Demonstration HCO
Value-Based Care Readiness Report
February 12, 2024

Value-Based Care Readiness

Expanding healthcare payment alternatives, such as shared savings and bundled payments, demand that a healthcare organization develop and implement new organizational capacities to deliver *value-based care.* Value-based care improves clinical quality, satisfies patients and families, advances community health, and utilizes resources wisely and efficiently.

The following Value-Based Care Readiness Report summarizes data from the Value-Based Care Strategic Planning Tool (VBC Tool). The VBC Tool assessed 80 value-based *capacities* within eight value-based care categories:

- Governance and Leadership
- Care Coordination
- Clinical Care
- Community Health
- Patient and Family Engagement
- Performance Improvement and Reporting
- Health Information Technology
- Financial Risk Management

Each value-based care capacity was assessed by the responding healthcare organization as one of six potential stages of capacity development and implemented.

1) Fully developed and implemented
2) Developed and incompletely implemented
3) In development
4) In discussion
5) Not applicable
6) Not considered

The Report may be used as a strategic planning tool, serving as the basis for value-based care action planning. The Report may also be used to inform the Demonstration HCO governing body, leadership, and other key stakeholders regarding the changing landscape of healthcare delivery and finance.

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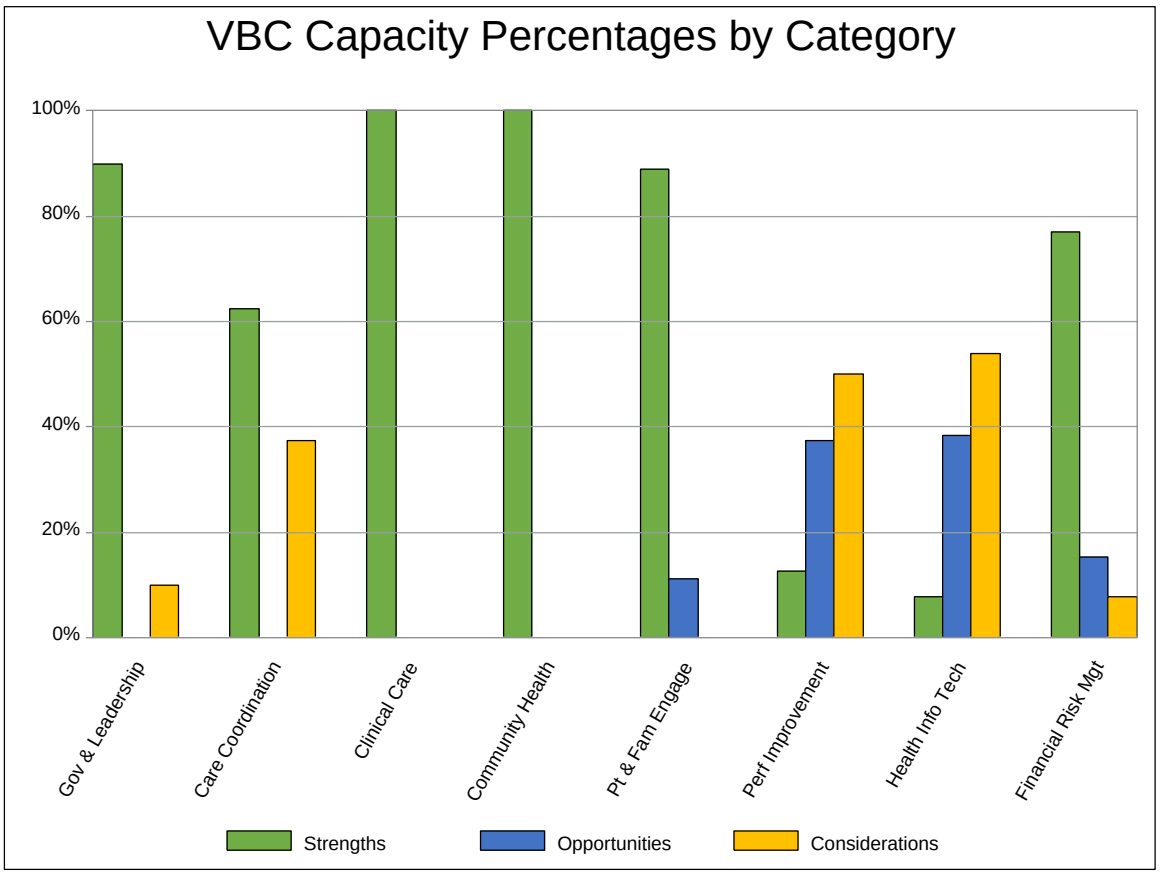
Summary

