Anytown USA Hospital
Value-Based Care Readiness Report
July 22, 2015

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 121 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 Anytown USA Hospital governing body, leadership, and other key stakeholders regarding the changing landscape of healthcare delivery and finance.

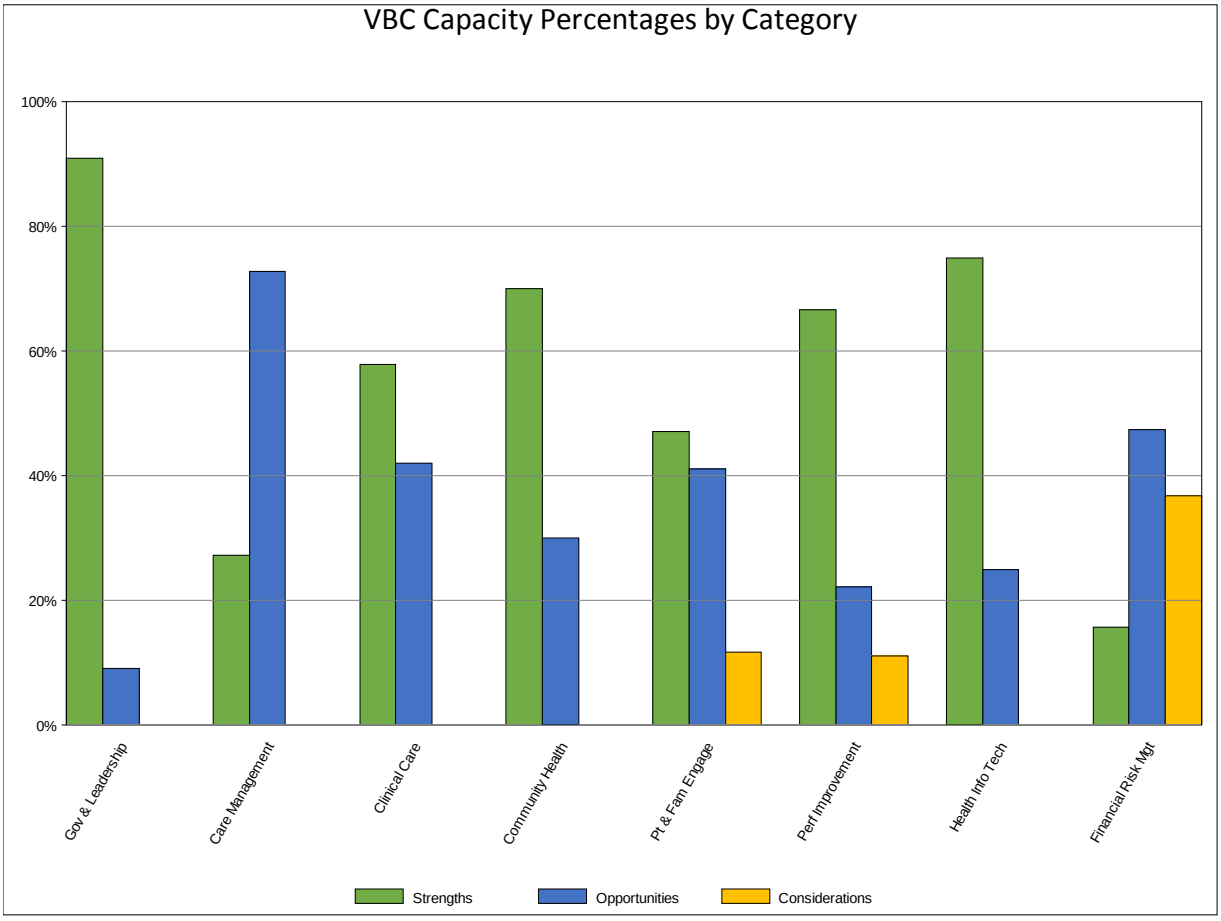
Anytown USA Hospital
Value-Based Care Readiness Report
July 22, 2015

