HMA

ASSESSING READINESS FOR VBP (BEHAVIORAL HEALTH)

WHY COMPLETE THIS ASSESSMENT

Healthcare has typically been reimbursed based on volume

The country has been on a steady trajectory toward paying for quality and efficiency

Behavioral health providers are uniquely qualified to positively impact quality and reduce overall costs of care

Engaging in value-based payment goes beyond providing clinical care, including the ability to measure outcomes, monitor quality, impact performance in real time, reduce cost of care

VBP requires an investment at all levels of the organization, including leadership and the governing body

Determine organization's current level of readiness, prioritize areas of need, and engage in alternative payment models understanding areas of strength and weakness

INSTRUCTIONS

The Health Management Associates VBP Readiness Assessment for Behavioral Health is designed to gain an understanding of your organizational readiness to guide successful engagement in payment reform models.

The following 12-item survey includes a series of statements to evaluate organizational readiness. You will provide an organizational assessment of readiness to each of the statements below. Levels 1-3 indicate low or initial readiness, levels 4-6 indicate moderate or basic readiness, and levels 7-9 indicate high or mature readiness. For each statement, assess the organizational level of readiness (low, moderate, or high) and then the level of sophistication your organization is within that level (1-3, 4-6, 7-9). This readiness assessment posits critical elements for success in value-based models and provides a basic description of the components of what readiness might include. All readiness levels build on one another, therefore an organization that is at the basic or advanced stage of readiness is assumed to be demonstrating the activities in the prior levels.

It is recommended that this readiness assessment be completed as a team to ensure multiple perspectives on organizational operations are captured. Respondents to this readiness assessment should use their own judgment and knowledge to determine where your organization falls within the levels for each statement. For example, an organization that has established a basic level of data reporting but does not have a dedicated analytic staff to support continuous monitoring should rank themselves a 4 rather than a 6.

This tool is not designed to provide a comprehensive assessment of organizational readiness. The results from this assessment will be used to guide discussion on potential opportunities to strengthen your organizational position for engagement in value-based care.

Domain Considerations

People: leadership, workforce capacity, culture, patient population, partners

Process: services, clinical model, workflow, data & reporting, performance metrics

Structure: technology, policy, equipment, funding, strategy, products, data capability

Readiness Level Descriptions

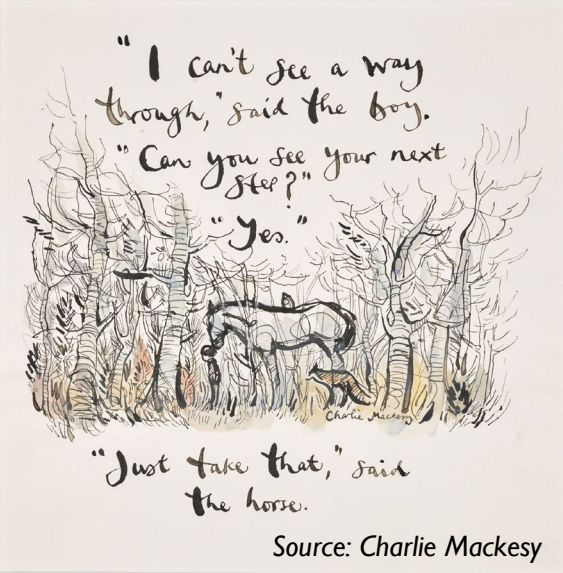
Organization has not yet established processes or has just begun development. Resources are not allocated or were just recently allocated. Experience in this area is limited or does not exist.	Organization is addressing the area at a basic level. Resources are allocated to support development and sustain work. Experience in this area is consistent	Organization prioritizes focus on this area. Resources allocated support current need, account for anticipated needs, and/or are customized to the organization needs. Experience in this area is advanced and innovative.
Preliminary	**Intermediate**	**Advanced**
1 to 3	4 to 6	7 to 9
Initial Development	Progressing	Mature

TIPS FOR COMPLETION

- ✓ Designate a readiness assessment lead to coordinate input, feedback, and responses
- ✓ Include broad organization representation for diverse perspectives
  - ✓ At a minimum this should include Clinical, Financial and Billing/Revenue Cycle, IT, and quality
- ✓ Foster open and creative discussion
- ✓ Discuss answers as a team and unpack divergent and common views
- ✓ Answer honestly – candidly scoring your position today will help tailor the recommendations to best get you to where you want to be
  - ✓ Think of this as an organizational preparedness opportunity and NOT a test
- ✓ Review and check your responses before submitting. Be sure only one box is checked for each question and that all questions are answered.

