

A close-up photograph of a person's hand holding a red pen, pointing at a bar chart on a document. The background is blurred, showing other documents and a desk. The lighting is warm and focused on the hand and pen.

NATIONAL  
COUNCIL  
*for Mental*  
Wellbeing

**VALUE-BASED  
PAYMENT  
PLANNING  
GUIDE**

# VALUE-BASED PAYMENTS PLANNING GUIDE

**As your practice begins the organizational transformation to tie value to payment and achieve the triple aim of patient satisfaction, improved quality of care, and operational efficiencies, your team will require a vision and strategic plan to shape the process.**

This planning guide was originally designed for National Council's work with practices participating in the Centers for Medicare and Medicaid Services Transforming Clinical Practice Initiative. It is an example 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 value-based payments (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 towards the long-term goal of preparedness for VBPs.

The guide is designed to prevent your organization from taking on too many changes at once and to promote a systematic approach towards transformation. The tool aims to support your organization in:



Mobilizing personnel needed to guide and support practice transformations



Identifying key performance measures, establish baselines and collect data to track progress over time



Creating a work plan to set aims, benchmark progress, sustain change and demonstrate value to payers

HAVE QUESTIONS?

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## SECTION 1: ASSEMBLE YOUR TEAM

Organizational transformation requires considerable resource allocation and, therefore, careful planning. 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. Despite these high stakes, 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 percent. Organizations across industries often attribute transformation initiative failure to the incubation of the change process within the C-suite.

This critical misstep 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 sub-committees 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:

The steering committee will meet every month on the following date and time:

## CREATE VBP SUBCOMMITTEES

Subcommittees will include representatives from the program targeted for change. The committee will be comprised of front line staff, clinical team members, and administrators. Examples of team members include:

- ▶ Director
- ▶ Practice 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 responsible 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 power 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 tools such as the [Risk Stratification and Chronic Conditions Cost Calculator](#) tools will assist your organization to embrace a population health management approach to both clinical care and business operations; these tools are forthcoming. These tools were developed using New York State guidance on chronic behavioral health conditions as a basis, and will shed light on the the populations you are serving and begin to answer the questions: what does my organization do best and who should I consider partnering within 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:

- A. Vision driven by patient population: diagnosis, payer mix, demographics
- B. Data on current program portfolio (program type, payer mix, regulatory body)
- C. Hospital admission and re-admission rates, ED visits, process measures
- D. Environmental scan for community partners with complementary services

## SECTION 3: VBP WORK PLAN

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

Year 1 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	<p><b>A.1.1</b> Implement patient and family survey</p> <p><b>A.1.2</b> Train staff in collaborative documentation</p> <p><b>A.1.3</b> Train staff in motivational interviewing</p> <p><b>A.1.4</b> Provide group visits for common chronic conditions</p> <p><b>A.1.5</b> Train staff in self-management goal-setting</p> <p><b>A.1.6</b> Educate patients and families on health care transformation</p>		
	A.2 Develop quality measures or indicators of patient and family engagement	<p><b>A.2.1</b> Identify a patient activation assessment</p> <p><b>A.2.2</b> Routinely share assessment results, along with appropriate education about the implications of those results, with staff and clients</p>		
B. Stratify Risk	B.1 Identify and implement a risk stratification approach	<p><b>B.1.1</b> Review <a href="#">DOH guidance on chronic behavioral health episodes of care</a></p> <p><i>Note: This is a NY-specific resource from DOH, let's cite this as an example and share that readers should check with their state for state-specific guidance</i></p> <p><b>B.1.2</b> Download EMR data to prepare for risk stratification tool</p> <p><b>B.1.3</b> Transformation sub-committee to determine working definition for active vs. inactive client</p> <p><b>B.1.4</b> Transformation sub-committee to analyze data based on diagnosis, medical co-morbidities, demographics, and payer</p> <p><b>B.1.4</b> Transformation sub-committee to complete a gap-analysis on workforce training needs and make recommendations on workforce development and training needs (evidence-based training)</p>		