VBC Tool results are combined to demonstrate the relative percent of value-based care capacity assessments within each category. Value-based care capacity assessment combinations include:

- Strengths – “Fully developed and implementedor “Developed and incompletely implemente(
- Opportunities – “In development”
- Considerations – “In discussion,” “Not applicable,” “Not considered,” or assessment left blank

Although the VBC Tool was not designed for value-based care capacity comparisons (between categories or between healthcare organizations), the chart below shows the percent of capacity assessments (strengths, opportunities, and considerations) within each category at your organization.



Strengths

VBC Tool analysis indicates that the following value-based care capacities are either “Fully developed and implementedor “Developed, incompletely implemented.” These capacities are Demonstration HCO **strengths.** The Rural Health Value Team recommends that you measure progress and celebrate fully developed and implemented value-based care capacities. Maintain implementation momentum of fully developed, incompletely implemented value-based care capacities.

Strengths: Governance and Leadership

- The HCO publicly identifies better care, improved community health, and smarter spending as priorities.
- The HCO demonstrates commitment to equitable access, treatment, and outcomes for everyone in the community. (e.g., in strategy, policy, and operations).
- The HCO governing body regularly evaluates value-based performance metrics with benchmark comparisons (i.e., clinical quality, patient satisfaction, community health, and cost of care).
- The governing body includes clinicians.
- Senior leadership engages clinicians in operational decision-making.
- The senior leadership team includes positions, identified by title and/or job description, who have clear accountability to improve clinical quality and patient safety, improve the patient experience, advance community health, and lower total costs.
- Senior leaders’ performance evaluation and compensation are partly linked to value-based care performance.
- Senior leaders employ regular “walkarounds” to support staff in delivering value-based care.
- The HCO invests in community-based resources that address health related social needs, support individual well-being, and improve community health in settings other than the facilities of the HCO.

Strengths: Care Coordination

• The HCO uses data to identify individuals at risk for poor outcomes and/or high resource utilization.

• The HCO assigns care coordinators to patients at risk for poor outcomes and/or high resource utilization.

• The HCO ensures that care coordination and transition support services are utilized for hospitalized patients.

• The HCO refers patients and families to community-based organizations (e.g., public health agencies, schools, human service agencies, community groups, and faith-based organizations) to support care coordination and transition management by addressing health-related social needs.

• The HCO receives follow-up information from community-based organizations after patient referrals (i.e., “closed loop referrals”).

Strengths: Clinical Care

• The HCO regularly measures and improves access to care (e.g., wait time to schedule a routine appointment, and ED wait times).

• A same-day scheduling system allows primary care practices to offer same day appointments to all patients.

• An after-hours care system (e.g., practice call line and extended clinic hours) supports access to care that can help reduce emergency department use for patients with non-emergent conditions.

• The primary care workforce is clinically integrated with the hospital, and other specialists, and clinical providers (e.g., shared clinical protocols, interoperable electronic health records, and common performance improvement measures).

• Primary care practices are accredited health homes (patient-centered medical homes).

• The HCO proactively ensures preventive care (e.g., action lists of due/overdue services and Medicare wellness visits).

• The HCO increases access to services to better meet patient needs locally (e.g., through telehealth, group visits, and other alternative patient encounters).

• Behavioral health professionals are integrated with primary care clinicians.

• Primary care clinicians refer patients to specialists, ancillary services, and hospitals that deliver high-quality care at lower cost.

• The HCO incorporates evidence-based guidelines into clinical prompts, workflow, and practices.

• Processes and training are in place to assure appropriate access to palliative care support, hospice services, and end-of-life care.

Strengths: Community Health

• The HCO defines and regularly reviews population size and demographic data including health disparities based on factors such as race, ethnicity, and socioeconomic status.

• The HCO regularly reviews and develops strategies to address health needs as identified through a community health needs assessment (or similar process).

• The HCO has an identified champion with specific accountabilities for community health improvement.

• The HCO has staff expertise and dedicated resources to support community health initiatives.

• The HCO works with other community organizations to identify shared goals and implement initiatives to address prioritized community health needs.