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 Anytown USA 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 mission (or equivalent public statement) specifically prioritizes better patient care, improved community health, and lower per capita costs.
- The strategic planning process determines priorities based on community needs.
- 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.
- The HCO governing body formally engages physicians in decision-making.
- The senior leadership team includes positions identified by title and/or job description who have clear accountability to improve clinical quality/patient safety, improve the patient experience, advance community health, and lower per capita costs.
- Senior leadership team responsible for operational decision-making includes physician(s).
- Senior leadership team performance evaluation and compensation are partly linked to value-based HCO performance.
- Senior leaders employ regular "walkarounds" as a leadership policy.
- Partnerships, joint ventures, or other contractual agreements facilitate resource (both investment and payment) allocation across multiple providers.
- The HCO has a specific strategy to address organizational affiliation/merger opportunities.

Strengths: Care Management

- 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 providers.

• The HCO provides or ensures the availability of palliative and/or hospice care.

Strengths: Clinical Care

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

• HCO regularly assesses access to care during office hours (e.g., wait time for routine appointment).

• Primary care workforce is employed by, or tightly aligned with, the HCO.

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

• HCO generates actions lists for providers of patients who are due/overdue for services.

• Clinical practices employ a team-based care model in which patients are directed to the appropriate provider based on clinical condition, not provider preference.

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

• Behavioral health professionals are co-located with primary care providers.

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

• HCO incorporates evidence-based guidelines into clinical prompts and/or practices.

• HCO measures compliance with evidence-based care.

Strengths: Community Health

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

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

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

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

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

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

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

Strengths: Patient and Family Engagement

- HCO visibly states its commitment to patient and family partnerships in healthcare decision-making.
- HCO modifies care based on patient and family cultural/language preferences.
- HCO generates reminders for patients who are due/overdue for services.
- Patients have web-based access to their own medical records.
- Patients have access to providers by email.
- Providers use shared-decision making approaches for clinical conditions in which care can vary by patient preference.
- HCO regularly acts upon patient/family satisfaction survey results.
- HCO policies support patients/families following error or harm.

Strengths: Performance Improvement and Reporting

- Senior leadership uses measureable performance data to drive strategic decision-making.
- HCO uses health care provider/team clinical quality data to support performance improvement.
- HCO tracks serious safety events.
- Performance compared to benchmarks is widely shared within the HCO.
- Clinical performance measures reflect evidence-based care.
- HCO publicly reports a comprehensive summary of clinical care, patient experience, and cost performance.
- Leadership discusses HCO VBC performance during most internal and public meetings.
- HCO actively works to reduce potentially avoidable readmissions.
- Managers have been trained in continuous quality improvement techniques.
- Managers use continuous quality improvement techniques to implement/evaluate performance improvement activities.
- Providers and other stakeholders collaborate to improve performance.
- HCO proactively participates in improvement initiatives and campaigns offered by external organizations which align with internal quality improvement goals and needs.

Strengths: Health Information Technology

- HCO has a comprehensive health information technology (HIT) strategy for achieving continually evolving stages of Meaningful Use.

- HCO participates in at least one health information exchange.
- All providers in the community use a common electronic health record (EHR), or different EHRs are interoperable.
- 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.
- EHR alerts providers regarding recommended patient-specific care at point-of-service (e.g., inpatient bedside and office visit).
- EHR supports medication reconciliation.
- EHR supports patient registries.
- HCO uses the e-prescribing function in its EHR.
- 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

- HCO can develop a pro forma budget for a patient population.
- HCO has access to capital to develop new value-based care initiatives.
- Provider contracts clearly define clinical accountabilities for patient care.

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 Anytown USA 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/XXX.XXX.

Opportunities: Governance and Leadership

- 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

- HCO assesses and identifies patients at high risk for poor outcomes or high resource utilization, and assigns care managers to them.
- HCO offers chronic disease management services.
- HCO ensures that post-hospital discharge care transition services are available and utilized.
- The care management team (if established) is alerted when a patient uses services outside of the HCO.
- HCO provides care transition services for patients hospitalized outside of the HCO service area.
- HCO utilizes a broad community resource network (e.g., public health agencies, schools, human service agencies, community groups, faith-based organizations) in care management.

