BUILDING STRONGER BUSINESS PRACTICES FOR VALUE-BASED PAYMENT READINESS:
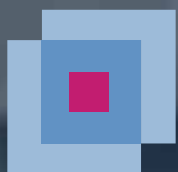
EXAMPLES FROM THE FIELD

Care Transitions Network

for People with Serious Mental Illness

PURPOSE OF THIS PAPER

Strong business practices are essential for behavioral health providers to transition to value-based payment. This paper explores best practices in core business competencies that many organizations may struggle with including:

Budget management and return on investment calculations;

Transparent sharing of financial data to enhance internal business competencies; and,

Demonstrating the value organizations can bring to value-based payment models.

The National Council for Behavioral Health's (National Council) Care Transitions Network utilizes the Center for Medicare and Medicaid Services' (CMS) Practice Assessment Tool that defines 22 milestones provider organizations can work toward in preparation for value-based payment. The Practice Assessment Tool originates from the Transforming Clinical Practice Initiative (TCPI)[1], but was adapted by the National Council to apply more directly to behavioral health. The tool has milestones that address several key areas such as developing quality improvement strategies, utilizing evidence-based practices and coordinating care across the health care neighborhood. Two of the milestones focus specifically on strong business practices:

Milestone 18	Practice uses sound business practices, including budget management and return on investment calculations.
Milestone 20	Practice shares financial data in a transparent manner within the practice and has developed the business capabilities to use business practices and tools to analyze and document the value the organization brings to various types of alternative payment models.

To help practices achieve these milestones, the Care Transitions Network conducted a series of interviews with 14 high-performing practices to garner success stories and lessons learned (see Appendix for a complete list of the practices). This paper shares findings from these interviews and provides guidance on best practices.

BUDGET MANAGEMENT AND RETURN ON INVESTMENT ANALYSIS: MILESTONE 18

Milestone 18 focuses on sound business practices that are fundamental to organizational sustainability and help lay the groundwork for transitioning to value-based payment. Key areas of achieving this milestone, which this paper will discuss, include:

- Developing and managing a budget, at the program or service level.
- Performing variance analysis.
- Creating efficiencies and controlling costs.
- Applying risk stratification and principles of utilization management.
- Conducting return on investment analyses.

MILESTONE 18 Practice uses sound business practices, including budget management and return on investment calculations to monitor value at the service line or clinical episode level, accounting for both costs/efficiency and clinical outcomes.

LEVEL 0: Practice operates on a cash basis, balancing revenue and expense regularly, but is not prospectively developing budgets and routinely using budget variance calculations and return on investment (ROI) calculations for new investments.

LEVEL 1: Practice has an annual operating budget at the practice level but does not regularly perform variance analysis or make required adjustments.

LEVEL 2: Practice reviews its budget against actual performance regularly. Variances are explained and adjustments made as needed. However, decisions on new or expanded programs/services are not systematically reviewed to determine expected ROI and how this impacts the budget.

LEVEL 3: Practice consistently uses sound business practices, managing budgets at both the practice and department level (if applicable). ROI calculations are factored into decisions on new programs and these are factored into budget projections.

DEVELOPING AND MANAGING THE BUDGET

In a health care environment increasingly driven towards value, it is essential that providers budget at the individual program level (e.g., budget for the ACT team) or clinic level (e.g., physical location or clinic site) and understand their costs for a given patient based on an episode of care. The basics of developing a budget are to gather historical practice data, develop key assumptions for the coming year and project anticipated revenues and expenses.

Best practices in budget development and management include:

■ **BUDGET AT THE INDIVIDUAL PROGRAM OR CLINIC LEVEL AND UNDERSTAND COSTS FOR A GIVEN PATIENT BASED ON AN EPISODE OF CARE.** Providers need to understand their actual costs, including personnel, fixed/occupancy costs, operating costs, administrative overhead and, ideally, be able to break this down by the individual location or clinic site.

Key questions to ask during budget preparation include but are not limited to: Do we expect increases or decreases in the demand for the services we provide? Are we adding new service lines, additional personnel or locations? Do we have any new capital costs such as buildings, health information technology or equipment? On the revenue side, what do we anticipate in terms of client-pay? Have there been any changes in reimbursement rates or "billable" services (e.g., new codes)? Have we obtained any new grants from public or private sources? Do we have any value-based (not fee-for-service) payments anticipated, such as incentive payments, per-member/per-month or shared savings that can be reinvested?