• The HCO implements community preventive health and wellness programs in addition to those that directly promote current HCO services.

• The HCO offers wellness programs, benefits, and/or incentives to its employees.

• The HCO works with other partners and organizations to help meet individual health-related social needs and to address social determinants of health more broadly in the community.

Strengths: Patient and Family Engagement

• The HCO has strategic action plans with measurable objectives which focus on improving patient and family engagement.

• The HCO has policies and practices in place to recognize families and other care partners as essential members of the care team (different from “visitors”).

• The HCO has a patient/family advisory council (or equivalent) that reflects the diversity of the community served.

• Senior leaders employ regular “walkarounds” interacting with patients/families.

• The HCO provides patients with user-friendly health education resources specific to the patient’s condition(s) and need(s).

• Patients have secure and user-friendly access to their care team.

• Clinicians use shared decision-making approaches and decision aids for clinical conditions in which evidence-based care can vary by patient values and preferences.

• The HCO policies and actions support patients and families following error or harm.

Strengths: Performance Improvement and Reporting

• The HCO actively works to limit potentially avoidable utilization (e.g., readmissions, inpatient admissions, and emergency department visits) for individuals with conditions that could be managed in non-hospital settings.

Strengths: Health Information Technology

- The HCO has a comprehensive health information technology (HIT) strategy to support value-based care that responds to continually evolving stages of federal and state mandates and incentive programs.

Strengths: Financial Risk Management

- The HCO monitors changes in the market (and market share) for different service lines.
- The HCO can forecast profit and loss when assessing alternative payment contracts (e.g., shared savings and bundled payment).
- The HCO can validate payer-defined cost targets and risk-adjustment methodologies.
- The HCO gains direct experience managing both financial and medical risk by self-insuring or contracting with a self-insured employer.
- The HCO has partnered with a payer or other organization participating in payer-driven initiatives (e.g., ACO or bundled payment program) to control costs or manage a specific patient population.
- The HCO implements projects to increase organizational efficiency.
- Financial strength (e.g., profit margin and reserves) allows the HCO to accept the risk of spending greater than targets.
- The HCO has access to capital to develop new value-based care initiatives.
- The HCO continuously monitors revenues compared to cost to deliver services, including alternative modalities.
- The HCO employs a cost-accounting system capable of quantifying cost per encounter/service.

Opportunities

VBC Tool analysis indicates that the following value-based care capacities are “In development.” These capacities may represent the greatest **opportunities** for improvement because capacities currently in development may require only modest Demonstration HCO leadership attention to reach full development and implementation. Therefore, the Rural Health Value Team recommends that you consider prioritizing these value-based care capacities for action. For suggestions regarding strategic prioritization and action planning using the VBC Tool, see resources at www.ruralhealthvalue.org/TnR/VBC/VBCActionPlan.pdf

Opportunities: Governance and Leadership

- none -

Opportunities: Care Coordination

- none -

Opportunities: Clinical Care

- none -

Opportunities: Community Health

- none -

Opportunities: Patient and Family Engagement

• The HCO provides care options for a variety of cultural, spiritual, and personal preferences (e.g., food options, religious and spiritual practices, care plans that accommodate personal needs).

Opportunities: Performance Improvement and Reporting

- The HCO senior leadership uses data regarding clinical quality, patient satisfaction, clinician and staff satisfaction, community health, and cost to drive strategic decision-making and evaluate performance.
- Performance compared to benchmarks is widely shared within the HCO.
- Standardized care processes are implemented to reduce variation unrelated to unique patient needs and preferences.

Opportunities: Health Information Technology

- The HCO uses the electronic health record (EHR) to create a continuity of care document (CCD) containing at a minimum: problems, allergies, and medications.
- Clinicians and care teams across settings and organizations receive electronic alerts regarding patient status changes (e.g., ED visit, hospital admission, hospital discharge, and transfer).
- The HCO clinicians use e-prescribing.
- Predictive analytic tool(s) identify patients at high risk for poor outcomes and/or high resource utilization.
- The HCO ensures complete and accurate diagnostic coding to support appropriate risk-adjustment based on hierarchical condition category (HCC) coding.

Opportunities: Financial Risk Management

- The clinician compensation system includes value-based incentives.
- The HCO has a documented and approved plan to distribute shared savings or pay-for-performance bonuses among clinicians (e.g., physicians) and/or other HCOs.