Opportunities: Clinical Care

- HCO utilizes an objective assessment to determine the optimum number of primary and specialty care providers required.
- 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).

- An after-hours care system (e.g., practice call line, extended clinic hours) reduces emergency department use for non-emergent conditions.
- Clinical practices offer group visits, e-visits, and other alternative patient encounters.
- Primary care providers have established a 'referral network,' preferentially referring patients to high-value specialists, ancillary services, and/or hospitals.
- Primary care practices encourage advanced care planning (including end-of-life planning).

Opportunities: Community Health

- HCO can identify the population health needs within its service area.
- HCO has the staff expertise and internal resources to support population health initiatives.
- Providers understand the relationship between community health improvement and emerging payment and care delivery models.

Opportunities: Patient and Family Engagement

- Patients/families are routinely interviewed during leadership 'walkarounds.'
- Patients have web-based access to health education resources.

Opportunities: Performance Improvement and Reporting

- HCO uses health care provider/team patient satisfaction data support performance improvement.
- HCO actively works to reduce inappropriate emergency department utilization.
- Internal feedback loops standardize care processes to reduce variation unrelated to unique patient needs/preferences.

Opportunities: Health Information Technology

- HIT system (or EHR) provides regular population health reports.
- HIT system (or EHR) provides regular utilization/financial reports.
- HIT system (or EHR) integrates cost-of-care or utilization data from services provided outside of HCO.
- HIT system (or EHR) extracts data from multiple sites to develop longitudinal performance reports.

Opportunities: Financial Risk Management

- HCO can develop a sensitivity analysis to predict profit/loss with alternate payment contracts (e.g., shared savings or bundled payment).
- Actuarial support can validate payer-defined cost targets.
- HCO has implemented efficiency strategies, such as Lean or Six Sigma.
- Financial strength (profit margin and/or reserves) allows HCO to accept risk of spending greater than targets.
- HCO continuously monitors cost to deliver services compared to revenues.
- HCO employs cost-accounting system capable of quantifying cost per encounter/service.
- 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).
- HCO can attribute cost-reduction investments to financial statements.
- Provider contracts clearly define financial risks associated with patient care.

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. Anytown USA Hospital leadership may have reasonable justifications for less attention to these capacities. However, the Rural Value Team believes that all 121 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

Considerations: Care Management

- HCO engages a non-traditional health care workforce (e.g., community paramedics, community health workers, health coaches) in care management.
- The HCO has established clear lines of responsibility and communication between HCO, payer, and/or social services care managers.

Considerations: Clinical Care

- HCO regularly assesses access to care during non-typical clinic hours to identify gaps and opportunities (e.g., emergency department use for non-emergent conditions).
- For non-urgent clinic visits, pre-visit planning occurs for complex patients.

Considerations: Community Health

Considerations: Patient and Family Engagement

- Leadership includes a position specifically tasked to oversee and develop patient and family engagement activities.
- Specific strategic programs with measureable objectives focus on improving patient and family engagement.
- Prior to each admission, HCO staff provides and discusses a planning checklist.

- HCO collects data regarding patient and family cultural/language preferences.
- HCO has a patient/family advisory council (or equivalent).
- In the past year, HCO has implemented new improvement programs in response to inpatient patient satisfactions surveys.
- In the past year, HCO has implemented new improvement programs in response to outpatient patient satisfactions surveys.

Considerations: Performance Improvement and Reporting

- HCO measures per-capita payment by each payer.
- HCO uses health care provider/team utilization data to support performance improvement.
- Performance data presentation is tailored to the stake-holder such that the data are actionable.

Considerations: Health Information Technology

Considerations: Financial Risk Management

- HCO monitors outmigration data (market share) for different service lines.
- HCO has managed payment contracts or specific patient populations that require cost-of-care management (e.g., shared savings plans or bundled payments).
- The HCO manages healthcare costs either with a self-insured employer or as a self-insured HCO.
- HCO has partnered with a payer to control costs.
- If executing financial risk contracts, stop-loss insurance or risk corridors are in place to mitigate risk.
- HCO has a legal plan to distribute shared savings or pay-forperformance bonuses.
- If present, the HCO shared savings distribution plan does not induce providers to reduce or limit medically appropriate 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 Anytown USA Hospital leaders to guide value-based care capacity development.

