Model for Advancing High Performance in Primary Care and Behavioral Health: MAHP 2.0 Assessment

Instructions

The MAHP 2.0 Assessment has been assembled to provide primary care and behavioral health clinics with one instrument with which they can assess their readiness or progress toward becoming high performing clinics using the Model for Advancing High Performance in Primary Care and Behavioral Health (MAHP 2.0). Individual items were selected from four source instruments to reflect the delivery of care from both primary care and behavioral health perspectives: NACHC Payment Reform Readiness Assessment Tool, TCPI Practice Assessment Tool 2.0, Integrated Certification Criteria Feasibility and Readiness Tool (I-CCFRT), and the Patient Centered Medical Home Assessment (PCMH-A). The tool is focused heavily on the "Invest in Infrastructure" strategy as that is the essential foundation for care and payment success. For additional assessment items, please see the source instruments or refer to the companion Crosswalk document.

Before you Begin: How to use this assessment

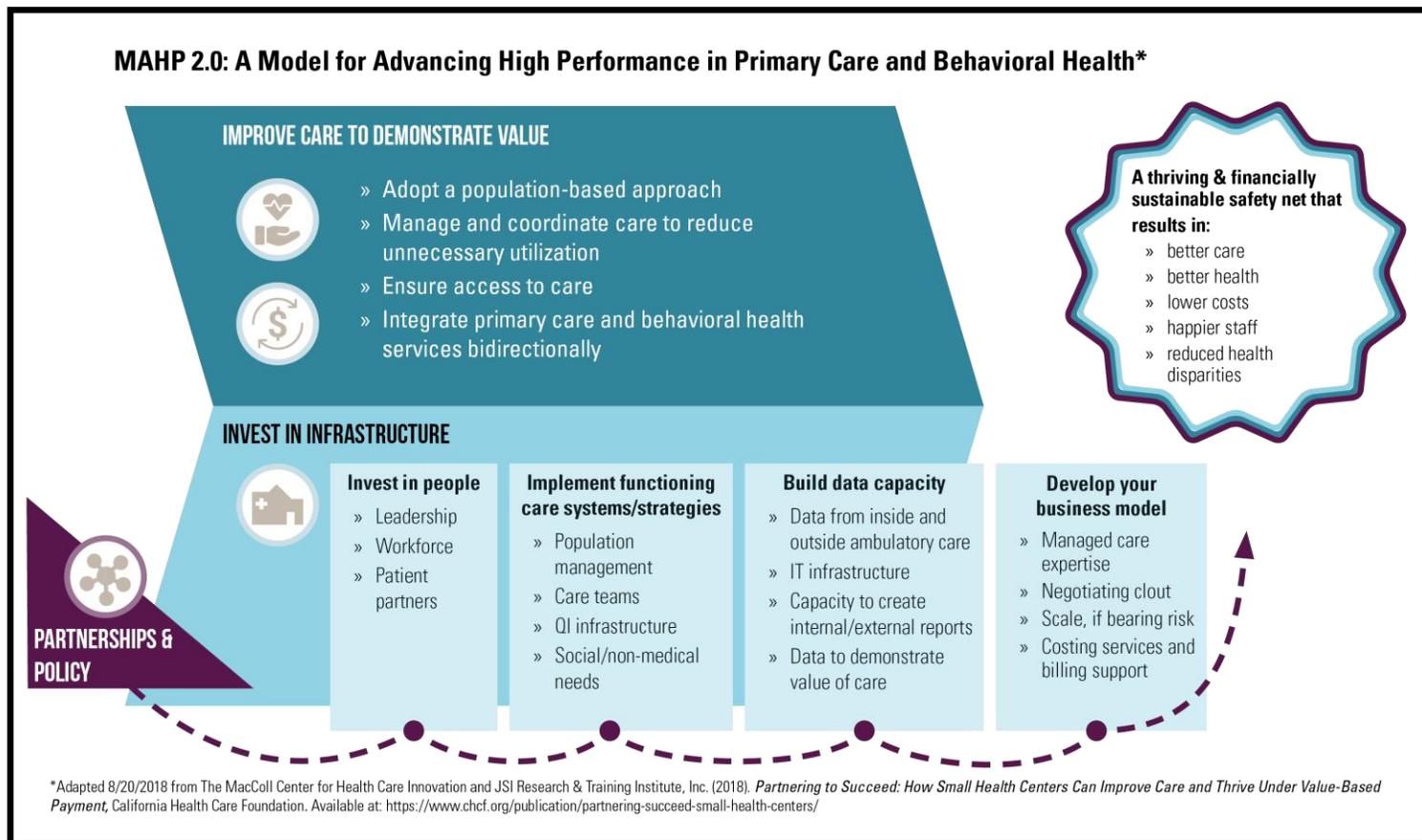### Identify a multidisciplinary group of practice staff
We strongly recommend that the MAHP 2.0 Assessment be completed by a multidisciplinary group (e.g., physicians, nurses, medical assistants, residents, other operations and administrative staff) in order to capture the perspectives of individuals with different roles within the practice and to get the best sense possible of 'the way things really work.' We recommend that staff members complete the assessment individually, and that you then meet together to discuss the results, produce a consensus version, and develop an action plan for priority improvement areas. We discourage sites from completing the MAHP 2.0 Assessment individually and then averaging the scores to get a consensus score without having first discussed as a group. The discussion is a great opportunity to identify opportunities and priorities for care delivery transformation.