Considerations

VBC Tool analysis indicates that the following value-based care capacities are either “In discussion,” “Not applicable,” “Not considered”, or the assessment was left blank. Demonstration HCO leadership may have reasonable justifications for less attention to these capacities. However, the Rural Value Team believes that all 80 capacities will eventually become important to the delivery of value-based care. Therefore, you should periodically **consider** these value-based care capacities.

Considerations: Governance and Leadership

- The HCO has a specific strategy to address organizational or programmatic affiliations designed to enhance its ability to participate in VBC.

Considerations: Care Coordination

- Non-traditional health care workers (e.g., community health workers, community paramedics health coaches, or patient navigators) are part of the care coordination team.
- The HCO ensures that appropriate advanced care planning (ACP) processes are in place, and that ACPs are documented and communicated across care settings.
- The HCO establishes clear lines of responsibility and communication between care coordinators and case managers assigned by the HCO, payer(s), and/or social service agencies.

Considerations: Clinical Care

- none -

Considerations: Community Health

- none -

Considerations: Patient and Family Engagement

- none -

Considerations: Performance Improvement and Reporting

- The HCO publicly reports data regarding clinical care, patient experience, cost performance, and health disparities.
- Performance data presentation is tailored to the needs of each intended audience such that the data are actionable.
- Continuous quality improvement techniques are embedded in clinician and staff training and processes.
- The HCO proactively participates in improvement initiatives and campaigns offered by external organizations which align with internal quality improvement goals and needs.

Considerations: Health Information Technology

- The HCO EHR supports medication reconciliation using an interoperable health information exchange.
- Clinicians exchange patient health information with other HCOs through interoperable EHRs and/or a health information exchange in a timely way.
- Clinical practice guidelines are used to trigger alerts and/or reminders in the EHR to support clinical decision-making.
- The HCO uses a population health data system to help manage population health.
- Clinicians use prescription drug monitoring programs to monitor prescribed controlled substances (e.g., opioids).
- The HCO regularly audits the HIT system to ensure data accuracy and uses a mitigation plan to resolve data discrepancies.
- The HCO employs data analytics to track service utilization at external organizations (e.g., claims data).

Considerations: Financial Risk Management

- If the HCO participates in risk contracts, stop-loss insurance or risk corridors are in place to mitigate financial risk.

Next Steps

The VBC Tool should be utilized to inspire strategic action planning. That is, the VBC Tool can assist you prioritize opportunities to build value-based care capacity, assess organizational interests and resources, and design action plans. Importantly, local knowledge and expertise should always inform action planning. The following steps may be used by Demonstration HCO leaders to guide value-based care capacity development.

1. Review Value-Based Care Strategic Planning Tool results with Demonstration HCO governing body and leadership team.

2. List opportunities to implement already developed value-based care capacities.

3. Begin value-based care capacity prioritization with capacities assessed as “In development,” but additionally consider other information such as operations data, population health data, and community health needs assessments.

4. Prioritize value-based care development opportunities based on:

   a. Leadership commitment to strategic value-based care capacity development.
   b. Resources (staff time and financing) available for value-based care capacity development.
   c. Organizational interest in value-based care capacity development.

5. Design, implement, and manage action plans to develop and implement individual value-based care capacities.

6. Design action plans that include:

   a. Measurable objectives.
   b. Single person accountabilities.
   c. Resource commitment.
   d. Timelines/due dates.

7. Remain involved with strategic action plans to facilitate progress, allocate resources, and demonstrate commitment.

8. See Value-Based Care Strategic Planning Tool Capacity List (below) for a complete list of all value-based care 80 capacities assessed included in the VBC Tool.

9. Contact Clint MacKinney at clint-mackinney@uiowa.edu or Karla Weng at kweng@stratishealth.org for additional information regarding the VBC Tool.

Value-Based Care Strategic Planning Tool Capacity List

Governance and Leadership – Decision-making authority, strategy development, leadership performance, and high-level HCO processes designed to deliver VBC.