One of the reasons to budget at the individual clinic level is to account for differential rates you may experience in costs, such as facility costs. *Horizon Health Services* shared the importance of accounting for cost variations in different settings. For example, rent and utilities costs may differ in an urban setting compared to a rural setting, yet reimbursement for services may stay stagnant. When developing their budget, *Horizon Health Services* looks at where services are being provided, cost per square foot at that location, administrative costs, direct care staff costs and service and payer mix by location. They also consider margins needed to keep enhancing their programs and meet equipment/information technology needs.

■ **USE DATA TO UNDERSTAND PATIENT UTILIZATION PATTERNS.** When budgeting, review the past year's productivity in terms of encounter rates, ideally broken down by type of service. Understanding patient utilization patterns can be helpful in predicting future patient behavior. It is also beneficial in projecting revenues to know the breakdown of patients by payer source.

■ **UNDERSTAND HOW COSTS COMPARE TO OTHER PROVIDERS.** Obtain national or state benchmark data and evaluate where your practice stands in relation to other providers so you can modify accordingly. For example, if a 20 percent overhead is standard, but your costs are closer to 25 percent, explore where you can cut down administrative expenses. Potential sources of data for benchmarks include the National Council of Nonprofits or state or regional associations of nonprofit organizations, trade associations such as association of community mental health providers, Agency for Healthcare Research and Quality (AHRQ) or the state office of behavioral health.

■ **ENSURE BUDGETING IS A COLLABORATIVE EFFORT ACROSS DEPARTMENTS.** Program and finance staff both bring critical knowledge to the budgeting process and it is important they work together to develop a budget incorporating financial, clinical and administrative realities.

Acacia Network uses a collaborative process between finance and program staff through three iterations of budget development. In drafting the initial budget, they look back at the previous year and consider their actual spending as well as income/revenue collection. They project and analyze for next year, taking into consideration personnel costs such as new hires and cost of living adjustments (COLA). In their second cut, the operations team assesses if they project any increases in patient census (e.g., new patients and/or growth in number of encounters). They also take their contract deliverables and what revenue they will need to ensure fiscal sustainability into consideration. The budget is finalized by finance and approved by their Board of Directors.

PERFORMING VARIANCE ANALYSIS

To make a budget useful, it must be closely monitored and evaluated through regular variance analyses – identifying any deviations in your actual finances from the expected norm (your budget), how much they vary and for what reason. Budget vs. actuals should be monitored on a regular basis (e.g., monthly or quarterly) so that potential issues can be identified early on. The information obtained from a variance analysis can be used to appropriately direct attention toward a solution.

Catholic Charities Neighborhood Services (CCNS) views budget setting and monitoring as a collective effort between financial and program teams. Budgets are detailed by line of service. Monthly reports are developed for monitoring purposes and expenses and revenue are reviewed by service line to meet projected goals for the quarter. This information is used to determine where they need to increase productivity, cut expenses by achieving efficiencies or make any other adjustments.

ACHIEVING EFFICIENCIES AND CONTROLLING COSTS

When conducting variance analyses, practices may find they are spending more or bringing in less revenue than anticipated. There are several key ways practices can work to control costs and achieve efficiencies. The National Council's Quality Improvement Toolkit offers additional useful strategies.

■ **ESTABLISH PRODUCTIVITY GUIDELINES AND HOLD STAFF ACCOUNTABLE FOR MEETING GOALS.** Nearly all practices interviewed cited the importance of this approach.

Lighthouse Guild International/JGB Mental Health and Mental Retardation Services shares productivity and census data every week, broken out by individual staff member. This transparency has encouraged accountability and buy-in from staff. Similarly, *Liberty Resources, Inc.*, clinicians see their own productivity data weekly during supervision. Any clinician can go into the organization's internal data warehouse to see where they fall in relation to their peers.

Sullivan County Department of Community Services established productivity guidelines for clinical staff and provided tools to help ensure staff could meet them. Each clinician knows they need five units of service per day. Data on their productivity is given to them monthly along with their case list. They also worked to enhance their billing and coding processes and ensure timely and accurate claims submission (within 24-48 hours).

■ **CONTROL COSTS THROUGH REVIEW OF CLINICAL WORKFLOWS AND IDENTIFICATION OF OPPORTUNITIES TO CREATE EFFICIENCIES.**

CCNS uses process mapping to identify and mitigate any bottlenecks and achieve efficient yet patient-centered workflows. Workflows are consistently revisited, and staff are engaged in discussion around potential improvements.