Have each site in an organization complete an assessment
If an organization has multiple practice sites, each site should complete a separate MAHP 2.0 Assessment. Practice transformation, even when directed and supported by organizational leaders, happens differently at the site level. Organizational leaders can compare MAHP 2.0 Assessment scores and use this information to share knowledge and cross-pollinate improvement ideas.

To those completing the tool

Consider where your practice is on the journey to high performance. Answer each question as honestly and accurately as possible. There is no advantage to overestimating or upcoding item scores, and doing so may make it harder for real progress to be apparent when the MAHP 2.0 Assessment is repeated in the future. It is fairly typical for teams to initially believe they are providing more advanced care or are more ready for payment reform than they actually are. Over time, as your understanding of advanced care for improving value increases and you continue to implement effective practice changes, you should see your MAHP 2.0 Assessment scores increase.

MAHP 2.0: A Model for Advancing High Performance in Primary Care and Behavioral Health*

IMPROVE CARE TO DEMONSTRATE VALUE

- » Adopt a population-based approach
- » Manage and coordinate care to reduce unnecessary utilization
- » Ensure access to care
- » Integrate primary care and behavioral health services bidirectionally

A thriving & financially sustainable safety net that results in:
- » better care
- » better health
- » lower costs
- » happier staff
- » reduced health disparities

INVEST IN INFRASTRUCTURE

PARTNERSHIPS & POLICY

Invest in people	Implement functioning care systems/strategies	Build data capacity	Develop your business model
» Leadership » Workforce » Patient partners	» Population management » Care teams » QI infrastructure » Social/non-medical needs	» Data from inside and outside ambulatory care » IT infrastructure » Capacity to create internal/external reports » Data to demonstrate value of care	» Managed care expertise » Negotiating clout » Scale, if bearing risk » Costing services and billing support

*Adapted 8/20/2018 from The MacColl Center for Health Care Innovation and JSI Research & Training Institute, Inc. (2018). *Partnering to Succeed: How Small Health Centers Can Improve Care and Thrive Under Value-Based Payment,* California Health Care Foundation. Available at: https://www.chcf.org/publication/partnering-succeed-small-health-centers/

STRATEGY 1: INVEST IN INFRASTRUCTURE

Invest in people

1. Administration and clinical leadership demonstrate commitment to payment reform model being pursued.[1]	Clinical and administrative leaders regularly communicate and demonstrate their support for payment reform (and related practice transformation) initiatives.			Leadership supports dedication of staff time, training and organizational resources to payment reform initiatives. Leadership regularly communicates health center objectives and progress on payment reform initiatives with staff.				Payment reform capacity is institutionalized through job expectations and evaluations, and is systematically included in BOD and staff strategic and operational planning.		
	1	2	3	4	5	6	7	8	9	10