1. The HCO publicly identifies better care, improved community health, and smarter spending as priorities.
2. The HCO demonstrates commitment to equitable access, treatment, and outcomes for everyone in the community. (e.g., in strategy, policy, and operations).
3. The HCO governing body regularly evaluates value-based performance metrics with benchmark comparisons (i.e., clinical quality, patient satisfaction, community health, and cost of care).
4. The governing body includes clinicians.
5. Senior leadership engages clinicians in operational decision-making.
6. The senior leadership team includes positions, identified by title and/or job description, who have clear accountability to improve clinical quality and patient safety, improve the patient experience, advance community health, and lower total costs.
7. Senior leaders' performance evaluation and compensation are partly linked to value-based care performance.
8. Senior leaders employ regular "walkarounds" to support staff in delivering value-based care.
9. The HCO invests in community-based resources that address health related social needs, support individual well-being, and improve community health in settings other than the facilities of the HCO.
10. The HCO has a specific strategy to address organizational or programmatic affiliations designed to enhance its ability to participate in VBC.

Care Coordination – Care coordination (particularly during care transitions and for patients with complex care needs) that facilitates patient-centered care, improved clinical outcomes, and efficient resource use.

1. The HCO uses data to identify individuals at risk for poor outcomes and/or high resource utilization.
2. The HCO assigns care coordinators to patients at risk for poor outcomes and/or high resource utilization.
3. The HCO ensures that care coordination and transition support services are utilized for hospitalized patients.
4. The HCO refers patients and families to community-based organizations (e.g., public health agencies, schools, human service agencies, community groups, and faith-based organizations) to support care coordination and transition management by addressing health-related social needs.
5. The HCO receives follow-up information from community-based organizations after patient referrals (i.e., “closed loop referrals”).
6. Non-traditional health care workers (e.g., community health workers, community paramedics health coaches, or patient navigators) are part of the care coordination team.
7. The HCO ensures that appropriate advanced care planning (ACP) processes are in place, and that ACPs are documented and communicated across care settings.
8. The HCO establishes clear lines of responsibility and communication between care coordinators and case managers assigned by the HCO, payer(s), and/or social service agencies.

Clinical Care – Clinical care efforts and processes are designed to deliver VBC within traditional medical care settings.

1. The HCO regularly measures and improves access to care (e.g., wait time to schedule a routine appointment, and ED wait times).
2. A same-day scheduling system allows primary care practices to offer same day appointments to all patients.
3. An after-hours care system (e.g., practice call line and extended clinic hours) supports access to care that can help reduce emergency department use for individuals with non-emergent conditions.
4. The primary care workforce is clinically integrated with the hospital, and other specialists and clinical providers (e.g., shared clinical protocols, interoperable electronic health records, and common performance improvement measures).
5. Primary care practices are accredited health homes (patient-centered medical homes).
6. The HCO proactively ensures preventive care (e.g., action lists of due/overdue services and Medicare wellness visits).
7. The HCO increases access to services to better meet patient needs locally (e.g., through telehealth, group visits, and other alternative patient encounters).

8. Behavioral health professionals are integrated with primary care clinicians.
9. Primary care clinicians refer patients to specialists, ancillary services, and hospitals that deliver high-quality care at lower cost.
10. The HCO incorporates evidence-based guidelines into clinical prompts, workflow, and practices.
11. Processes and training are in place to assure appropriate access to palliative care support, hospice services, and end-of-life care.

Community Health – Assessments and strategies designed to enhance the health of all individuals in a community across a spectrum of ages and conditions.

1. The HCO defines and regularly reviews population size and demographic data including health disparities based on factors such as race, ethnicity, and socioeconomic status.
2. The HCO regularly reviews and develops strategies to address health needs as identified through a community health needs assessment (or similar process).
3. The HCO has an identified champion with specific accountabilities for community health improvement.
4. The HCO has staff expertise and dedicated resources to support community health initiatives.
5. The HCO works with other community organizations to identify shared goals and implement initiatives to address prioritized community health needs.
6. The HCO implements community preventive health and wellness programs in addition to those that directly promote current HCO services.
7. The HCO offers wellness programs, benefits, and/or incentives to its employees.
8. The HCO works with other partners and organizations to help meet individual health-related social needs and to address social determinants of health more broadly in the community.

Patient and Family Engagement – The active involvement of patient/family decision-making and preferences in health care design and delivery.

1. The HCO has strategic action plans with measurable objectives which focus on improving patient and family engagement.
2. The HCO has policies and practices in place to recognize families and other care partners as essential members of the care team (different from “visitors”).
3. The HCO provides care options for a variety of cultural, spiritual, and personal preferences (e.g., food options, religious and spiritual practices, care plans that accommodate personal needs).
4. The HCO has a patient/family advisory council (or equivalent) that reflects the diversity of the community served.
5. Senior leaders employ regular “walkarounds” interacting with patients/families.