■ **OPTIMIZE STAFF TO THE TOP OF THEIR LICENSURE.** As part of process mapping, organizations can look at each member of the care team's roles and responsibilities and identify any duplication of effort or opportunities to utilize team member differently. This can help ensure that all providers are working to the top of their licensure. For example, who is collecting vitals during the patient visit? Does the clinic fully utilize their medical assistant (MA) and/or nursing staff?

Central Nassau Guidance and Counseling Services (Central Nassau) realized some prescribers were doing their own prior-authorization work, which was detracting from their time with patients. They established a more efficient and cost-effective process; now administrative staff handles prior authorization.

Warren-Washington Association for Mental Health (WWAMH) found it to be more cost-effective to utilize psychiatric nurse practitioners (NPs) in lieu of psychiatrists (MDs). They determined that NPs can provide the exact same service and the same quality of care at half the cost. Rather than employing full-time psychiatrists, they utilize one 0.10 psychiatrist who provides supervision to one-and-a-half full-time psychiatric NPs, who provide the direct services to patients.

MAXIMIZE BILLING AND CODING. Providers should revisit clinical practices to ensure they are capturing all billable services and coding appropriately for all services. Sometimes slight modifications to services may enable practices to maximize billing. For example, *CCNS* previously used a Modified Simple Screening Instrument for Substance Abuse (MSSI-SA) but realized if it they moved to a full Screening, Brief Intervention and Referral to Treatment (SBIRT) model, it would be reimbursable.

Concurrent or collaborative documentation saves clinicians the time of going back into the client record later to complete notes, maximizing productivity. *Sullivan County Department of Community Services* trained all clinical staff in concurrent collaborative documentation and bought the necessary equipment to ensure all group rooms had what was needed to facilitate the process. This has resulted in higher productivity.

UTILIZATION MANAGEMENT (UM) AND RISK STRATIFICATION

Risk stratification is essential for providers to target interventions appropriately, improve patient outcomes and control costs. The National Council's Risk Stratification Tool and User Guide offers useful guidance. Rather than giving all patients the same level of care or set of services, providers can better manage their limited resources. This concept, referred to as utilization management (UM), is most commonly applied in the context of managed care organizations (MCOs). However, some types of value-based payment contracts shift some of the responsibility for UM to the provider. For example, in a population-based payment arrangement (e.g., bundled payment or capitation) providers are paid a set amount per patient for a designated time-frame regardless of how many services a patient utilizes. In these arrangements there are often tiered levels of payment based on a patient's level or risk. Providers are thus incentivized to manage their costs by ensuring services are appropriate to the patients' level of risk.

While population-based payments are not currently common for behavioral health in New York, some providers are applying these principles. *Institute for Family Health (IHF)* uses a risk stratification tool to help make appropriate referrals for care management. Risk scores are auto-populated into their electronic health records (EHR) system and referrals may be made by either a primary care physician (PCP) or behavioral health provider. This helps them identify and direct appropriate candidates for care management rather than assuming all clients require that level of assistance.

Metropolitan Center for Mental Health employs a risk stratification protocol. Scores derived from evidence-based screenings that assess categories of risk are collected for all patients at initial assessment. Exceeding thresholds on these screening tools automatically designates a patient to be at-risk for a specific category (e.g., harm to self or others, decompensation), which prompts a specific care pathway that meet the needs highlighted by the risk category (e.g., expedited psychiatric evaluation, specialized treatment plan, case monitoring by the quality management [QM] department). Differentiated care pathways stemming from risk stratification also trigger quality measures that would play a determining role in a value-based payment (VBP) arrangement.

Liberty Resources differentiates between patients who qualify for case management vs. care coordination. For patients who meet the MCO's qualifying factors, care coordination is a billable service. Yet all patients still have access to case management, which assists patients in addressing immediate needs such as affordable housing, emergency services, etc. The agency

has found that the investment in case management, while not a billable service, is important as it impacts client engagement and outcomes.

Central Nassau uses risk stratification to ensure that patients who are at high risk receive additional support – "more eyes and more touches" to help keep them safe. Simultaneously, they help patients who are low risk or have come further along in their recovery process to "step down" from more intensive services and replace them with natural community supports when possible. While they do not "kick people off" services, they do work to show them how far they've come and use standardized tools to demonstrate patient progress.

RETURN ON INVESTMENT ANALYSES

When organizations invest in a new program, service line, quality improvement intervention or health information technology, it is important to know what kind of financial return the investment will yield. An ROI analysis calculates the net financial gains (or losses), accounting for all the resources invested and all the amounts gained through increased revenue, reduced costs or both. As providers move into value-based payment arrangements, it is increasingly important to consider the impact of an investment in achieving improved health outcomes.