2. The responsibility for conducting quality improvement activities[2]	is not assigned by leadership to any specific group.		is assigned to a group without committed resources.			is assigned to an organized quality improvement group who receive dedicated resources.			is shared by all staff, from leadership to team members, and is made explicit through protected time to meet and specific resources to engage in QI.	
	1	2	3	4	5	6	7	8	9	10

3. The organization's hiring and training processes[2]	focus only on the narrowly defined functions and requirements of each position.		reflect how potential hires will affect the culture and participate in quality improvement activities.			place a priority on the ability of new and existing staff to improve care and create a patient-centered culture.			support and sustain improvements in care through training and incentives focused on rewarding patient-centered care.	
	1	2	3	4	5	6	7	8	9	10

4. 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.[3]	The milestone has not yet been addressed by the practice.	Work on the milestone is beginning or developing.	The milestone is being implemented or partially operating.	The milestone is functioning, performing and producing results.
	1 2	3 4 5	6 7 8	9 10

Implement functioning care systems/strategies

5. Practice has a process in place to measure and promote continuity so that patients and care teams recognize each other as partners in care. [3]	The milestone has not yet been addressed by the practice.	Work on the milestone is beginning or developing.	The milestone is being implemented or partially operating.	The milestone is functioning, performing and producing results.
	1 2	3 4 5	6 7 8	9 10

6. Practice has a reliable process in place for identifying risk level of each patient and providing care appropriate to the level of risk. [3]	The milestone has not yet been addressed by the practice.	Work on the milestone is beginning or developing.	The milestone is being implemented or partially operating.	The milestone is functioning, performing and producing results.
	1 2	3 4 5	6 7 8	9 10

7. Practice sets clear expectations for each team member's functions and responsibilities to optimize efficiency, outcomes and accountability. [3]	The milestone has not yet been addressed by the practice.	Work on the milestone is beginning or developing.	The milestone is being implemented or partially operating.	The milestone is functioning, performing and producing results.
	1 2	3 4 5	6 7 8	9 10

8. Clinical support staff[4]	work with different providers every day.	are linked to providers in teams but are frequently reassigned.	consistently work with a small group of providers and staff in a team.	consistently work with the same provider(s) almost every day.
	1 2	3 4 5	6 7 8	9 10

9. As appropriate for the individual's needs, the clinic designates an interdisciplinary treatment team to coordinate the medical, psychosocial, emotional, therapeutic and wellness needs of patients.[5]	Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
	1 2	3 4	5 6	7 8	9 10

10. The clinic uses a rapid cycle change management process, develops a change management plan and moves forward with timely decision-making about the solutions needed. [5]	Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
	1 2	3 4	5 6	7 8	9 10

11. Quality improvement activities are conducted by[2]	a centralized committee or department.	topic specific QI committees.	all practice teams supported by a QI infrastructure.	practice teams supported by a QI infrastructure with meaningful involvement of patients and families.
	1 2	**3 4 5**	**6 7 8**	**9 10**

12. Social needs of patients are[6]	not routinely addressed.	sometimes assessed and documented to inform clinical care.	systematically assessed and documented and addressed by referral to community resources as available.	systematically assessed and documented and addressed by established links to community resources or by in-house programs created to fill community gaps.
	1 2	**3 4 5**	**6 7 8**	**9 10**

Build data capacity

13. Performance Measures[2]	are not available for the clinical site.	are available for the clinical site, but are limited in scope.	are comprehensive—including clinical, operational, and patient experience measures—and available for the practice, but not for individual providers.	are comprehensive—including clinical, operational, and patient experience measures—and fed back to individual providers.
	1 2	**3 4 5**	**6 7 8**	**9 10**

14. The health center has robust Health Information Exchange (HIE) with providers/partners of proposed payment reform effort.[1]	The health center *obtains data on hospitalizations of its patients* through a manual process. Data is claims based and not available "real time. "			Payment reform partners exchange data on patient medication, lab results, health status assessment, and behavioral health assessments through manual or request- based processes. The partners have a shared referral tracking and follow-up system. The health center participates in state or regional- level all-payer claims data efforts.				*Data is exchanged among partners in real-time using HIE. The health center is able to leverage cost and utilization data available from partners for advanced data analysis and management.*		
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