6. The HCO provides patients with user-friendly health education resources specific to the patient's condition(s) and need(s).
7. Patients have secure and user-friendly access to their care team.
8. Clinicians use shared decision-making approaches and decision aids for clinical conditions in which evidence-based care can vary by patient values and preferences.
9. The HCO policies and actions support patients and families following error or harm.

Performance Improvement and Reporting – HCO performance measurement and reporting designed to improve patient care, increase population health, and lower per capita cost.

1. The HCO senior leadership uses data regarding clinical quality, patient satisfaction, clinician and staff satisfaction, community health, and cost to drive strategic decision-making and evaluate performance.
2. Performance compared to benchmarks is widely shared within the HCO.
3. The HCO publicly reports data regarding clinical care, patient experience, cost performance, and health disparities.
4. Performance data presentation is tailored to the needs of each intended audience such that the data are actionable.
5. The HCO actively works to limit potentially avoidable utilization (e.g., readmissions, inpatient admissions, and emergency department visits) for individuals with conditions that could be managed in non-hospital settings.
6. Standardized care processes are implemented to reduce variation unrelated to unique patient needs and preferences.
7. Continuous quality improvement techniques are embedded in clinician and staff training and processes.
8. The HCO proactively participates in improvement initiatives and campaigns offered by external organizations which align with internal quality improvement goals and needs.

Health Information Technology – Use of electronic systems in support of patient care, and in clinical and organizational planning and decision making.

1. The HCO has a comprehensive health information technology (HIT) strategy to support value-based care that responds to continually evolving stages of federal and state mandates and incentive programs.
2. The HCO uses the electronic health record (EHR) to create a continuity of care document (CCD) containing at a minimum: problems, allergies, and medications.
3. The HCO EHR supports medication reconciliation using an interoperable health information exchange.
4. Clinicians exchange patient health information with other HCOs through interoperable EHRs and/or a health information exchange in a timely way.
5. Clinicians and care teams across settings and organizations receive electronic alerts regarding patient status changes (e.g., ED visit, hospital admission, hospital discharge, and transfer).

6. Clinical practice guidelines are used to trigger alerts and/or reminders in the EHR to support clinical decision-making.
7. The HCO uses a population health data system to help manage population health.
8. The HCO clinicians use e-prescribing.
9. Clinicians use prescription drug monitoring programs to monitor prescribed controlled substances (e.g., opioids).
10. Predictive analytic tool(s) identify patients at high risk for poor outcomes and/or high resource utilization.
11. The HCO regularly audits the HIT system to ensure data accuracy and uses a mitigation plan to resolve data discrepancies.
12. The HCO employs data analytics to track service utilization at external organizations (e.g., claims data).
13. The HCO ensures complete and accurate diagnostic coding to support appropriate risk-adjustment based on hierarchical condition category (HCC) coding.

Financial Risk Management – HCO capacities that moderate the risk of harm or optimize risk of benefit relative to VBC.

1. The HCO monitors changes in the market (and market share) for different service lines.
2. The HCO can forecast profit and loss when assessing alternative payment contracts (e.g., shared savings and bundled payment).
3. The HCO can validate payer-defined cost targets and risk-adjustment methodologies.
4. The HCO gains direct experience managing both financial and medical risk by self-insuring or contracting with a self-insured employer.
5. The HCO has partnered with a payer or other organization participating in payer-driven initiatives (e.g., ACO or bundled payment program) to control costs or manage a specific patient population.
6. The HCO implements projects to increase organizational efficiency.
7. Financial strength (e.g., profit margin and reserves) allows the HCO to accept the risk of spending greater than targets.
8. If the HCO participates in risk contracts, stop-loss insurance or risk corridors are in place to mitigate financial risk.
9. The HCO has access to capital to develop new value-based care initiatives.
10. The HCO continuously monitors revenues compared to cost to deliver services, including alternative modalities.
11. The HCO employs a cost-accounting system capable of quantifying cost per encounter/service.
12. The clinician compensation system includes value-based incentives.
13. The HCO has a documented and approved plan to distribute shared savings or pay-for-performance bonuses among clinicians (e.g., physicians) and/or other HCOs.