Demonstration Hospital
Value-Based Care Readiness Report
August 17, 2018

Value-Based Care Readiness

Expanding healthcare payment alternatives, such as shared savings and bundled payments, demand that a healthcare organization develop and deploy 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 115 value-based *capacities* within eight value-based care categories:

- Governance and Leadership
- Care Management
- Clinical Care
- Community Health
- Patient and Family Engagement
- Performance Improvement
- 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 deployment.

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

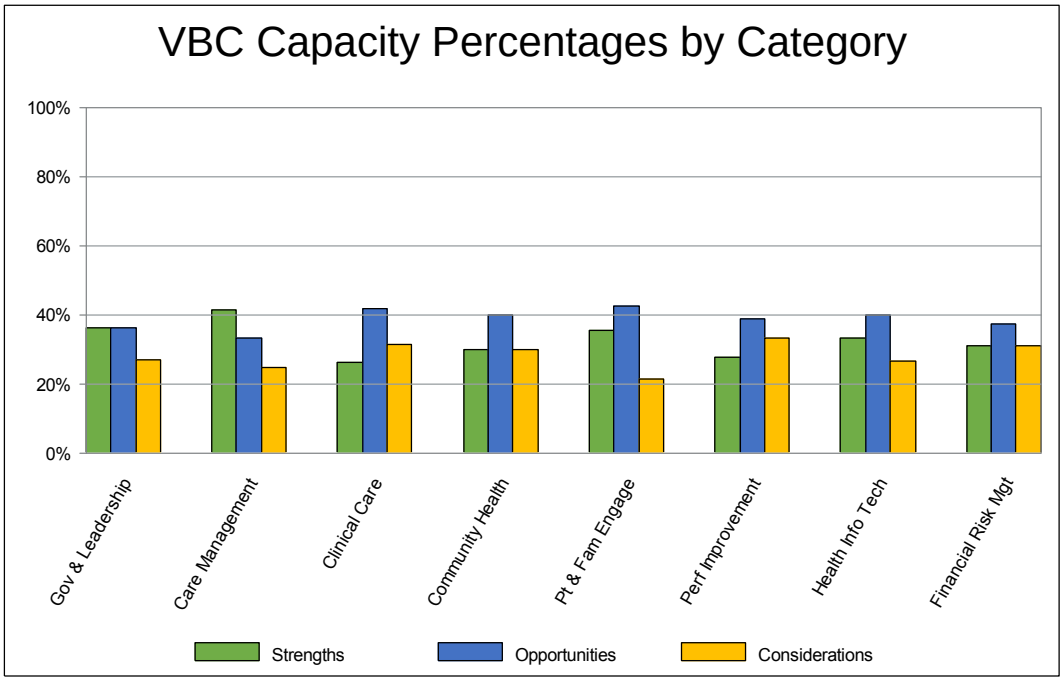
The Report may be used as a strategic planning tool, serving as the basis for value-based care action planning. The Report may also be used to inform the Demonstration Hospital governing body, leadership, and other key stakeholders regarding the changing landscape of healthcare delivery and finance.

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 deployed" or "Developed and incompletely deployed"
- 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 deployed” or “Developed, incompletely deployed.” These capacities are Demonstration Hospital **strengths.** The Rural Health Value Team recommends that you measure progress and celebrate fully developed and deployed value-based care capacities. Maintain deployment momentum of fully developed, incompletely deployed value-based care capacities.

Strengths: Governance and Leadership

- The HCO publicly identifies better patient care, improved community health, and lower per capita costs as priorities.
- The HCO strategic planning process determines priorities based on community needs.
- Partnerships, joint ventures, or other contractual agreements facilitate resource (both investment and payment) allocation across multiple organizations that serve or support patients.
- The HCO has a specific strategy to address organizational affiliation or merger opportunities.