University of Rochester, Strong Ties/Medicine in Psychiatry Services (URMC) has a particularly sophisticated approach to ROI, hiring a health economist to support this work. When conducting ROI analysis, they take into consideration any reduction in high cost utilization and improvements to the patient's quality of life. They work from the assumption that a higher quality of care should lead to a reduction in the cost of care in the long-run. URMC utilizes data from their EHR and the hospital system, but recognize limitations in data on care being received from other providers. They are in discussions with several potential partners to obtain additional information, such as Medicaid claims data, and have a collaborative partnership with a major MCO, actively working to obtain total cost of care data.

Several other interviewees shared the importance of looking at ROI over an extended timeframe. *Mosaic Mental Health* invested in a Critical Time Intervention for clients with high utilization rates in partnership with a local hospital. Despite barely breaking even in the first year of the program, they continued offering the service due to evidence of impact on clients. In reviewing Medicaid utilization data, they found they had significantly reduced hospital costs. Mosaic Mental Health concluded it was strategic to continue the program and share this data with managed care companies with the hope that in the long term they will be able to participate in shared savings.

> URMC's approach to ROI is longitudinal. According to Carole Farley-Toombs, senior program administrator for the Department of Psychiatry, "We don't always have a positive direct margin in our clinics, but that doesn't mean that we shut them down. It means that we continue to engage in performance improvement activities to address the issues that are risking financial viability. We know that it takes time to get an ROI. Patients don't turn around overnight and transforming services to improve access and engagement takes time, so you have to have some patience."

CCNS considers the "social ROI" in addition to financial ROI – taking into consideration community needs and most essential services in the eyes of stakeholders and community partners. They are willing to bear upfront costs for new investments considered worthwhile to the community. In the coming year they are also planning to look at program- or service-level financial data side-by-side with outcome data to identify what it costs to deliver specific outcomes to certain populations.

MILESTONE 20

Milestone 20 focuses on engagement of non-finance staff in the concepts of value-based care and alternative payment models (APM), as well as defining roles in contributing to the organization's overall financial strength. It addresses how organizations demonstrate value to current and prospective payers. Key activities to achieve this milestone, which this paper will address, include:

- Staff training to build financial acumen and readiness for VBP.
- Documenting value/developing a value proposition.

MILESTONE 20 Practice shares financial data in a transparent manner within the practice and has developed the business capabilities to use business practices and tools to analyze and document the value the organization brings to various types of APMs.

LEVEL 0: Practice, or the larger system to which it may belong, has not developed business acumen in the various types of APMs. Financial skills development is limited to finance staff.

LEVEL 1: Practice has educated team members on value-based payment arrangements for behavioral health and the impact they have on revenue streams.

LEVEL 2: Practice provides specialized training to those at the practice level who may be involved in analysis of value-based payment arrangements and in contracting for services. Training extends beyond finance staff to clinical supervisors or others responsible for clinical service design.

LEVEL 3: Practice can analyze and document its cost-per-service and demonstrate its value vis-a-vis various types of value-based payment arrangements.

STAFF TRAINING/BUILDING FINANCIAL ACUMEN FOR NON-FINANCE STAFF AND PREPARING STAFF FOR VBP

Many interviewees reported providing clinicians and other non-finance staff with some level of training on basic financial concepts such as how to read and understand a balance sheet, reducing no-shows and reaching productivity targets, accurate and comprehensive coding and billing and level-setting around value-based payment and changes within the health care environment. These trainings are important to increase financial acumen of clinical and line staff and help them better understand the evolving health care landscape and the financial impact of the services they provide.

Horizon Health Services did a level-setting webinar for all staff to paint a picture of health care reform and what the implications of their work would mean down the road.

Acacia Network brought in professional coders in both mental health and primary care throughout their network who provided clinical staff with trainings about billing to ensure providers understood what services are billable and how those services are correctly coded in the EHR.

Many interviewees noted that managers may require more extensive training – such as understanding actual deliverables in contracts – to help support staff they supervise in transitioning to value-based care.

Central Nassau quickly learned the importance of obtaining buy-in at all levels when they began communicating about VBPs to all clinical staff before they had the full buy-in of middle managers. Managers felt unprepared to support staff in understanding and adapting to shifts in practice. They also learned the importance of asking the opinions of line staff before making workflow changes or other significant shifts within the clinic.