UNDERSTANDING YOUR RESULTS

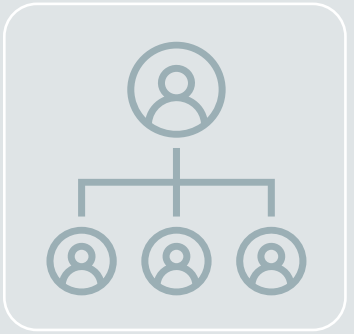
- The content in the each of the readiness levels is not an exhaustive list of activities that indicate readiness. Instead, they are meant to serve as guiderails to consider represent common practices which all follow an evolution of sophistication.
- Regardless if you find your organization to be advanced, progressing, initiating development, you can participate in VBP. This assessment is not intended to prescribe when you can or should participate in an arrangement. Rather it should serve as a way to identify meaningful progressive steps you can take to strengthen your organizational position within the VBP space.
- The more honest of an assessment you can provide, the more useful this tool will be to your organization. While it is easy to score from a perspective of where we might like to be, the reality of where you really are is going to be what provides you with clear next steps.
- Speaking of scoring from where you want to be, this assessment tool can be used as an opportunity to re-assess your state to determine how organizational evolution is occurring over time. Maybe you are on the cusp of preliminary and intermediate now. But after a year of targeted development and change, you may be curious to see if you are truly in the intermediate space. And you may even discover you are closer to advanced than you thought! The only way to know is to re-assess over time. Your current readiness state is situational and will change as you invest in areas you discover opportunities in.
- Finally, remember, that organizational change is often a slow race. Do not feel discouraged if much work lies ahead of you. This assessment is meant to help you see the next step.



Source: Charlie Mackesy

ASSESSMENT DOMAINS

Ability to Measure Outcomes



Board & Leadership Readiness

Technological Capabilities

Partnerships and Collaborative Agreements

Engaging with Payers

Financial Management & Cash Flow Reserves

READINESS ASSESSMENT

ABILITY TO MEASURE OUTCOMES

ORGANIZATION'S DATA USAGE TO UNDERSTAND THE SPECIFIC HEALTH NEEDS OF THE POPULATION

Preliminary			Intermediate			Advanced		
• Organization has capacity to monitor primary health conditions and, in some cases, data can be analyzed for broader population needs with limited specificity • Available insurance or socio-economic data is examined infrequently, typically in preparation for external reporting • Organization has ability to track performance against publicly available quality or utilization benchmarks • Data is not readily available and/or challenging to collect • Data is limited to annual aggregate measures. • Electronic Health Record (EHR) is functional but has little interoperability with other organizational data • Decisions are made regularly with limited or incomplete data			• Organization regularly examines internal and external data sources • Reporting capacity has ability to stratify data by meaningful groups, health needs including those with Severe Mental Illness (SMI), those with co-occurring disorders, high-risk chronic conditions, etc. • Organization can conduct trend analysis over time but requires dedicated staff to develop • There is a strategy in place to integrate EHR and analytic platforms across organization for system-level data reporting • Integration of patient-level clinical, administrative, care management, claims, and other data (SDOH, HRSN assessments, etc.) is available for analysis • Availability of practice-level dashboards to track performance against quality and utilization targets			• Organization regularly uses data with meaningful stratifications to understand the needs and gaps within the population, assess organizational performance of specific health needs, and monitor utilization patterns of the population based on data • Organization has an established feedback loop to incorporate patient input into CQI activities, and this loop is communicated with patients • Data on patient need/acuity is used to drive targeted interventions to those most in need • Common EHR analytics and care management platform is used across organization • Ingrained understanding of data-driven decision-making processes • Significant investment in advanced data-driven strategy		
1	2	3	4	5	6	7	8	9

Comments:

Instructions: Place an 'x' in the box that best describes your organization

ORGANIZATION TRACKS QUALITY MEASURES

Beginner			Intermediate			Advanced		
1	2	3	4	5	6	7	8	9

- Organization does not have defined key performance indicators for quality
- Data available to the organization is dependent on claims data
- Organization can track and report National Measure Sets (HEDIS, NOMs, TEDS, UDS, CMS Core, etc.)
- Reports include clinical variables such as diagnosis, risk factors, co-morbid conditions, length of stays, etc.
- Limited reporting is available on outcomes (reduced use/improved depression symptoms)
- Available quality reporting is primarily process measure based

- The organization has defined metrics for client services.
- Patient assessments are completed and associated with patient outcomes or improvement.
- Regular reports are available to monitor metrics, but no formal performance targets have been set
- A quality strategy guides a PDSA process across the organization to monitor and capture actions taken based on data
- Client assessment scores and/or SDOH/HRSN data is captured at a single point in time
- Data on acute ED or inpatient events is available to the organization but is not actionable or received timely
- Reports and dashboards are used when manually refreshed

- Well defined quality metrics exist amongst programs.
- Organization uses data regularly to monitor volume, outcomes and process
- Available data includes client assessment scores or SDOH/HRSN needs over time, co-morbid conditions, risk factors, hospital/ED utilization, service length of stay and cost of care as examples.
- Real time actionable data is available such as ED or inpatient admissions
- Organization has access to closed loop referral data or data external to the organization through an HIE.
- Reports and dashboards are automatically updated and used daily/routinely by management and staff to track outcomes.

Comments:

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BOARD & LEADERSHIP READINESS

LEADERSHIP AND BOARD RECEIVE METRICS ASSOCIATED WITH POPULATION HEALTH MANAGEMENT STRATEGIES

Beginner	Intermediate	Advanced
• Board/Governing Body receives performance data infrequently or only as needed. • Board/Governing Body meetings do not include regular review of performance data • Board/Governing Body receive limited or no performance data • Board/Governing Body receive information on state transformation efforts	• Board/Governing Body receives performance data on a quarterly basis • Board/Governing Body is apprised of VBP performance as deemed necessary • Board/Governing Body information includes a semi-annual review of data and updates on VBP programs and program successes and challenges • Board/Governing Body understands the importance of reform efforts	• Leadership and Board/Governing Body are aware of all measures • Data presented to the Board/Governing Body is prioritized to assess the desirability of risk-based arrangement • Board/Governing Body information includes data at regular frequencies and is reviewed at majority of meetings • Board/Governing Body can describe the population implications for engaging in reform efforts

1	2	3	4	5	6	7	8	9

Comments:

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LEADERSHIP HAS A SHARED VISION FOR VALUE TRANSFORMATION IN ALIGNMENT WITH THE MISSION & SERVICES

Beginner			Intermediate			Advanced		
• Population needs are assessed and identified, including meaningful population stratifications and the degree to which the provided services meet the needs of the population • Data is shared with leadership and transformation opportunities have been discussed • Organization's vision and key priorities are not data-informed or are set without a focus on value-transformation • Leadership staff have discussed reform opportunities and the relationship between reform and mission			• There is a comprehensive strategic plan with a shared vision for engaging in transformation efforts • Data is regularly shared across the organization to inform all improvement efforts and is linked to reform opportunities • Performance is communicated and disseminated throughout all levels of the organization • Organization has a performance improvement plan with defined quality measures monitored in VBP performance data			• Organization's vision is data-informed and reflects the role of the organization within the delivery spectrum, recognizing interdependency and collaboration opportunities throughout the system which support whole-person care • Organization has strong data partnerships and understands levels of care and services it does not provide • Organization receives and utilizes person and population data from key referral partners to close the loop on all referral pathways		
1	2	3	4	5	6	7	8	9

Comments:

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TECHNOLOGICAL CAPABILITY TO MEASURE MICRO AND MACRO RESULTS

ORGANIZATION STAFF HAVE ACCESS TO DAILY REPORTING OR DASHBOARDS TO ANALYZE AND ADDRESS CARE GAPS

Beginner			Intermediate			Advanced		
• Data is available on the diagnoses for which the person is seeking services within your organization • Data is available on primary health conditions of the population • Data is analyzed for health needs of specific populations (age, gender, race/ethnicity) within the patient population			• Regular reporting methods are used to assess broader health needs and utilization patterns within the patient population including complex behavioral needs • Regular reporting methods are used to assess broader health needs and utilization patterns within the patient population including complex behavioral and physical needs, comorbidities, and primary prevention needs • Data on broader health needs and utilization is used to drive service delivery and program planning			• Dashboards using multiple data sources are employed to understand the specific health needs and utilization patterns of the population and is easily able to identify areas of opportunity • Automated, interactive dashboards using multiple data sources are employed to understand the specific health needs and utilization patterns of the population and is easily able to identify areas of opportunity • Dashboards are shared with leadership to drive planning and resource allocation		
1	2	3	4	5	6	7	8	9

Comments:

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ORGANIZATION'S ABILITY TO MANAGE INTERNAL AND EXTERNAL DATA TO USE DATA & DATA-BASED METRICS TO CHALLENGE ASSUMPTIONS & INSIGHTS ON POPULATION HEALTH OUTCOMES

Beginner			Intermediate			Advanced		
• Data is siloed or difficult to aggregate • Standard reporting is available to the organization but is limited to query reporting, extracts, or descriptive analytics • Data integrity issues lead to inconsistent versions of the truth- leading to unactionable data • Cumbersome manual reporting make data-informed actions a challenge for the organization			• Data is accumulated and managed in a centralized location • IT has developed data automation to allow for more robust reporting, visualization, and analysis to assess population health and improve quality outcomes • Diagnostic analytics on the patient population are available for the organization to make actionable decisions • Reports and dashboards are used to evaluate programs and assess outcomes			• Data is available through an enterprise data warehouse, or modernized FHIR data lake • Dynamic dashboards integrating multiple sources of data are available to the organization • Analysis of business needs can be accomplished through self-service data access and advanced analysis of data, such as predictive modeling, informs performance improvement activities • Interactive dashboards are available to staff to provide continuous monitoring of outcomes		
1	2	3	4	5	6	7	8	9

Comments:

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PARTNERSHIPS AND COLLABORATIVE AGREEMENTS

ORGANIZATION HAS AGREEMENTS IN PLACE WITH STRATEGIC PARTNERS TO ACHIEVE TRANSFORMATION INCLUDING SYSTEMS TO SUPPORT DATA SHARING

Beginner	Intermediate	Advanced
• Informal relationships or MOUs that have not been implemented with other providers and payers exist. (3) • Positive working relationships exist with key partners such as hospitals, specialists, community organizations, employers, justice-involved agencies, etc. within the service area (1) • Organization works regularly with community partners but has no formal agreements or ability to share data (2)	• Focused and dedicated partnerships are in development to improve quality and outcomes using targeted strategies to address identified utilization issues or gaps in care.(6) • Data is analyzed together or shared amongst partners to identify opportunities for improvement (5) • MOUs are in development and partners meet to discuss data (4)	• Formal partnerships are in place with rigorous MOUs and BAA/DSAs to develop strategies and services to address targeted population needs or to engage in meaningful VBP opportunities. (8) • Access to timely, actionable, and accurate data, reporting, or other mechanisms are available to all partners (9) • MOU participants meet monthly to review data and meet needs of the population served (7)

1	2	3	4	5	6	7	8	9

Comments:

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ORGANIZATION HAS AN SDOH/EQUITY STRATEGY TO COORDINATE NEEDED SUPPORTS THROUGH COMMUNITY ORGANIZATION PARTNERSHIPS

Beginner	Intermediate	Advanced
• Organization understands referral resources to address SDOH/HRSN in the community • Organization has referral relationships with community organizations addressing SDOH/HRSN • Organization has communication mechanisms with referral partners • Data available can be stratified by race/ethnicity, language preference, and other demographic indicators	• Organization has formal relationships or an MOU with referral partners • Organization holds regular meetings or engages in consistent communication with referral partners to address progress • Organization has referral tracking and follow-up systems with primary responsibility on the clinical team to provide care coordination • Stratified data can be shared across community partners to connect to necessary resources	• Data on disparities is acted upon by the organization through development of targeted strategies engaging necessary community partners to address needs • Organization has referral tracking and follow-up systems and a workforce to support those systems in care coordination including addressing SDOH/HRSN • Organization has a dedicated care team to coordinate with community services for SDOH/HRSN • Ability to provide seamless coordination of social service needs to address preventative care, primary care, pharmacy, or other health needs in addition to behavioral health