Goal	Objective	Key Action Steps	Responsible Party	Deadline
B. Stratify Risk	B.2 Develop and implement care pathways	<p><b>B.2.1</b> Meet with transformation sub-committee to analyze data for care pathways workflows</p> <p><b>B.2.2</b> Develop implement policy and procedure on care pathways</p> <p><b>B.2.3</b> Use on-site care managers to proactively monitor and coordinate care for the highest risk populations</p> <p><b>B.2.4</b> Train therapists and supervisors in evidence-based interventions to support populations served</p> <p><b>B.2.5</b> Assign responsibility for care management</p> <p><b>B.2.6</b> Implement a standard to documenting care plans</p> <p><b>B.2.7</b> Use a consistent method to assign and adjust global risk status for all clients to allow risk stratification into actionable risk cohorts</p> <p><b>B.2.8</b> Use registry to support management of patients at low and intermediate risk</p>		
C. Use Community Resources	<p><b>C.1</b> Complete environmental scan of community providers and referral sources</p> <p><b>C.2</b> Develop relationships with primary care physicians, hospital systems, and referral sources</p>	<p><b>C.1.1</b> Vet all potential referral providers and agencies</p> <p><b>C.1.3</b> Consider formal partnerships including discussions with board about plans for sustainability</p> <p><b>C.2.1</b> Leverage potential relationships to cultivate referral opportunities</p>		

Goal	Objective	Key Action Steps	Responsible Party	Deadline
C. Use Community Resources	C.3 Integrate whole-health into intake process and ongoing treatment	<p><b>C.3.1</b> Review intake process to include physical health assessment</p> <p><b>C.3.2</b> Develop policy and procedure to include outreach to primary care physician at intake and treatment planning intervals</p> <p><b>C.3.3</b> Maintain an inventory of community resources that may be available to patients</p> <p><b>C.3.4</b> Provide a guide to available community resources</p>		
D. Use an organized QI approach	<p><b>D.1</b> Use an interdisciplinary staff committee to lead change and improvement within the organization</p> <p><b>D.2</b> Engage leadership in QI strategy</p> <p><b>D.3</b> Set aims</p>	<p><b>D.1.2</b> Leverage training and technical assistance support to build QI capacity, such as National Council's <a href="#">Practice Transformation Academy</a></p> <p><b>D.1.3</b> Use a defined model, like the Model for Improvement, as the QI structure</p> <p><b>D.1.4</b> Establish a QI committee that includes staff from clinical and administrative settings as well as finance</p> <p><b>D.2.1</b> Align the organization's QI plan with its strategic, operational, and business plans</p> <p><b>D.2.2</b> Create direct lines of communication with transformation lead to CEO or leadership</p> <p><b>D.2.3</b> Define specific timelines for improvement with identified opportunities</p> <p><b>D.3.1</b> Collect baseline clinical and financial utilization data</p> <p><b>D.3.2</b> As a team, set clinical and financial utilization goals</p>		
E. Build QI capacity	E.1 Quality Improvement incorporated across workforce and departments	<p><b>E.1.1</b> Include the transformation agenda and QI skills in new staff/provider orientation</p> <p><b>E.1.2</b> 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</p> <p><b>E.1.2</b> Include involvement in QI as part of individual job descriptions and expectations</p>		