Strengths: Care Management

- The senior leadership team understands the role of care management in achieving cost and quality goals necessary for success in new payment models.
- Partnerships, joint ventures, or other contractual agreements facilitate care coordination across multiple organizations that serve or support patients.
- Non-traditional health care workers (e.g., community paramedics, community health workers, health coaches) are utilized as part of the care management team.
- The HCO provides or ensures the availability of palliative and/or hospice care.
- 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.

Strengths: Clinical Care

• The senior leadership team understands the business case for clinical quality and patient safety.

• The HCO utilizes an objective assessment to determine the optimum number of primary and specialty care providers to serve the population.

• For non-urgent clinic visits, pre-visit planning occurs for complex patients.

• Clinical practices employ a team-based care model to best match patient needs with care team expertise.

• The clinician compensation system includes both volume- and value-based incentives.

Strengths: Community Health

• The HCO can define and regularly update the population size and demographic characteristics within its service area.

• The HCO can identify and regularly update the population health needs within its service area.

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

Strengths: Patient and Family Engagement

• The HCO visibly states its commitment to patient and family partnerships in healthcare decision-making.

• Leadership includes a position specifically tasked to oversee and develop patient and family engagement activities.

• The HCO provides patients with web-based access to health education resources specific to the patient's condition(s) and needs(s).

• Patients have web-based access to their own medical records.

• Patients have secure electronic access to clinicians (e.g., email, EHR portal).

Strengths: Performance Improvement and Reporting

• The senior leadership uses measurable performance data to drive strategic decision-making.

• The HCO measures per-capita costs and payments by payer.

• The HCO publicly reports a comprehensive summary of clinical care, patient experience, and cost performance.

• The HCO management and leadership discusses HCO VBC performance during most internal and public meetings.

• The HCO actively works to reduce potentially avoidable readmissions.

Strengths: Health Information Technology

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

• The HCO electronically exchanges information with other clinical care organizations as needed to serve patient needs.

• The HCO clinicians use e-prescribing.

• Clinical data sharing between providers (e.g., between primary and specialty care) is concurrent.

• Predictive analytic tool(s) identify patients at high risk for poor outcomes or high resource utilization.

Strengths: Financial Risk Management

• The HCO monitors outmigration data (market share) for different service lines.

• The HCO can forecast profit and loss when assessing alternative payment contracts (e.g., shared savings or bundled payment).

• The HCO continuously monitors cost to deliver services compared to revenues.

• The HCO employs a cost-accounting system capable of quantifying cost per encounter/service.

• The HCO financial system can manage total cost of care for a defined population (e.g., cost of care reports, high cost patient identification, changing risk profile, case mix change).

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 Hospital leadership attention to reach full development and deployment. 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

- The HCO governing body specifically evaluates HCO value-based performance (i.e., clinical quality, patient satisfaction, community health, and cost of care) with benchmark comparisons at each meeting.
- Clinical employee job descriptions and/or performance evaluations specifically address competencies and/or performance linked to better care, improved health, and lower costs.

Opportunities: Care Management

- The HCO has data and a system that assesses and identifies patients at high risk for poor outcomes or high resource utilization.
- The HCO engages community resources (e.g., public health agencies, schools, human service agencies, community groups, faith-based organizations) to support care management.

Opportunities: Clinical Care

- The HCO regularly measures access to care during office hours (e.g., wait time for routine appointment).
- The HCO generates action lists for clinicians of patients who are due/overdue for services.
- Clinical practices offer group visits, e-visits, and other alternative patient encounters.
- Processes and training are in place to assure appropriate advanced care planning (including end-of-life planning) occurs, is documented, and is shared with those needing the information.

Opportunities: Community Health

• The HCO has implemented programs in response to needs identified in a Community Health Needs Assessment survey (or similar assessment).

• The HCO has implemented community preventive health programs in addition to those that directly promote current HCO services.

Opportunities: Patient and Family Engagement

• Specific strategic programs with measurable objectives focus on improving patient and family engagement.