1	2	3	4	5	6	7	8	9

Comments:

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ENGAGING WITH PAYERS WHO WANT TO TALK ABOUT APM/VBP

ORGANIZATION HAS EXPERIENCE AND CAPACITY TO MANAGE PERFORMANCE-BASED CONTRACTS

Beginner			Intermediate			Advanced		
• Organizations operates solely on fee for service billing • Organization has experience negotiating and/or managing fee for service volume based and managed care contracts • Contracts with managed care organizations are in place and include performance expectations			• Organization has experience negotiating pay-for-performance based contracts or contracts with upside risk only • Organization has experience negotiating and managing pay-for-performance based contracts or contracts with upside risk only • Contracts with managed care organizations are in place and include an incentive based VBP arrangement or APM			• Organization has experience with negotiating downside risk-bearing contracts or the ability to use experience to inform current contracting strategies • Risk adjustment strategies are available to support higher payment for higher need patients and risk-related data is monitored for impact to quality • Managed care contracts have upside and/or downside risk sharing VBP agreements		
1	2	3	4	5	6	7	8	9

Comments:

Instructions: Place an 'x' in the box that best describes your organization

FINANCIAL MANAGEMENT CAPABILITIES AND CASH-FLOW RESERVES

ORGANIZATION'S EHR/EMR IS CONFIGURED TO PROVIDE INTEGRATED DATA ACCESS, ANALYSIS, AND DATA-SHARING TO SUPPORT REVENUE CYCLE MANAGEMENT

Beginner			Intermediate			Advanced		
• Processes are primarily paper-based or EHR/EMR provides basic functionality for practice management such as scheduling, billing, communication, and documentation of progress notes and forms • EHR/EMR provides basic functionality for practice management • Data integrity challenges limit usability of reports, reports from EHR/EMR is not tied to billing/revenue cycle, and/or a lack of full functionality of EHR/EMR capabilities exist • EHR/EMR only used for notes and/or billing			• EHR/EMR is configured for information management including episodic searches, quick entry tools, forms, and calculators • Additional functionality of reminders and alerts are available at the point of care • Actionable and efficiency reporting on value-based metrics (configured to capture metrics), ad hoc processes and reports • EHR/EMR is configured for information management and workflow processes are in place • System can capture value-based metrics and reporting is available • EHR/EMR is used to pull reports for VBP payment and provided to MCOs			• EHR/EMR is configured to provide diagnosis and treatment support including results management, referral and consultation tracking, prevention and screening, and complex care/disease management • Additional functionality includes dashboarding of whole populations, practice level analysis, and integration capabilities such as portals, hubs, and data sharing from EHR/EMR • EHR/EMR functionality includes dashboards for population data, practice-level analysis, integration with patient portals, and data sharing from EHR/EMR • Data from EHR/EMR is used to optimize revenue cycle through automated queries to identify opportunities for improvement in coding and documentation • Data dashboards are used to monitor program outcomes and track population health		
1	2	3	4	5	6	7	8	9

Comments:

Instructions: Place an 'x' in the box that best describes your organization

ORGANIZATION ANALYZES CURRENT FINANCIAL PERFORMANCE UNDER EXISTING SERVICE DELIVERY AND PAYMENT MODELS

Beginner			Intermediate			Advanced		
• Organization has general volume-based targets known to the financial team • Finance and clinical team meet quarterly to inform the clinical team of their performance • Regular reports on financial indicators are conducted for monitoring overall operating margins and financial performance			• Key Performance Indicators (KPI) are monitored regularly • KPIs are monitored including trends for meaningful metrics in VBP such as net income, payer mix, and utilization rates • Finance and clinical teams meet regularly to review KPIs and trends • Total Cost of care or other financial metrics are regularly monitored alongside patient gaps or needs			• Financial KPIs are tracked and compared to benchmarks to identify strategies for improvement • Reports on financial health are available to the organization • Reports on financial health are used as basis for negotiating value-based contracts • Organization can assess financial impact of services provided to patients		
1	2	3	4	5	6	7	8	9

