Care Transitions Network

for People with Serious Mental Illness

Completing the Specialty Practice Assessment Tool: Guide for Behavioral Health Organizations and Divisions

Instructions: Please find below guiding questions for behavioral health organizations or divisions as they complete the Specialty Practice Assessment Tool. The Specialty Practice Assessment Tool was developed by the Centers for Medicare and Medicaid Services (CMS) to help organizations and practices benchmark their progress towards becoming high performing practices that provide excellent patient- and family-centered care, have robust quality improvement practices in place, and the business acumen to engage in alternative payment models. The Practice Assessment Tools (both Primary Care and Specialty) are being used by practices nationwide.

This guide is designed to translate practice milestones to behavioral health settings. Each milestone is linked to one of the change concepts detailed in the Transforming Clinical Practice Initiative's change package, which describes the changes needed to transform clinical practice. For each milestone identified in the Practice Assessment Tool, we have included some clarifying information and considerations. Please use the guiding questions to prompt thinking or conversation with your team.

Each individual practice will complete the Specialty Practice Assessment Tool. We encourage you to assess your practice as openly and candidly as possible. We anticipate that every practice--regardless of its size, IT capacity, location or patient population--will identify strengths and opportunities for improvement. **No practice will initially score in the fifth phase of transformation.** At this stage, we expect that most practices have not yet set goals to achieve the milestones outlined below.

Scoring Guidelines: We recognize that the team member who completes this assessment will not necessarily be able to assess every milestone. If you are unable to assess a particular milestone, please score "0." Also, if your practice does not collect data relevant to a particular milestone, please insert a score for that milestone of "0."

Please direct questions to: CareTransitions@theNationalCouncil.org

Results Related to Aims		
Change Concept Reference	**Practice Milestone**	**Guiding Questions**

None	Practice has met its targets and has sustained improvements in practice-identified metrics for at least one-year	• Has your practice set quality improvement targets? *Examples of quality improvement targets for behavioral health:*
		  • *Reduction in hospitalization rates; emergency department visits; number of days between referral and intake, intake and first session, referral to first prescriber visit; no show rates.*
		  • *Increase in use of long acting injectable medications, clozapine, metabolic screenings, substance use screening and tobacco screening.*
		• Does your practice have baseline data against which it can measure progress over time?
		• If your practice has already set targets and collected baseline data, has your practice seen sustained improvements in the past 12 months?

1.6.5	Practice has reduced unnecessary tests, as defined by the practice	This milestone does not directly correlate to behavioral health practice. When you think about this milestone, please consider your use of screening tools and psychopharmacology. For example: • Has your practice increased use of screening tools for metabolic measures? • Has your practice increased use of screening tools such as PHQ-9, Audit-C, and GAD-7? • Does your practice follow evidence-based approaches regarding the use of anti-psychotics and other psycho-pharmacology?
None	Practice has reduced unnecessary hospitalizations	• Does your practice routinely collect data on hospitalization rates? • If so, has your practice decreased hospitalization rates from its baseline in the last 12 months?

Patient and Family Engagement		
1.1.3	Practice can demonstrate that it encourages patients and families to collaborate in goal setting, decision making, and self-management	• Does your practice include patients and their families through treatment approaches? (*Examples include collaborative documentation when completing progress notes and treatment plans, encouraging self-management through the use of technology and applications for safety planning, health monitoring, skill practice, or recovery support*)
1.1.2	Practice has a formal approach to obtaining patient and family feedback and incorporating this into the QI system, as well as the strategic and operational decisions made by the practice	• Does your practice have a formal system for obtaining patient feedback? *(An example may be client satisfaction surveys)* • Does your practice have a policy and procedure to use patient feedback to improve the quality of care? • Does your practice routinely and consistently incorporate patient feedback into management systems and use it to improve quality? • Does your practice routinely include a peer participant in the utilization review process?
Team-based Relationships		
1.2.2	The practice sets clear expectations for each team member's functions and responsibilities to optimize efficiency, outcomes, and accountability	• Does your practice have clear job descriptions, including specific roles and responsibilities, for all team members? (*Please consider the roles of nursing, substance abuse counselor, therapist, care manager, peers, and prescriber)* • Has the practice matched the work that must be done before, during and after patient care with the specific team member(s) who will do the work? *(Please consider roles, responsibilities and accountability lines re: intake and discharge processes)* • Does your practice facilitate routine consultation and collaboration between team members? (*Examples may include having designated times for team members to collaborate on care for high risk clients, or using daily huddles for case consultation)*
Population Management		
1.3.3	Practice has a reliable process in place for identifying risk level of each patient and providing care appropriate to the level of risk. Risk	• Does your practice have a defined process to identify patients at all risk levels? • Has your practice developed corresponding descriptions of the type of care required at each risk level? • Does your practice maintain an accurate record of its highest risk clients?