• Leadership routinely interacts with patients/families during leadership 'walkarounds' with appropriate attention to confidentiality.

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

Opportunities: Performance Improvement and Reporting

• The HCO uses health care provider/team utilization data to support performance improvement efforts.

• Performance data presentation is tailored to the stakeholder such that the data are actionable.

• The HCO actively works to reduce inappropriate service utilization, including inpatient admissions and emergency department visits for conditions that could be managed in non-hospital settings.

Opportunities: Health Information Technology

• All HCOs and clinicians in the community use a shared electronic health record (EHR), or if different EHRs are in use, the EHRs are interoperable and data are shared in a timely way.

• The HCO EHR supports patient registries.

• The HIT system (or EHR) provides regular population health reports.

Opportunities: Financial Risk Management

• The HCO can validate payer-defined cost targets and risk-adjustment methodologies.

• The HCO has access to capital to develop new value-based care initiatives.

• Clinician contracts define clinical accountabilities for patient care, such as quality improvement participation, patient confidentiality maintenance, and/or board certification.

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 Hospital leadership may have reasonable justifications for less attention to these capacities. However, the Rural Value Team believes that all 115 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 governing body engages clinicians in strategic decision-making.
- 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 per capita costs.
- Senior leaders' performance evaluation and compensation are partly linked to value-based care performance.
- Senior leaders employ regular “walkarounds” of front-line care as a leadership practice.

Considerations: Care Management

- The HCO assigns care managers to patients at high risk for poor outcomes or high resource utilization.
- The HCO offers chronic disease management services.
- The HCO provides or ensures that post-hospital-discharge care transition services are available and utilized when a patient is hospitalized by the HCO or within the HCO service area.
- The care management team (if established) is alerted when a patient uses services outside of the HCO.
- The HCO provides or ensures that post-hospital-discharge care transition services are available and utilized when the patient is hospitalized outside the HCO service area.

Considerations: Clinical Care

• A same day scheduling system allows primary care practices to offer same day appointments to all patients, regardless of the nature of their problem (routine or urgent).

• The HCO regularly measures access to care during non-typical clinic hours to identify gaps and opportunities (e.g., emergency department use for non-emergent conditions).

• An after-hours care system (e.g., practice call line, extended clinic hours) reduces emergency department use for non-emergent conditions.

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

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

• Mental health professionals are integrated with primary care clinicians.

• Medication reconciliation occurs during each patient encounter within the HCO.

• Primary care clinicians have established a 'referral network,' which prioritizes patient referrals to high-value specialists, ancillary services, and hospitals.

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

• The HCO measures compliance with evidence-based care.

Considerations: Community Health

• The HCO works with other community organizations and services to identify and prioritize shared goals and initiatives for high priority community health needs.

• The HCO has identified a champion specifically tasked with accountability for community health improvement.

• The HCO has the staff expertise and internal resources to support population health initiatives.

• Senior leadership understands the relationship between community health improvement and emerging payment and care delivery models.

• Clinicians understand the relationship between community health improvement and emerging payment and care delivery models.

Considerations: Patient and Family Engagement

• Prior to each planned hospital admission, the HCO staff provides and discusses a planning checklist with the patient and/or family.

• The HCO collects data regarding patient and family cultural/language preferences.

• The HCO modifies care based on patient and family cultural/language preferences.

• The HCO generates reminders for patients who are due/overdue for preventive and follow-up services and acts on them.

- The HCO has a patient/family advisory council (or equivalent).
- The HCO policies and actions support patients and families following error or harm.