IFH decided that managers needed a higher-level understanding of VBP models, while for clinicians the micro-level was more appropriate and immediate. Utilizing their existing structure of regional management meetings, *IFH* offered presentations around VBP and APMs for managers with the hope that managers will then share a modified level of information down to line staff. Each site has a monthly all-provider meeting. *IFH* began integrating discussion about VBP and outcome measures into those meetings by introducing specific scenarios and doing role plays. These focused more on clinicians' and other staff members' role in containing costs, reaching financial targets and achieving outcomes.

URMC used a similar approach, working from the philosophy that since their clinicians are working with patients with very complex health care needs, they did not want to overwhelm staff or ask for an excessive amount of their time. According to Maria Romana, psychiatric nurse practitioner, "We want to give them an environment where they feel like they can focus on the patients they are taking care of. We certainly engage the staff all the time in performance improvement opportunities…. We try to think about what is appropriate for them to manage within the scope of their practice." For example, *URMC* shares data on no-show rates for the month and other data that would be useful to nurses and clinicians to help them utilize Lean principle and implement Plan-Do-Study-Act processes around issues such as patient engagement.

DOCUMENTING VALUE: DEVELOPING A VALUE PROPOSITION

In simplest terms, a value proposition is a positioning statement that explains what benefit an organization provides, for who and how the organization does it uniquely well. It describes the targeted customer/patient/client, the problem(s) the organization seeks to address and how and why the organization is better than their competitors. Developing a value proposition can be very beneficial for behavioral health providers in negotiating with payers around value-based payment.

The Care Transitions Network developed a PowerPoint template, Understanding Value-based Payment: A Primer for Staff, to support behavioral health provider organizations in their efforts to facilitate the shift to VBP. Organizations can use or adapt this template to teach clinicians and staff about the fundamentals of VBP and their role in the changing health care landscape.

Mosaic Mental Health is working to carve out their niche as a specialty care provider while still building alliances with hospitals and other strategic partners. According to Mosaic Mental Health's executive director, Donna Friedman, Ph.D., LCSW, "I have found that it is an opportunity for us to partner with organizations and that has been powerful. Part of being able to do that is having the courage to know that just because we are small, that doesn't mean that we don't have value and that we shouldn't have a voice. We realize that we have something very important to offer. Those who use Medicaid the most are those who need help the most and who walked through our doors. Don't underestimate the power of sharing your impact because of your size."

Dr. Friedman added, "Part of our strategic plan has been to grow in the areas that are most highly sought after as a small organization so that we have a reason for being in this world where people are getting gobbled up and consolidating."

Several interviewees discussed the importance of building community partnerships, particularly with primary care – and/or integrating with primary care. This creates additional opportunity for behavioral health providers to help curb the total cost of care and expand on their value proposition. For example, *URMC* is focusing on patients with serious mental illness and co-morbid diabetes or cardiovascular disease. Registered nurses (RNs) do primary care screenings and monitoring and make sure patients get their lab work done according to evidence-based standards. They also closely coordinate with the patient's primary care provider or work to get them into primary care if they lack a provider. As a result, they anticipate a reduction of acute services utilization, unnecessary testing and hospitalizations and other indicators that increase overall health care costs.

WORKING WITH IPAS OR BHCCS TO DOCUMENT VALUE

Many interviewees found it strategic to negotiate with payers as part of an independent providers association (IPA). Participation in an IPA gives behavioral health providers collective bargaining power, an enhanced value proposition and larger impact in terms of number of covered lives/people served. In New York, some behavioral health providers were provided funds to create Behavioral Health Care Collaboratives (BHCCs) to invest in infrastructure to improve health outcomes, manage costs and participate in VBP arrangements as defined in the New York State Value Based Payment Roadmap. BHCCs may take the form of an IPA. While IPAs and BHCCs may be collectively negotiating with payers, individual organizations may still need to demonstrate their value to the IPA/BHCC so their community partners understand all that they bring to the table.

Most of the interviewed organizations said that data was one of the biggest focus areas for their IPA or BHCC. For example, the *Institute for Family Health* is part of an IPA that is creating a data warehouse so all members can share data and negotiate as a group. In the IPA that *Metropolitan* is participating in, the network is working to integrate and align all EHRs to capture the same level of data for all patients and use this data for population health management.

Multiple practices interviewed mentioned that health outcomes are another key focus and negotiating tool within the coalitions. *CCNS*'s IPA is doing analytics on network integration through a pilot program. Their IPA is trying to build a comprehensive network of providers that can address social determinants of health care – the current pilot is working with care coordination programs. *Lighthouse Guild* is part of a behavioral health network that is focused on clinical results, looking at treatment plans and health outcomes.