15. The health center uses data to understand its role within the broader health care marketplace, and its market share. [1]	The health center regularly examines its penetration rate for low-income and uninsured populations in its service area. The health center has gathered data on other safety net providers serving the same patient population and their penetration rate.			The health center analyzes penetration into the service area/target population for a specific initiative. Understanding of other providers seen by own patient population: has mapped out specialty and hospital referral patterns.				Knows penetration in service area population, untapped demand within service area for specific services and/ or populations; major competitors and how much of market they capture.		
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

16. The health center's electronic health record (EHR) supports clinical practice and care management of client populations. [1]	The health center has separate health records and practice management systems. The EHR captures visit-level data and diagnosis, but is not integrated with lab, pharmaceutical, or case management data.			The EHR includes patient and provider reminder functionality, e-prescribing, and clinical decision support components. The EHR facilitates reporting on Meaningful Use, UDS, and Medicare Shared Savings Program quality measures.				Health center systems facilitate analysis of both clinical and cost data for specific groups of patients. The health center uses existing data to analyze potential impact of specific initiatives on patient care and access.		
	1	2	3	4	5	6	7	8	9	10

17. Reports on care processes or outcomes of care[2]	are not routinely available to practice teams.		are routinely provided as feedback to practice teams but not reported externally.			are routinely provided as feedback to practice teams, and reported externally (e.g., to patients, other teams or external agencies) but with team identities masked.			are routinely provided as feedback to practice teams, and transparently reported externally to patients, other teams and external agencies.	
	1	2	3	4	5	6	7	8	9	10

18. The health center's health information technology (HIT) systems allow for tracking of client and service information needed to inform payment/service delivery models. [1]	The health center's systems are able to capture unique encounters, services provided, utilization and diagnosis. The system readily produces reports on encounters, utilization and diagnoses in the aggregate.			The health center's systems are able to capture and report on unique encounters, services provided, utilization and health outcomes for specific groups of patients (age, chronic conditions, dual eligibles, high utilizers, etc.).				The health center's systems capture and produce reports on patient social determinants of health, including environmental factors (health habits; mental health; patient perspective and preferences for issues such as involvement in decision making and communication modalities; risk assessments). Health center information systems capture and report on non-traditional "touches" such as email, phone call, group visits for diabetes management and prenatal care, etc. and enabling services.		
	1	2	3	4	5	6	7	8	9	10

Develop your business model

19. The health center has experience and capacity to manage performance-based contracts. [1]	The health center has experience negotiating and managing fee for service volume-based and managed care contracts.			The health center has experience negotiating and managing pay-for performance based contract, and/or contracts with upside risk only.				The health center has (in house or contracted) experience negotiating risk-bearing contracts. The health center has analyzed its success under past contracts to inform current contracting strategies.		
	1	2	3	4	5	6	7	8	9	10

20. The health center has identified the up-front costs of participation in the proposed payment model. [1]	The health center has used historical costs to identify up-front costs associated with the payment reform initiative including staffing, space and HIT costs. Cost estimates for service delivery are based on historical health center per-visit costs.			Cost estimates have been adjusted to account for patient population to be served (vis-à-vis average health center patient) and specific health needs and/ or utilization patterns they experience.				Health center has developed a per-member-per-month cost for the full scope of services to be offered. Health center has analyzed this cost in comparison to expected reimbursement.		
	1	2	3	4	5	6	7	8	9	10

21. The health center has analyzed its ability to engage in risk-based contracts. [1]	The health center has not conducted an analysis of its ability to bear risk, other than identifying reserves available to cover risk. The health center has limited its interest to up-side risk (sharing in cost savings or profit) only.			The health center has identified the size of its patient population that would be served, and the potential for variation in cost and performance measures. The health center has analyzed its ability to benefit from up-side risk and absorb down-side risk on its own.				The health center has ability to be grouped with additional partners for performance assessment and risk sharing. Health center is able to set aside revenues from existing reimbursement methodologies to prepare for risk-based reimbursement.		
	1	2	3	4	5	6	7	8	9	10