Comments:

Instructions: Place an 'x' in the box that best describes your organization

ORGANIZATION HAS ANALYZED ITS FINANCIAL CAPACITY TO ENGAGE IN RISK-BASED CONTRACTS

Beginner	Intermediate	Advanced
• Organization has not analyzed its cost of delivering services • Organization understands its cost of delivering services, but organization has not conducted an analysis of its ability to bear risk and limited interest to up-side risk, cost savings, profit only arrangements • Organization is in the planning phases of conducting an analysis of its ability to bear risk and limited interest to upside risk, cost savings, profit only arrangements • Cost estimates for service delivery are based on historical health center per-visit costs • Organization has not conducted an analysis of its ability to bear risk, other than identifying reserves available to cover risk.	• Organization has conducted an analysis of its ability to bear risk and limited interest to up-side risk, cost savings, profit only arrangements • A financial model is available to anticipate the impact of the patient population and potential variation in cost and performance measures • The ability to participate in up-side risk and absorb down-side risk has been conducted • Cost estimates have been adjusted to account for patient population to be served • Analysis on degree to which payment reform incentives/ payment mechanisms would result in revenue exceeding existing PPS and/or APM rates has been completed or is underway	• Organization has meaningful financial models available and has determined the capacity to partner with others for performance assessment and risk-sharing • A reserve has been established to support payment reform planning and implementation including risk-bearing arrangements • Organization has utilized its financial models to begin negotiations for risk-sharing contracts • Organization can quantify return on investments related to care transformation initiatives • Analysis of impact of proposed APMs on revenues and operating cash flows has been completed

1	2	3	4	5	6	7	8	9

Comments:

Instructions: Place an 'x' in the box that best describes your organization

DATA DEFINITIONS

- Healthcare Effectiveness Data & Information Set (HEDIS)
- National Outcomes Measurement System (NOMS)
- Treatment Episode Data Set (TEDS)
- Uniform Data System (UDS)
- CMS Core Data
- Child and Adolescent Needs & Strengths (CANS)
- Level of Care Utilization for Psychiatric and Addiction Services (LOCUS)
- American Society of Addiction Medicine (ASAM) Criteria Assessment
- Patient Health Questionnaire – 9 (PHQ-9)

DEFINITIONS

- Alternative Payment Model (APM) - the specific mechanism by which those approaches are implemented, which range from FFS payments that include quality or bonus payments for improving outcomes or quality scores, to full risk-based capitation payments in which a provider is responsible for offering an agreed-upon set of covered services to a patient for a single monthly payment (known as capitation).
- Business Associate Agreement (BAA) - establishes a legally-binding relationship between HIPAA-covered entities and business associates to ensure complete protection of PH
- Data Lake - a centralized repository designed to store, process, and secure large amounts of structured, semi-structured, and unstructured data
- Data Sharing Agreement (DSA) - an agreement between two or more parties that outlines which data will be shared and, most importantly, how the data can be used
- ETL- Exact, transform, load- Combining data from multiple sources into a large, central repository called a data warehouse.
- FHIR- Fast Healthcare Interoperability Resources - defines how healthcare information can be exchanged between different computer systems regardless of how it is stored in those systems
- Health Related Social Needs (HRSN) - the social and economic needs that individuals experience that affect their ability to maintain their health and well-being. HRSN are more immediate individual, or family needs impacted by those condition
- Memorandum of Understanding (MOU) - a starting point of negotiations between multiple parties to signal the intent of doing business or coming to an agreement
- Outcome Measure- Focuses on the health status of a person (or change in health status) resulting from health care (desirable or adverse)
- Population Health - The health outcomes of a group of individuals, including the distribution of such outcomes within the group.
- Process Measure – Focuses on the steps that should be followed to provide good care.
- Social Determinants of Health (SDOH) - the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks
- Stratification – Slicing patient data by age, race, gender, ethnicity, language and other variables, including socio-economic conditions and social determinants of health
- Value Based Purchasing/Payment (VBP) - ties provider payments to patient outcomes, aligning incentives to improve care and reduce unnecessary costs