While all these networks are made of different providers, it is clear what participants hope to gain from participation: a strong network of organizations that leverage each other's data, resources, knowledge and passion to negotiate with payers for

value-based contracts. Alone, these organizations may not have the ability to obtain or succeed under value-based contracts. Several practices interviewed noted that without the IPA/BHCC they are at the mercy of the payer and aren't taken seriously when looking to contract. Either the practice is too small, they don't have enough data or their target population is too narrow for payers to see the value to the community and their clients. *WWAMH* noted that they were indirectly told they wouldn't be able to independently contract on a larger scale with a managed care organization. The IPAs and BHCCs have given these practices the opportunity to build stronger relationships with the payers providing a platform for practices to showcase their value amongst other practices.

ADDITIONAL BEST PRACTICES

Beyond the strategies interviewees utilized to achieve milestones 18 and 20, they highlighted best practices in several other important areas related to readiness for VBP. These apply across the board for transformation initiatives and enhancing business practices. Additional best practices discussed in this paper include:

- Culture change and messaging.
- Embedding value-based care in organizational policies and procedures.
- Strategic planning.

CULTURE CHANGE AND MESSAGING

Organizational culture is a tremendous factor in supporting or inhibiting success under VBP. Leadership plays a key role in shaping organizational culture and communicating with staff about internal changes and the external factors necessitating those changes. Several interviewees spoke about the importance of connecting the dots, so clinicians understand why changes are being made and how those changes relate to health care reform and the shifting expectations of payers.

Metropolitan Center's Executive Director, Robert Basile, Psy.D., developed a letter to staff that addressed changes in the external environment and how the agency is adapting to those changes. *Metropolitan Center*'s leadership will continue to keep staff appraised of changes and how they can have a voice in that process. According to Dr. Basile, "Staff need to understand not only the what, but the why."

Metropolitan Center also decided it was important to acknowledge the great work staff are already doing, as well as broadly communicate the changes being made that will help demonstrate and quantify their impact so their work is recognized by payers and the community at large. *Lighthouse Guild* found that effective messaging with staff revolved around the theme, "We are all in this together." This messaging helped staff see that leadership was approaching organizational change in a collaborative way and with the best interests of their patients in mind.

Multiple interviewees discussed the impact of seeing other agencies close programs, lay-off staff or shut down entirely. For example, *Horizon Health Services* discussed that seeing this happen around them drove a sense of urgency for staff. Leadership worked to build staff buy-in for change by conveying that they are an organization that respects and prioritizes the people who come in through the door but also recognizes that "no margin = no mission." *Horizon Health Services* also commented they were aware that "change will either happen WITH us or change will happen TO us" (and they would rather lead).

CCNS's executive team has been visiting team meetings to help build staff awareness and understanding of agency efforts. They found this a beneficial approach to create dialogue and eliminate any sense of "the ivory tower."

Sullivan County Department of Community Services leadership worked to provide a clear message that value-based care is for the betterment of the staff and the betterment of the clients being served. They also communicated that employees at all levels are valued and that leadership needs to hear from the bottom up because that is where the work is being done. If clinicians identify something that would help make changes easier to implement (such as some kind of additional technology or training), leadership is supportive of making that happen.

EMBEDDING VALUE-BASED CARE IN ORGANIZATIONAL POLICIES AND PROCEDURES

Some interviewees have taken additional steps to facilitate culture change by clearly articulating expectations of staff around participation in quality improvement (QI) efforts, use of data and nimbleness or flexibility. *Central Nassau* adapted clinician job descriptions to reflect the organizational value around QI and being data-driven. They also adapted their interview routine to ask about how people respond and adapt to change and build these expectations into new staff orientation.

CCNS clinicians are informed about their financial responsibility to the clinic during the application and interview process. This has proven beneficial to the organization in attracting high quality staff and is appealing to applicants that the organization is financially viable.

STRATEGIC PLANNING

Liberty Resources developed a strategic plan around readiness for VBP and created new structures (which are ongoing) to implement the plan through cross-departmental teams, which include staff at all levels across finance, administrative staff, clinicians, front office staff, etc. Liberty believed it was important that everyone came together to develop a shared mission and vision. This kind of work requires that leadership allows staff to spend time in this way and provide structure that facilitates the planning and implementation work.

