%
- 2020: 85%
- 2021: 90%

Furthermore, the Healthier Washington Medicaid Transformation Project Toolkit ties these purchasing goals to specific Alternative Payment Models (APM) for each year of the Medicaid demonstration as described below:

> Value-based payment (VBP) categories as defined by the Health Care Payment Learning Action Network (HCP-LAN) framework will be used for the purposes of calculating the annual targets below. Targets will be calculated by dividing the total Medicaid dollars spent in HCP-LAN categories 2C and higher by total Medicaid dollars spent.

Annual Targets: Percentage of Provider Payments in HCP-LAN APM Categories at or above which Incentives are Provided to Providers and MCOs

VBP Targets	DY 1	DY 2	DY 3	DY 4	DY 5
HCP-LAN Category 2C-4B	30%	50%	75%	85%	90%
Subset of goal above: HCP-LAN Category 3A-4B	-	10%	20%	30%	50%
Payment in Advanced APMs	-	-	TBD	TBD	TBD

The work plan is consistent with the phases of transformation and change package designed by CMS and used across the nation as part of the Transforming Clinical Practice Initiative.

2017–18 TRANSFORMATION TASKS: SETTING AIMS AND ESTABLISHING A BASELINE

Goal	Objective	Key Action Steps	Responsible Party	Deadline
A. Collaborate with patients and families	A.1 Develop and implement protocol and procedures to incorporate patient and families in treatment planning	A.1.1 Implement patient and family survey A.1.2 Train staff in collaborative documentation A.1.3 Train staff in motivational interviewing A.1.4 Consider providing group visits for common chronic conditions A.1.5 Train staff in self-management goal-setting A.1.6 Educate patients and families on health care transformation		
	A.2 Develop quality measures or indicators of patient and family engagement	A.2.1 Identify a patient activation assessment A.2.2 Routinely share assessment results, along with appropriate education about the implications of those results, with staff and clients		
B. Risk Stratification	B.1. Identify and implement a risk stratification approach	B.1.1 Identify indicators you plan to use to determine high, medium and low risk B.1.2 Weight indicators based on significance to create a risk profile and algorithm for your patient population B.1.3 Map EHR data to your risk stratification tool B.1.4 Transformation sub-committee to determine working definition for active vs. inactive client B.1.5 Transformation sub-committee to analyze data based on diagnosis, medical co-		

Goal	Objective	Key Action Steps	Responsible Party	Deadline
		morbidities, demographics, and payer B.1.6 Transformation sub-committee to complete a gap-analysis on workforce training needs (evidence-based training) B.1.7 Develop policy and procedure to stratify risk across your patient population (consider intake, supervision, treatment planning, missed appointments, case closure).		
	B.2 Develop and implement care pathways	B.2.1 Meet with transformation sub-committee to analyze data for care pathways workflows B.2.2 Develop and implement policy and procedure on care pathways B.2.3 Use on-site care managers to proactively monitor and coordinate care for the highest risk populations B.2.4 Train therapists and supervisors in evidence-based interventions to support populations served B.2.5 Assign responsibility for care management B.2.6 Implement a standard to documenting care plans B.2.7 Use a consistent method to assign and adjust global risk status for all clients to allow risk stratification into actionable risk cohorts B.2.8 Use registry to support management of patients at low and intermediate risk		
C. Use Community	C.1 Complete environmental scan of community	C.1.1 Consider formal partnerships including discussions with board about plans for		

Goal	Objective	Key Action Steps	Responsible Party	Deadline
Resources	providers and referral resources	sustainability		
	C.2 Develop relationships with primary care physicians, hospital systems, and referral sources	C.2.1. Leverage potential relationships to cultivate referral opportunities		
	C.3 Integrate whole-health into intake process and ongoing treatment	C.3.1. Review intake process to include physical health assessment C.3.2 Develop policy and procedure to include outreach to primary care physician at intake and treatment planning intervals C.3.3 Maintain an inventory of community resources that may be available to patients C.3.4 Provide a guide to available community resources		
D. Use an organized QI approach	D.1 Use an interdisciplinary staff committee to lead change and improvement within the organization	D.1.1 Complete a gap analysis or SWOT analysis to assess workforce capacity and skill-set related QI D.1.2 Use a defined model, like the Model for Improvement, as the QI structure D.1.3 Establish a QI committee that includes staff from clinical and administrative settings, as well as finance		
	D.2 Engage leadership in QI strategy	D.2.1 Align the organization's QI plan with its strategic, operational, and business plans D.2.2 Create direct lines of communication with transformation lead to CEO and/or leaderships D.2.3 Define specific timelines for improvement with identified		