Goal	Objective	Key Action Steps	Responsible Party	Deadline
E. Build QI capacity	E.2 Set organizational expectations for QI and incorporate QI into the hiring process	<p><b>E.2.1</b> Hire for fit with the organizational quality culture through effective pre-employment screening</p> <p><b>E.2.2</b> Track progress toward goals at each program and individual provider level</p> <p><b>E.2.3</b> Integrate practice change/quality improvement into staff duties</p> <p><b>E.2.4</b> Promote transparency by sharing practice level quality of care, patient experience and utilization data</p> <p><b>E.2.5</b> Regular meetings with leadership and program staff to review data, celebrate success, identify opportunities, and develop improvement plan</p>		
F. Use data transparently	<p><b>F.1</b> Align clinical and financial goals with practice and organizational vision and mission</p> <p><b>F.2</b> Create a culture of learning</p>	<p><b>F.1.1</b> Define measures that the practice will monitor, relate these to strategic aims and use the to drive performance</p> <p><b>F.1.2</b> Monitor measures frequently and consistently and share metrics with staff during staff meetings, group supervision, and individual supervision</p> <p><b>F.1.3</b> Use run charts to display data over time and link changes implemented to the data points</p> <p><b>F.1.4</b> Adopt a philosophy of performance data transparency</p> <p><b>F.2.1</b> Use data walls to share metrics and progress and celebrate success</p> <p><b>F.2.2</b> Use relevant data sources to create benchmarks and goals for performance at the practice level</p> <p><b>F.2.3</b> Train supervisors in using data in clinical supervision</p> <p><b>F.2.4</b> Develop individual-professional development plans linked to desired outcomes</p>		

Goal	Objective	Key Action Steps	Responsible Party	Deadline
G. Use sound business operations	<p><b>G.1</b> Strategic Use of Revenue</p> <p><b>G.3</b> Benchmark progress toward reduce costs</p>	<p><b>G.1.1</b> Identify cash reserves for discussion on sustainability and future allocation of funds (technology/tools, training/billing capacity)</p> <p><b>G.2.1</b> Review National Council's <a href="#">Case Rate Toolkit</a></p> <p><b>G.2.2</b> Review <a href="#">DOH guidance on behavioral health chronic behavioral health conditions</a></p> <p><b>G.3.1</b> Download EMR data to prepare for Chronic Conditions Cost of Care tool</p> <p><b>G.3.2</b> VBP sub-committee to use data to create baseline for costs to serve populations with chronic behavioral health conditions</p> <p><b>G.3.3</b> Demonstrate cost to provide un-billable services (operations support tied to individual service)</p> <p><b>G.3.4</b> Identify behavioral health VBP pilot project most representative of your population</p> <p><b>G.3.5</b> Begin shadow accounting for VBP pilots</p>		

## Year 2 Transformation Tasks: Establishing a Baseline and Benchmarking Progress

Goal	Objective	Key Action Steps	Responsible Party	Deadline
A. Listen to patient and family voice	<p><b>A.1</b> Ensure patient and family voice is incorporated into operations</p> <p><b>A.2</b> Reinforce patient and family experience is at the forefront of clinical and administrative decision making</p>	<p><b>A.1.1</b> Ensure patient and family representation on the organization's board or steering committee</p> <p><b>A.1.2</b> Implement a patient and family advisory group</p> <p><b>A.1.3</b> Include patients and families in quality improvement initiatives</p> <p><b>A.2.1</b> Use client stories to start all-staff meetings</p> <p><b>A.2.2</b> Run focus groups to obtain patient and family feedback</p> <p><b>A.2.3</b> Incorporate client voice into policy and procedures</p>		
B. Clarify team roles	<p><b>B.1</b> Using data from the risk stratification and care pathways exercises, identify gaps on care team</p>	<p><b>B.1.1</b> 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</p> <p><b>B.1.2</b> Use process maps to clarify responsibilities once roles are assigned</p> <p><b>B.1.3</b> Identify staff interest and talents and align with available opportunities</p> <p><b>B.1.4</b> Add fields to the EHR to capture care team member roles</p>		