Liberty Resources also discussed the importance of being nimble as an organization to be able to pivot and shift. They encourage team members to be creative and think about new and creative ways of solving problems or addressing challenges. One of their lessons learned in preparing for value-based payment is that it is OK to try something out, make mistakes and learn from them.

SUMMARY OF THE KEY CHALLENGES PRACTICES FACE

Behavioral health providers face numerous challenges in the evolving health care landscape that may impede their ability to be successful under VBP arrangements. While the Care Transitions Network has focused on helping build new organizational capacity and provider competencies, there remain systemic factors that are beyond the control of individual agencies. Interviewees cited a number of these challenges including:

■ TRANSITIONAL COSTS.

There may be costly upfront investment required to build data analytics and other infrastructure to support value-based payment. Several providers referred to this as an "unfunded mandate." Interviewees spoke about the challenges in freeing staff

time to work on quality improvement and other activities that are necessary to make VBP work while they are still operating in a predominately fee-for-service environment.

Potential opportunities for offsetting these costs include organizations sharing costs through partnerships such as IPAs or BHCCs or applying for grants from local government or private foundations.

◼ INFORMATION SHARING WITH OTHER PROVIDERS IN THE HEALTH CARE NEIGHBORHOOD AND NAVIGATING CONFIDENTIALITY REQUIREMENTS.

Interviewees noted challenges in sharing information with other providers in the health care neighborhood for shared patients. Navigating confidentiality requirements that are more extensive in behavioral health and finding ways of integrating data across separate EHRs have made this difficult. Providers who are participating in IPAs or BHCCs seem hopeful that collectively they will develop strategies to help mitigate these challenges. Regional Health Information Organizations (RHIOs) RHIOs may also prove beneficial in facilitating information sharing.

◼ LACK OF ALIGNMENT ACROSS PAYERS AND INITIATIVES.

When it comes to behavioral health, payers may have differing priorities or are moving to implement changes at varied timelines. Agencies serving patients with a mix of payer sources also reported challenges to tracking various requirements and measures between Medicare, Medicaid MCOs and private insurance carriers. Some providers are hopeful that the State of New York's VBP roadmap will guide this work and help create better alignment among the MCOs. At the national level, the Healthcare Payment Learning Action Network (HCPLAN) may help promote alignment or, at a minimum, shared definitions on payment models.[2]

CONCLUSION

The Care Transitions Network developed this paper to help behavioral health providers enhance internal business competencies and gain best practices from high-performing organizations. Milestones 18 and 20 are stepping stones toward provider readiness for value-based payment and emphasize core business competencies, including the ability to develop and manage clinic or program level budgets and perform return on investment analyses. Transparent sharing of financial and outcome data is also essential to create staff buy-in and demonstrate the value organizations can bring to value-based payment models. The fourteen high-performing Care Transitions Network practices interviewed have achieved these milestones, yet nearly all fourteen described their work as ongoing. As the health care landscape continues to evolve, behavioral health providers must also embrace change and help staff in developing new competencies. Continued opportunities for practice transformation support and peer-to-peer learning may be needed. The Care Transitions Network aims to use this paper to help additional participating organizations achieve these milestones and develop an organizational culture that embraces value-based care.

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1. TCPI is an initiative of the Center for Medicare and Medicaid Innovation and is designed to help clinicians achieve large-scale health transformation. The initiative supports clinician practices over four years in sharing, adapting and further developing their comprehensive quality improvement strategies. The National Council was awarded a cooperative agreement to serve as one of the TCPI Practice Transformation Networks and formed the Care Transitions Network. The Care Transitions Network supports behavioral health providers throughout the State of New York.

2. The HCPLAN is a public-private partnership established to accelerate transition in the healthcare system from a fee-for-service (FFS) payment model to ones that pays providers for quality care, improved health and lower costs (see https://hcp-lan.org/).

APPENDIX

The National Council and the Care Transitions Network would like to thank the following agencies and individuals for sharing their time and expertise with us for this paper.