Considerations: Performance Improvement and Reporting

- The HCO uses health care provider/team clinical quality data to support performance improvement efforts.
- The HCO uses health care provider/team patient experience data to support performance improvement efforts.
- The HCO tracks serious safety events.
- Performance compared to benchmarks is widely shared within the HCO.
- The HCO's clinical performance measures reflect evidence-based care.
- Internal feedback loops standardize care processes to reduce variation unrelated to unique patient needs and preferences.
- Managers have been trained in continuous quality improvement techniques.
- Managers use continuous quality improvement techniques to implement and evaluate performance improvement activities.
- Clinicians and other stakeholders collaborate to improve performance.
- 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 has developed a master patient index (across all care sites) that includes important patient-specific demographic, clinical, and payer data.
- Care teams across settings and organizations receive alerts regarding patient status change (e.g., ED visit, hospital admission, hospital discharge).
- Clinical practice guidelines imbedded within the EHR provide clinical decision support.
- The HCO EHR alerts clinicians regarding recommended patient-specific care at point-of-service (e.g., inpatient bedside and office visit).
- The HCO EHR supports medication reconciliation.
- The HIT system (or EHR) provides regular utilization/financial reports.
- The HIT system (or EHR) integrates cost-of-care or utilization data from services provided outside of the HCO to develop longitudinal performance reports (e.g. claims data, fees).

Considerations: Financial Risk Management

• 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 (e.g., in an ACO or a bundled payment program) to control costs or manage a specific patient population.

• The HCO has implemented efficiency strategies, such as Lean or Six Sigma.

• Financial strength (profit margin and/or reserves) allows the HCO to accept risk of spending greater than targets.

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

• Clinician contracts define financial rewards and incentives related to patient care.

• 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.

• If present, the HCO shared savings distribution plan does not induce providers to reduce or limit medically appropriate care or services.

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 Hospital leaders to guide value-based care capacity development.

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

2. List opportunities to deploy 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 deploy individual value-based care capacities.

6. Design action plans that include:

   a. Measureable 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 115 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 patient care, improved community health, and lower per capita costs as priorities.
2. The HCO strategic planning process determines priorities based on community needs.
3. The HCO governing body specifically evaluates HCO value-based performance (i.e., clinical quality, patient satisfaction, community health, and cost of care) with benchmark comparisons at each meeting.
4. The governing body engages clinicians in strategic decision-making.
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 per capita costs.
7. Senior leaders' performance evaluation and compensation are partly linked to value-based care performance.
8. Senior leaders employ regular “walkarounds” of front-line care as a leadership practice.
9. Clinical employee job descriptions and/or performance evaluations specifically address competencies and/or performance linked to better care, improved health, and lower costs.
10. Partnerships, joint ventures, or other contractual agreements facilitate resource (both investment and payment) allocation across multiple organizations that serve or support patients.
11. The HCO has a specific strategy to address organizational affiliation or merger opportunities.

Care Management – Care integration and coordination (particularly during medical care transitions and for clinically complex patients) that facilitate patient-centered care, improved clinical outcomes, and efficient resource use.

1. The senior leadership team understands the role of care management in achieving cost and quality goals necessary for success in new payment models.
2. Partnerships, joint ventures, or other contractual agreements facilitate care coordination across multiple organizations that serve or support patients.
3. The HCO has data and a system that assesses and identifies patients at high risk for poor outcomes or high resource utilization.
4. The HCO assigns care managers to patients at high risk for poor outcomes or high resource utilization.
5. The HCO offers chronic disease management services.
6. The HCO provides or ensures that post-hospital-discharge care transition services are available and utilized when a patient is hospitalized by the HCO or within the HCO service area.
7. The care management team (if established) is alerted when a patient uses services outside of the HCO.
8. The HCO provides or ensures that post-hospital-discharge care transition services are available and utilized when the patient is hospitalized outside the HCO service area.

9. The HCO engages community resources (e.g., public health agencies, schools, human service agencies, community groups, faith-based organizations) to support care management.
10. Non-traditional health care workers (e.g., community paramedics, community health workers, health coaches) are utilized as part of the care management team.
11. The HCO provides or ensures the availability of palliative and/or hospice care.
12. 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 foci and processes are designed to deliver VBC within traditional medical care settings.