22. The health center has developed a business case for linking reimbursement to utilization and social complexity of health center patients and health center cost structure. [1]	The health center is able to identify data on its cost, patient utilization rates, and enabling service needs for its overall patient population.			The health center is able to identify data on its cost, patient utilization rates, and enabling service needs of specific group(s) of patients to be involved in payment reform.				The health center has data comparing its patients to the patient population, and is able to demonstrate how its robust services lead to better outcomes/costs. The health center can clearly articulate how enabling services will contribute to achievement of clinical and cost goals of specific payment reform efforts.		
	1	2	3	4	5	6	7	8	9	10

STRATEGY 2: IMPROVE CARE TO DEMONSTRATE VALUE

Adopt a population-based approach

23. The health center has experience managing care for groups of patients and/or populations with chronic conditions. [1]	The health center identifies high-risk patients informally or through chart review. Health center has implemented a HRSA sponsored or similar disease collaborative at a minimum of one site.			Disease registries are used to categorize subpopulations by clinical priorities. All service delivery sites participate in disease collaboratives. Lessons learned and best practices are shared across the organization. Specific disease conditions are included in CQI eff orts on an ongoing basis.				The health center engages in regular and continuous management of patient visits for specific chronic conditions. Model of care includes systematic preventive, follow-up and planned visits for chronic care.		
	1	2	3	4	5	6	7	8	9	10

24. Visits[2]	largely focus on acute problems of patient.	are routinely provided as feedback to practice teams but not reported externally.	are organized around acute problems but with attention to ongoing illness and prevention needs if time permits. The practice also uses subpopulation reports to proactively call groups of patients in for planned care visits.	are organized to address both acute and planned care needs. Tailored guideline-based information is used in team huddles to ensure all outstanding patient needs are met at each encounter.
	1 2	**3 4 5**	**6 7 8**	**9 10**

Manage and coordinate care to reduce unnecessary utilization

25. The health center has experience managing high-utilizer/high cost patients.[1]	The health center has not engaged in specific initiatives for high-utilizer/high cost patients. The health center systematically identifies its own patients who are high utilizers of health center and/or system resources.	The health center participates in Managed Care Organization (MCO) or hospital initiatives to address inappropriate utilization and prevent hospital re-admissions or admissions for ambulatory care sensitive conditions.	The health center has contract with ACO or MCO to conduct care management/ coordination for its own high utilizer patients. Health center has contract with ACO/MCO to provide care management/ coordination for high utilizer patients in the service area, beyond its own patients.
	1 2 3	**4 5 6 7**	**8 9 10**

26. The health center provides robust care coordination.[1]	The health center focuses primarily on obtaining specialty, behavioral health and hospital care for patients needing follow-up care. Referrals are made and tracked, but there is not a system for determining whether referral is successfully completed.	The health center has robust referral tracking and follow-up system. Care coordination includes motivational interviewing and eff orts to address social determinants of health. Health center uses promotoras/community health workers to support care coordination. Health center coordinates care with major specialty and hospital groups. Health center is able to provide and/or receive information about care provided by specialty groups and hospitals.	The health center has systemic process for establishing patient-driven care plan, and ongoing follow-up and patient support for the plan, using motivational interviewing or other techniques. Health center is involved in partnerships to reduce hospital readmissions and to develop systems to coordinate behavioral and physical health care, or otherwise coordinate care across providers. Robust health information exchange allows health center to share information with other health care providers in real time.
	1 2 3	4 5 6 7	8 9 10

Ensure access to care

27. The clinic provides outpatient clinical services during times and at locations that ensure accessibility and meet the needs of the consumer populations to be served, including some nights and weekend hours; offers transportation assistance, utilizes telehealth and on-line treatment options and engages in outreach activities to assist consumers to access services. [5]	Serious Challenge		Quite a bit of Concern		Moderate Concern		Small Concern		Not A Challenge	
	1	2	3	4	5	6	7	8	9	10

Integrate primary care and behavioral health services bidirectionally

28. Practice identifies the primary care provider, behavioral health provider or care team of each patient seen and communicates to the team about each visit/encounter. [5]	Serious Challenge		Quite a bit of Concern		Moderate Concern		Small Concern		Not A Challenge	
	1	2	3	4	5	6	7	8	9	10