Goal	Objective	Key Action Steps	Responsible Party	Deadline
		opportunities		
	D.3 Set aims	D.3.1 As a team, set clinical and financial utilization goals		
E. Build QI capacity	E.1 Incorporate quality improvement across workforce and departments	E.1.1 Include the transformation agenda and QI skills in new staff/provider orientation E.1.2 Train all staff in how to act on data: how to interpret graphs and where to go and what to do with information to continue, accelerate or initiate improvement E.1.2 Include improvement in QI as part of individual job descriptions and expectations		
	E.2 Set organizational expectations for QI and incorporate QI into the hiring process	E.2.1 Hire for fit with the organizational quality culture through effective pre-employment screening E.2.2 Track progress toward goals at each program and individual provider level E.2.3 Integrate practice change/ quality improvement into staff duties E.2.4 Promote transparency by sharing practice level quality of care, patient experience and utilization data E.2.5 Regular meetings with leadership and program staff to review data, celebrate success, identify opportunities, and develop improvement plan		
F. Use data transparently	F.1 Align clinical and financial goals with practice and organizational vision and mission	F.1.1 Define measures that the agency will monitor, relate these to strategic aims and use the to drive performance F.1.2 Monitor measures frequently and consistently and share metrics with staff during		

Goal	Objective	Key Action Steps	Responsible Party	Deadline
		staff meetings, group supervision, and individual supervision F.1.3 Use run charts to display data over time and link changes implemented to the data points F.1.4 Adopt a philosophy of performance data transparency		
	F.2 Create a culture of learning	F.2.1 Use data walls to share metrics and progress and celebrate success F.2.2 Use relevant data sources to create benchmarks and goals for performance at the practice level F.2.3 Train supervisors in using data in clinical supervision F.2.4 Develop individual-professional development plans linked to desired outcomes		
G. Use sound business operations	G.1 Strategic use of revenue	F.1.1 Identify cash reserves for discussion on sustainability and future allocation of funds (e.g., technology/tools, training/billing capacity) F.1.2 Review National Council's Case Rate Toolkit F.1.3 Use lean principles across the organization, such as defining waste and identifying value through the client's eyes		
	G.2 Benchmark progress toward reduced costs	G.3.1 Download EHR data to prepare for Chronic Conditions Financial Calculator G.3.2 VBP sub-committee to use data to create baseline for costs to serve populations with chronic behavioral health conditions defined G.3.3 Demonstrate cost to provide unbillable services (operations support tied to		

Goal	Objective	Key Action Steps	Responsible Party	Deadline
		individual service) G.3.4 Identify behavioral health VBP pilot project most representative of your population G.3.5 Begin shadowing accounting for VBP pilots		

2018-19 TRANSFORMATION TASKS: BENCHMARKING PROGRESS AND SUSTAINING CHANGE

Goal	Objective	Key Action Steps	Responsible Party	Deadline
A. Listen to patient and family voice	A.1 Ensure patient and family voice is incorporated into operations	A.1.1 Ensure patient and family representation on the organization's board or steering committee A.1.2 Implement a patient and family advisory board A.1.3 include patients and families in quality improvement initiatives		
	A.2 Reinforce that patient and family experience is at the forefront of clinical and administrative decision-making	A.2.1 Use client stories to start all-staff meetings A.2.2. Run focus groups to obtain patient and family feedback A.2.3 Incorporate client voice into policy and procedures		
B. Clarify team roles	B.1 Using data from the risk stratification and care pathways exercises, identify gaps in care team	B.1.1 Inventory the work to be done prior to a client visit, during the visit, and after the visit and determine who in the organization can do each part of the work by matching their training and skills sets B.1.2 Use process maps to clarify responsibilities once roles are assigned B.1.3 Identify staff interest and		

Goal	Objective	Key Action Steps	Responsible Party	Deadline
		talents and align with available opportunities B.1.4 Add fields to the HER to capture care team member roles		
C. Establish medical neighborhoods	C.1 Establish formal relationships with community providers	C.1.1 Develop both personal and electronic relationships among medical neighborhood providers to ensure information sharing C.1.2 Develop written agreements or compacts that define information needs of all parties		
	C.2 Reinforce that patient and family experience is at the forefront of clinical and administrative decision making	C.2.1 Formalize lines of communication with local care settings (including hospitals, residential, substance use, etc.) in which clients receive care to ensure documented flow of information and clear transitions of care C.2.2 Ensure that useful information is shared with patients and families at every care transition; partner with clients and families in developing processes and tools to make that happen C.2.3 Engage payer disease management and complex care management staff to help avoid patient/family confusion		
D. Implement evidence-based protocols	D.1 Develop and implement care pathways	D.1.1 Use National Council Risk Stratification Tool or alternative registry to map chronic behavioral health conditions to care pathways D.1.2 Use pre-visit planning (e.g., huddles including HH care managers, therapists, nursing and prescribers) to optimize team management of clients with		