1. The senior leadership team understands the business case for clinical quality and patient safety.
2. The HCO utilizes an objective assessment to determine the optimum number of primary and specialty care providers to serve the population.
3. The HCO regularly measures access to care during office hours (e.g., wait time for routine appointment).
4. A same day scheduling system allows primary care practices to offer same day appointments to all patients, regardless of the nature of their problem (routine or urgent).
5. The HCO regularly measures access to care during non-typical clinic hours to identify gaps and opportunities (e.g., emergency department use for non-emergent conditions).
6. An after-hours care system (e.g., practice call line, extended clinic hours) reduces emergency department use for non-emergent conditions.
7. The primary care workforce is clinically integrated with the hospital, sub-specialists, and other clinical providers (e.g., established referral processes, shared clinical protocols, interoperable electronic health records, common performance improvement measures).
8. Primary care practices are accredited health homes (patient-centered medical homes).
9. The HCO generates action lists for clinicians of patients who are due/overdue for services.
10. For non-urgent clinic visits, pre-visit planning occurs for complex patients.
11. Clinical practices employ a team-based care model to best match patient needs with care team expertise.
12. The clinician compensation system includes both volume- and value-based incentives.
13. Clinical practices offer group visits, e-visits, and other alternative patient encounters.
14. Mental health professionals are integrated with primary care clinicians.
15. Medication reconciliation occurs during each patient encounter within the HCO.
16. Primary care clinicians have established a 'referral network,' which prioritizes patient referrals to high-value specialists, ancillary services, and hospitals.
17. The HCO incorporates evidence-based guidelines into clinical prompts, workflow, and practices.
18. The HCO measures compliance with evidence-based care.
19. Processes and training are in place to assure appropriate advanced care planning (including end-of-life planning) occurs, is documented, and is shared with those needing the information.

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

1. The HCO can define and regularly update the population size and demographic characteristics within its service area.
2. The HCO can identify and regularly update the population health needs within its service area.
3. The HCO has implemented programs in response to needs identified in a Community Health Needs Assessment survey (or similar assessment).
4. The HCO works with other community organizations and services to identify and prioritize shared goals and initiatives for high priority community health needs.
5. The HCO has identified a champion specifically tasked with accountability for community health improvement.
6. The HCO has the staff expertise and internal resources to support population health initiatives.
7. Senior leadership understands the relationship between community health improvement and emerging payment and care delivery models.
8. Clinicians understand the relationship between community health improvement and emerging payment and care delivery models.
9. The HCO has implemented community preventive health programs in addition to those that directly promote current HCO services.
10. The HCO offers wellness programs, benefits, and/or incentives to its employees.