Acacia Network: *Acacia Network is a non-profit organization that was created in the 1960s and 70s by men and women from Puerto Rico who wanted to create a better living environment for their Latino community. The founders' vision of integrated care through social services and housing programs is still represented today in Acacia's mission. Located in the Bronx, Acacia continues to serve the community's underserved population.*

- Vicky Gatell
- Kevin Heslop

Catholic Charities Neighborhood Services, Inc.: *Catholic Charities Neighborhood Services is a non-profit organization serving communities in Brooklyn and the Queens areas of New York City. Catholic Charities Neighborhood Services has a network of practices with independent structures, but united in a common vision of care. The practices protect and nurture children and youth, feed the hungry and shelter the homeless, strengthen families and resolve crises, support the physically and emotionally challenged and welcome and integrate immigrants and refugees.*

- Jim Norcott
- Delroy Davey
- Claudia Salazar
- Alan Wolinetz

Central Nassau Guidance and Counseling Services, Inc.: *Central Nassau Guidance and Counseling Services is a non-profit organization located in Long Island, N.Y. Central Nassau works to improve the quality of life for individuals affected by mental health and/or substance use disorders in the area. Driven by a belief that every individual has the ability to recover, the organization works to integrate mental health and physical health care.*

- Lindsay Ragona
- Joanna Contreras
- Lina Vinas
- Jean Furdella

Hudson Valley Mental Health, Inc.: *Hudson Valley Mental Health is a non-profit corporation providing behavioral health services to the communities of Dutchess County and Ulster County. Operating eight clinics, Hudson Valley Mental Health is dedicated to providing comprehensive and integrated services to adults living in the community. The services range from individual and group therapy to treatment and re-entry programs for inmates at the Dutchess County jail.*

- Robin Peritz
- Joan Crawford
- Ranjeet Sivaraman

Horizon Health Services, Inc.: *Horizon Health Services, located in Buffalo, N.Y., assists hospitals in managing their behavioral health programs through planning, development and implementation of new behavioral health service lines as well as the management of struggling existing services.*

- Judy Tejada
- Paige Prentice

Institute for Family Health: *Institute for Family Health is a non-profit, Federally Qualified Health Center, with practices throughout New York City, which are all working to address health disparities, advance the use of health information technology, address women's health, depression, diabetes and HIV. Given IFHs strong commitment to improve the health care system, all individuals in the community are able to receive services from IFH.*

- Michaela Frazier

Jawonio, Inc.: *Jawonio, is a non-profit provider organization dedicated to improving the lives of individuals with disabilities and special needs – focusing on developmental disabilities, behavioral health challenges and chronic medical conditions. Located in the Hudson Valley area of New York, Jawonio provides care to more than 10,000 individuals each year.*

- Jane Mullin

Liberty Resources, Inc.: *Liberty Resources is a non-profit provider organization, based in Syracuse, N.Y. – with satellite sites in Oneida, Rochester and Fulton, N.Y. These practices provide shelter, treatment and counseling to around 16,000 clients.*

- Jennifer Fuller
- Kelly Kogesie
- Miriam Shore
- Alicia Clifford

Lighthouse Guild International/JGB Mental Health and Mental Retardation Services: *Lighthouse Guild International, a non-profit provider located in New York City, is dedicated to helping those with vision disabilities. The organization works to coordinate eye health, visual rehabilitation, behavioral health and related services to their clients with the goal of reducing the burden of living with vision impairment.*

- Ed Ross

Metropolitan Center for Mental Health: *Metropolitan Center for Mental Health is located throughout New York City. As a non-profit organization, Metropolitan offers a wide range of services for individuals of all ages. In addition to their services provided at the clinic level, staff also provide consultation to community schools, religious organizations and other interested local groups.*

- Robert Basile

Mosaic Mental Health, Formerly Riverdale Mental Health: *Mosaic Mental Health is a non-profit that provides mental health services for individuals of all ages and income levels. Located in the Bronx, Mosaic works to improve the lives of their community members with specific programs for children and families, adults and seniors.*

- Donna Friedman

University of Rochester, Strong Ties/Medicine in Psychiatry Services: *The University of Rochester Medical Center is a non-profit research university. The Strong Memorial Hospital, located in Rochester, New York, is a national renowned clinical care institution with top clinical programs serving the community.*

- Carmella Re
- William Gutschow
- Carole Farley-Toombs
- Maria Romana
- Dr. Daniel D. Maeng
- Joanne Cianci
- Julie Moeller

Sullivan County Department of Community Services: *Sullivan County Department of Community Services is a county entity located in Monticello, N.Y. The practice provides mental health and substance use disorder treatment for all residents of Sullivan County.*

- Melissa Stickle
- Francis Cole
- Katherine Johnson
- Heidi Reimer

Warren-Washington Association for Mental Health: *The Warren-Washington Association for Mental Health, located in Hudson Falls New York, provides mental health services for the individuals in the community. The services range from residential services, clinical counseling, benefits management, and care management.*

- Andrea Deepe

Have questions about this resource?

Contact Mindy Klowden, MNM, Director of Training and Technical Assistance, at MindyK@TheNationalCouncil.org.