Goal	Objective	Key Action Steps	Responsible Party	Deadline
		chronic/high risk conditions		
E. Provide 24/7 access to care	E.1 Establish formal relationships with community providers	E.1.1 Provide 24/7 access to provider care team for advice about urgent or emergent care E.1.2 Develop written agreements or compacts that define information needs of all parties		
	E.2 Reinforce that patient and family experience is at the forefront of clinical and administrative decision-making	E.2.1 Formalize lines of communication with local care settings (including hospitals, residential, substance use, etc.) in which clients receive care to ensure documented flow of information and clear transitions of care E.2.2 Ensure that useful information is shared with patients and families at every care transitions; partner with clients and families in developing processes and tools to make that happen E.2.3 Engage payer disease management and complex care management staff to help avoid patient/ family confusion		
F. Use sound business operations	F.1 Implement Same Day Access and Just in Time Prescribing	F.1.1 Provide 24/7 access to provider or care team for advice about urgent or emergent care F.1.2 Provide care team with access to medical records after hours F.1.3 Expand hours to evenings and weekends		
	F.2 Use community partnerships to provide a continuum of care and coverage for all clients	F.2.1 Implement contractual agreements with supporting community partners F.2.2 Use warm hand-offs for cross coverage		

Goal	Objective	Key Action Steps	Responsible Party	Deadline
G. Streamline work	G.1 Using financial utilization data and VBP pilot-project accounting data to benchmark progress in operational efficiencies	G.1.1 Train staff in lean approaches and the concept of value G.1.2 Consider hiring or training internal experts in process improvement G.1.3 Use lean principles across the organization, such as defining waste and identifying value through the client's eyes		

2019-20 TRANSFORMATION TASKS: BENCHMARKING PROGRESS AND SUSTAINING CHANGE

Goal	Objective	Key Action Steps	Responsible Party	Deadline
A. Workforce Development	A.1 Develop data skills	A.1.1 Cross-train staff members in key skills in the use of health information system		
	A.2 Cultivate joy	A.2.1 Celebrate suggestions for improvement and solution ideas developed by staff A.2.2 Give staff time for innovation A.2.3 Include expectations about participation in QI in performance reviews A.2.4 Use incentives to reward improvement at the individual and teamlevels A.2.5 Tie compensation to team, departmental and organizational goals A.2.6 Ensure performance standards and expectations are clear A.2.7 Get staff/provider input at all levels		

Goal	Objective	Key Action Steps	Responsible Party	Deadline
B. Manage total cost of care/Cost of Care Behavioral Health Conditions	B.1 Understand your costs and outcomes	B.1.1 Consider third party business intelligence tools B.1.2 Train appropriate staff on interpretation of cost and utilization information		
	B.2 Articulate your value	B.2.1 Use available data regularly to analyze opportunities to reduce cost through improved care B.2.2 Educate staff about factors that impact total cost of care B.2.3 Ask staff to identify opportunities to manage cost to facilitate understanding		

2020-21 TRANSFORMATION PLAN: PREPAREDNESS FOR VBP ARRANGEMENTS

Goal	Objective	Key Action Steps	Responsible Party	Deadline
A. Develop financial acumen	A.1 Tie the triple aim together across departments and on the front line (e.g., better health, better care, and lower costs)	A.1.1 Conduct business fundamentals training as a lunch-and-learn session A.1.2 Ensure budget preparation occurs at the level the costs are incurred A.1.3 Share prices charge for various services A.1.4 Dedicate a meeting to explaining the organization's financial statements		
B. Document value	B.1 Articulate value to payers and community partners	B.1.1 Analyze internal costs of care by service and by population characteristics B.1.2 Use external benchmarks to compare internal cost and revenue metrics, such as cost per visit and revenue metrics, such as cost per visit and revenue per provider full-time equivalent		

Goal	Objective	Key Action Steps	Responsible Party	Deadline
		B.1.3 Determine profitability by site and service		

The Value-Based Payment Planning Guide was originally designed for practices enrolled in the Care Transitions Network for People with Serious Mental Illness, a 4-year initiative in New York State to support healthcare providers' transition to value-based payments. The Care Transitions Network is a partnership between the National Council for Behavioral Health, Montefiore Medical Center, Northwell Health, the New York State Office of Mental Health, and Netsmart Technologies. The project described was supported by Funding Opportunity Number CMS-1L1-15-003 from the U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. This updated version incorporates information for Washington State's Healthier Washington initiative, with funding made possible by Funding Opportunity Number CMS-1G1-14-001 from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services.

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