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

1. The HCO visibly states its commitment to patient and family partnerships in healthcare decision-making.
2. Leadership includes a position specifically tasked to oversee and develop patient and family engagement activities.
3. Specific strategic programs with measurable objectives focus on improving patient and family engagement.
4. Prior to each planned hospital admission, the HCO staff provides and discusses a planning checklist with the patient and/or family.
5. The HCO collects data regarding patient and family cultural/language preferences.
6. The HCO modifies care based on patient and family cultural/language preferences.
7. The HCO generates reminders for patients who are due/overdue for preventive and follow-up services and acts on them.
8. The HCO has a patient/family advisory council (or equivalent).
9. Leadership routinely interacts with patients/families during leadership 'walkarounds' with appropriate attention to confidentiality.
10. The HCO provides patients with web-based access to health education resources specific to the patient's condition(s) and needs(s).
11. Patients have web-based access to their own medical records.
12. Patients have secure electronic access to clinicians (e.g., email, EHR portal).
13. Providers use shared-decision making approaches and decision aids for clinical conditions in which evidence-based care can vary by patient values and preferences.
14. 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 senior leadership uses measurable performance data to drive strategic decision-making.
2. The HCO measures per-capita costs and payments by payer.
3. The HCO uses health care provider/team utilization data to support performance improvement efforts.
4. The HCO uses health care provider/team clinical quality data to support performance improvement efforts.
5. The HCO uses health care provider/team patient experience data to support performance improvement efforts.
6. The HCO tracks serious safety events.
7. Performance compared to benchmarks is widely shared within the HCO.
8. The HCO's clinical performance measures reflect evidence-based care.
9. Performance data presentation is tailored to the stakeholder such that the data are actionable.
10. The HCO publicly reports a comprehensive summary of clinical care, patient experience, and cost performance.
11. The HCO management and leadership discusses HCO VBC performance during most internal and public meetings.
12. The HCO actively works to reduce potentially avoidable readmissions.
13. The HCO actively works to reduce inappropriate service utilization, including inpatient admissions and emergency department visits for conditions that could be managed in non- hospital settings.
14. Internal feedback loops standardize care processes to reduce variation unrelated to unique patient needs and preferences.
15. Managers have been trained in continuous quality improvement techniques.
16. Managers use continuous quality improvement techniques to implement and evaluate performance improvement activities.
17. Clinicians and other stakeholders collaborate to improve performance.
18. 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 – Electronic systems (hardware, software, and supporting processes) that collect, collate, integrate, and disseminate performance data.

1. The HCO has a comprehensive health information technology (HIT) strategy to support value-based care, and to achieve continually evolving stages of federal and state mandates and incentive programs.
2. The HCO electronically exchanges information with other clinical care organizations as needed to serve patient needs.
3. All HCOs and clinicians in the community use a shared electronic health record (EHR), or if different EHRs are in use, the EHRs are interoperable and data are shared in a timely way.
4. The HCO has developed a master patient index (across all care sites) that includes important patient-specific demographic, clinical, and payer data.
5. Care teams across settings and organizations receive alerts regarding patient status change (e.g., ED visit, hospital admission, hospital discharge).

6. Clinical practice guidelines imbedded within the EHR provide clinical decision support.
7. The HCO EHR alerts clinicians regarding recommended patient-specific care at point-of-service (e.g., inpatient bedside and office visit).
8. The HCO EHR supports medication reconciliation.
9. The HCO EHR supports patient registries.
10. The HCO clinicians use e-prescribing.
11. Clinical data sharing between providers (e.g., between primary and specialty care) is concurrent.
12. Predictive analytic tool(s) identify patients at high risk for poor outcomes or high resource utilization.
13. The HIT system (or EHR) provides regular population health reports.
14. The HIT system (or EHR) provides regular utilization/financial reports.
15. The HIT system (or EHR) integrates cost-of-care or utilization data from services provided outside of the HCO to develop longitudinal performance reports (e.g. claims data, fees).

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

1. The HCO monitors outmigration data (market share) for different service lines.
2. The HCO can forecast profit and loss when assessing alternative payment contracts (e.g., shared savings or 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 (e.g., in an ACO or a bundled payment program) to control costs or manage a specific patient population.
6. The HCO has implemented efficiency strategies, such as Lean or Six Sigma.
7. Financial strength (profit margin and/or reserves) allows the HCO to accept 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 risk.
9. The HCO has access to capital to develop new value-based care initiatives.
10. The HCO continuously monitors cost to deliver services compared to revenues.
11. The HCO employs a cost-accounting system capable of quantifying cost per encounter/service.
12. The HCO financial system can manage total cost of care for a defined population (e.g., cost of care reports, high cost patient identification, changing risk profile, case mix change).
13. Clinician contracts define clinical accountabilities for patient care, such as quality improvement participation, patient confidentiality maintenance, and/or board certification.
14. Clinician contracts define financial rewards and incentives related to patient care.
15. 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.
16. If present, the HCO shared savings distribution plan does not induce providers to reduce or limit medically appropriate care or services.