Goal	Objective	Key Action Steps	Responsible Party	Deadline
C. Establish medical neighborhoods	C.1 Establishing formal relationships with community providers	<p><b>C.1.1</b> Develop both personal and electronic relationships among medical neighborhood providers to ensure information sharing</p> <p><b>C.1.2</b> Develop written agreements or compacts that define information needs of all parties</p>		
	C.2 Reinforce patient and family experience is at the forefront of clinical and administrative decision making	<p><b>C.2.1</b> 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</p> <p><b>C.2.2</b> 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</p> <p><b>C.2.3</b> Engage payer disease management and complex care management staff to help avoid patient/family confusion</p>		
D. Implement evidence-based protocols	D.1 Develop and implement care pathways	<p><b>D.1.1</b> Use National Council's risk stratification tool to map chronic behavioral health conditions to care pathways</p> <p><b>D.1.2</b> Train prescribers in use of evidence-based practices, such as long-acting injectable medications and clozapine</p> <p><b>D.1.3</b> Use pre-visit planning (huddles including HH care managers, therapists, nursing and prescribers) to optimize team management of clients with chronic/high risk conditions</p>		
	D.2 Leverage technology to maximize on operational efficiencies and reinforce work-flows	<p><b>D.2.1</b> Use the risk stratification or clinical registry tools to identify services that are due for the patient</p> <p><b>D.2.2</b> Use reminders and outreach</p> <p><b>D.2.3</b> Document protocols through flow sheets, process maps, care maps or other visual depiction</p> <p><b>D.2.4</b> Embed protocols in the EMR</p>		

Goal	Objective	Key Action Steps	Responsible Party	Deadline
E. Provide 24/7 access to care	<p><b>E.1</b> Implement Same Day Access and Just in Time Prescribing</p> <p><b>E.2</b> Use community partnerships to provide a continuum of care and coverage for all clients</p>	<p><b>E.1.2</b> Provide 24/7 access to provider or care team for advice about urgent or emergent care</p> <p><b>E.1.3</b> Provide care team with access to medical record after hours</p> <p><b>E.1.4</b> Expand hours to evenings and weekends</p> <p><b>E.2.1</b> Implement contractual agreements with supporting community partners</p> <p><b>E.2.2</b> Use warm hand-offs for cross coverage</p>		
F. Streamline work	<b>F.1</b> Using VBP pilot-project accounting data benchmark progress in operational efficiencies	<p><b>F.1.1</b> Train staff in lean approaches and the concept of value</p> <p><b>F.1.2</b> Consider hiring or training internal experts in process improvement</p> <p><b>F.1.3</b> Use lean principles across the organization such as defining waste and identifying value through the client's eyes</p>		

## Year 3 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	<p>A.2.1 Celebrate suggestions for improvement and solution ideas developed by staff</p> <p>A.2.2 Give staff time for innovation</p> <p>A.2.3 Include expectations about participation in QI in performance reviews</p> <p>A.2.4 Use incentives to reward improvement at the individual and team levels</p> <p>A.2.5 Tie compensation to team, departmental and organizational goals</p> <p>A.2.6 Ensure performance standards and expectations are clear</p> <p>A.2.7 Get staff/provider input at all levels</p>		
B. Manage total cost of care/ Cost of Care for Chronic Behavioral Health Conditions	B.1 Understand your costs and outcomes	<p>B.1.1 Consider third party business intelligence tools</p> <p>B.1.2 Use data and dashboards collected over time to estimate costs of hospital and emergency department care saved through utilization reductions</p> <p>B.1.3 Train appropriate staff on interpretation of cost and utilization information</p>		
	B.2 Articulate your value	<p>B.2.1 Use available data regularly to analyze opportunities to reduce cost through improved care</p> <p>B.2.2 Educate staff about factors that impact total cost of care</p> <p>B.2.3 Ask staff to identify opportunities to manage cost to facilitate understanding</p>		

### Year 4 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 (patient experience, quality improvement, and efficiency)	<p>A.1.1 Conduct business fundamentals training as a lunch and learn session</p> <p>A.1.2 Ensure budget preparation occurs at the level the costs are incurred</p> <p>A.1.3 Share prices charged for various services</p> <p>A.1.4 Dedicate a meeting to explaining the organization's financial statements</p>		
B. Document value	B.1 Articulate value to payers and community partners	<p>B.1.1 Analyze internal costs of care by service and by population characteristics</p> <p>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</p> <p>B.1.3 Determine profitability by site and service</p>		