	identification may be done within the specialty practice or may be obtained from the patient's primary care provider. Practice ensures that patients assessed to be at highest risk receive care management support or have a care plan in place that the practice is following.	• Does your practice provide appropriate case management for and promote regular assessment of its highest risk clients? (*Assessment of highest risk clients may occur during clinical and administrative supervision, team meetings, a referral process for care management, and/or a plan in place to engage and motivate clients who are high risk and not attending treatment consistently)*
Practice as a Community Partner		
1.4.4	Practice facilitates referrals to appropriate community resources, including community organizations and agencies as well as direct care providers.	• Does your practice have formal and/or informal relationships with community-based care providers in your community? (*Examples include primary care providers, housing providers, PROS programs)* • Does your practice facilitate appropriate referrals to community resources?
Coordinated Care Delivery		
1.5.2	Practice works with the primary care practices in its medical neighborhood to develop criteria for referrals for episodic care, co-management, and transfer of care/return to primary care, processes for care transition, including communication with patients and family	• Does your practice have established relationships with community-based primary care providers? • Has your practice worked with primary care providers to support appropriate patient referral, co-management, care transition, and communication with patients and their families? *(For example, your practice may have a system to coordinate with health home care managers)*
None	Practice identified the primary care provider or care team of each patient seen and (where there is a primary care provider) communications to the	• Does your practice have a protocol to communicate with primary care practices or health home care managers about each client? • If yes, is this protocol part of treatment planning?

	team about each visit/encounter	

Organized Evidence-based Care		
1.6.3	Practice uses evidence-based protocols or care maps where appropriate to improve patient care and safety	• Does your practice consistently incorporate evidence-based practice recommendations into policies and protocols? *(Clinical examples include policies around LAI's, clozapine, or polypharmacy)* • Does your practice ensure that therapists receive training in evidence based practices specific to your patient population?
Enhanced Access		
1.7.1	Practice has mechanisms in place for patients to access their care team 24/7	• Does your practice make a clinician available to speak with patients after-hours, and provide the clinician with access to the patient's medical record? • During normal business hours, does your practice provide enhanced access to care? *(Examples include same day access and just in time prescribing)*
2.1.2	Practice has developed a vision and plan for transformation that includes specific clinical outcomes and utilization aims that are aligned with national TCPI aims and that are shared broadly within the practice.	• Has your practice developed and disseminated a plan for transformation to all team members that includes how it intends to achieve key clinical outcomes? (i.e. a reduction in all-cause hospitalization, reduced time between referral and intake, etc).
Quality Improvement Strategy Supporting & Culture of Quality		
2.2.1	Practice uses an organized approach (e.g. use of PDSA's, Model for Improvement, Lean Six Sigma) to identify and act on improvement opportunities	• Does your practice's administrative and clinical leadership currently use an organized approach to quality improvement? • If so, does your practice routinely collect data to monitor the effectiveness/impact of QI projects and initiatives?
2.2.2	Practice builds QI capability in the practice and empowers staff to innovate and improve	• Have <u>all</u> team members received training in QI methods, including therapists, nurses, front office staff, and prescribers? • Does your practice's leadership, including supervisors,

		explicitly encourage all team members to identify challenges and use QI methods to propose, implement and evaluate solutions to improve performance and patient outcomes?
Transparent Measurement and Monitoring		
2.3.1	Practice regularly produces and shares reports on performance at both the organization and provider/care team level, including progress over time and how performance compares to goals. Practice has a system in place to assure follow up action where appropriate.	• Does your practice regularly produce and disseminate information to all team members on performance, including progress toward meeting its quality goals and financial targets? • Does your practice have a system in place that addresses barriers to progress?
Optimize the use of Health Information Technology		
2.4.1	Practice uses technology to offer scheduling and communication options that improve patient access by including alternative visit types and electronic communication approaches	Does your practice use technology to improve communication and increase access to care, including use of technology to provide alternative types of visits? (*Examples include tele-health technology, smart phone applications and text message appointment reminders)*
Strategic Use Of Practice Revenue		
3.1.1	Practice uses sound business practices, including budget management and return on investment calculations	• Does your practice prospectively develop budgets and routinely use ROI calculations to inform decision-making regarding new programs? • Does your practice regularly review its annual budget against actual performance? • Does your practice conduct regular variance analyses and make adjustments as needed?
Workforce Viability and Joy in Work		
3.2.3	Practice has effective strategies in place to cultivate joy in work and can document results	• Does your practice routinely employ pro-active strategies to cultivate joy in the workplace? *(Examples may include reward and recognition programs, staff development, social activities)* • If so, can your practice demonstrate the results?

		(Examples may include metrics such as staff survey results and retention rates)

Capability to Analyze and Document Value		
3.3.3	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	• Does your practice share financial data in a transparent manner within the practice? • Has your practice trained team members on alternative payment arrangements for behavioral health and the impact they have on revenue streams? • Can your practice analyze and document its cost-per-service, and demonstrate its value vis-a-vis various types of alternative payment models? • Does your practice provide specialized training to those at the practice level that may be involved in analysis of alternative payment arrangements and in contracting for services?
3.3.4	Practice considers itself ready for migrating into an alternative based payment arrangement	• Does your practice currently have the internal capability to succeed in an alternative payment system? • Is the practice confident in its readiness to migrate into alternative payment approaches?
Efficiency of Operations		
3.4.1	Practice uses a formal approach to understanding its work processes and increasing the value of all processing steps	• Has your practice reviewed its work flows and identified opportunities to eliminate waste? • Does your practice use a formalized, consistent, and focused approach to reviewing work flows and processes to eliminate waste? (*Please consider intake, discharge and referral processes)* • Do <u>all</u> team members in your practice understand the value of each process step to the patient and other customers?