29A. [FOR PRIMARY CARE PRACTICES] Behavioral health services are integrated with primary care services. [5]	The health center has strong referral relationships with behavioral health providers.			Behavioral health services are offered on site with warm hand-off. Behavioral health team members are integrated into care team at some sites, or partially.				Behavioral health services are integrated in care at all sites. Health Center has substantive partnerships/collaborations with behavioral health entities.		
	1	2	3	4	5	6	7	8	9	10

29B. [FOR BEHAVIORAL HEALTH PRACTIES] The clinic has formal contracts or agreements with entities with which they coordinate care that offer services not directly provided through the clinic. [1]	Serious Challenge		Quite a bit of Concern		Moderate Concern		Small Concern		Not A Challenge	
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

	Coordinated			Co-located				Integrated		
30. Levels of Collaboration/Integration: At what level is your clinic?[6]	Key Element: Communication between PC & BH We do minimal collaboration or some collaboration at a distance			Key Element: Physical Proximity between PC & BH We have basic collaboration onsite or close collaboration onsite with some system integration.				Key Element: Practice Change between PC & BH We have close collaboration approaching an integrated practice or full collaboration in a transformed / merged integrated practice.		
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

STRATEGY 3: PARTNERSHIPS & POLICY

31. The health center has experience developing partnerships to address service area needs and take advantage of opportunities in the local health care marketplace. [1]	The health center has stablished informal referral relationships with other service delivery providers. The health center is able to articulate its "competitive advantage" (e.g. the particular strengths and opportunities it brings to partnerships).	The health center has developed formalized partnerships with other service providers to address specific needs of target population. The health center has established and articulated a negotiation /partnership strategy to guide its efforts.	The health center has led partnership development eff orts involving multiple partners to develop integrated service delivery approaches for meeting target population needs, and /or leveraging new funding opportunities. The health center is involved in partnerships that focus on developing community-level systems of care, including consolidation of redundant services.
	1 **2** **3**	**4** **5** **6** **7**	**8** **9** **10**

32. The health center partners with local hospitals and specialists to meet the goals of the payment reform models. [1]	The health center has established positive working relationships with hospitals and specialists in the service area. The health center has participated in community needs assessment activities conducted by not for profit hospitals. The health center has a detailed understanding of the motivations and challenges driving hospital and specialty practice partnership eff orts and participation in payment reform initiatives.	The health center has participated in shared service delivery models including co-location of services, or other focused collaborations with specific utilization and/or health outcome goals, such as hospital diversion programs or service integration. The health center, hospital and /or specialty groups have together analyzed utilization patterns and service delivery needs of the service area population, and opportunities to address them.	The health center and hospital/specialty groups have developed new product/services to meet target population needs or to take advantage of new payment reform opportunities. The health center has analyzed the cost-effectiveness and outcomes of partnership efforts.
	1 **2** **3**	**4** **5** **6** **7**	**8** **9** **10**

Item Source:

1. **National Association of Community Health Centers "NACHC Payment Reform Readiness Assessment" Tool**
   http://www.nachc.org/wp-content/uploads/2015/11/NACHC_PR_ReadinessAssessmentTool_Final_CORRECTED_8.5.2014-2.pdf
2. **Safety Net Medical Home Initiative "Patient-Centered Medical Home Assessment" Tool**
   http://www.safetynetmedicalhome.org/sites/default/files/PCMH-A.pdf
3. **Transforming Clinical Practice Initiative "Practice Assessment Tool 2.0"**
   http://calquality.org/storage/documents/pat2.0%20and%20part%20guide%20041916.pdf
4. **Learning from Effective Ambulatory Practices initiative "Primary Care Team Guide Assessment"**
   http://www.improvingprimarycare.org/assessment/full
5. **Certified Community Behavioral Health Clinics "Integrated Certification Criteria Feasibility and Readiness Tool"**
   https://www.thenationalcouncil.org/wp-content/uploads/2015/06/CCBHC-Criteria-Readiness-Assessment-FINAL-EFORM-5-29-15-2.pdf
6. **Measure created for RWJF Delta Center Initiative**