1. Review Value-Based Care Strategic Planning Tool results with Anytown USA 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 121 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 mission (or equivalent public statement) specifically prioritizes better patient care, improved community health, and lower per capita costs.
2. The 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 HCO governing body formally engages physicians in decision-making.
5. The senior leadership team includes positions identified by title and/or job description who have clear accountability to improve clinical quality/patient safety, improve the patient experience, advance community health, and lower per capita costs.
6. Senior leadership team responsible for operational decision-making includes physician(s).
7. Senior leadership team performance evaluation and compensation are partly linked to value-based HCO performance.
8. Senior leaders employ regular "walkarounds" as a leadership policy.
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 providers.
11. The HCO has a specific strategy to address organizational affiliation/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. 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 providers.
3. HCO assesses and identifies patients at high risk for poor outcomes or high resource utilization, and assigns care managers to them.
4. HCO offers chronic disease management services.
5. HCO ensures that post-hospital discharge care transition services are available and utilized.
6. The care management team (if established) is alerted when a patient uses services outside of the HCO.
7. HCO provides care transition services for patients hospitalized outside of the HCO service area.
8. HCO utilizes a broad community resource network (e.g., public health agencies, schools, human service agencies, community groups, faith-based organizations) in care management.

9. HCO engages a non-traditional health care workforce (e.g., community paramedics, community health workers, health coaches) in care management.
10. The HCO provides or ensures the availability of palliative and/or hospice care.
11. The HCO has established clear lines of responsibility and communication between HCO, payer, and/or social services care managers.

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

1. Senior leadership team understands the business case for clinical quality and patient safety.
2. HCO utilizes an objective assessment to determine the optimum number of primary and specialty care providers required.
3. HCO regularly assesses access to care during office hours (e.g., wait time for routine appointment).
4. HCO regularly assesses access to care during non-typical clinic hours to identify gaps and opportunities (e.g., emergency department use for non-emergent conditions).
5. 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).
6. An after-hours care system (e.g., practice call line, extended clinic hours) reduces emergency department use for non-emergent conditions.
7. Primary care workforce is employed by, or tightly aligned with, the HCO.
8. Primary care practices are accredited health homes (patient-centered medical homes).
9. HCO generates actions lists for providers 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 in which patients are directed to the appropriate provider based on clinical condition, not provider preference.
12. Provider compensation system includes both volume and value-based incentives.
13. Clinical practices offer group visits, e-visits, and other alternative patient encounters.
14. Behavioral health professionals are co-located with primary care providers.
15. Medication reconciliation occurs during each patient encounter within the HCO.
16. Primary care providers have established a 'referral network,' preferentially referring patients to high-value specialists, ancillary services, and/or hospitals.
17. HCO incorporates evidence-based guidelines into clinical prompts and/or practices.
18. HCO measures compliance with evidence-based care.
19. Primary care practices encourage advanced care planning (including end-of-life planning).

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. HCO can define the population size and demographic characteristics within its service area.
2. HCO can identify the population health needs within its service area.

3. HCO has implemented programs in response to needs identified in a Community Health Needs Assessment survey (or similar assessment).
4. HCO works with other community organizations and services to identify and prioritize shared goals/initiatives for high priority community health needs.
5. HCO has identified a champion specifically tasked with accountability for community health improvement.
6. 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. Providers understand the relationship between community health improvement and emerging payment and care delivery models.
9. HCO has implemented community preventive health programs in addition to those that directly promote current HCO services.
10. The HCO offers wellness programs/benefits/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. 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 measureable objectives focus on improving patient and family engagement.
4. Prior to each admission, HCO staff provides and discusses a planning checklist.
5. HCO collects data regarding patient and family cultural/language preferences.
6. HCO modifies care based on patient and family cultural/language preferences.
7. HCO generates reminders for patients who are due/overdue for services.
8. HCO has a patient/family advisory council (or equivalent).
9. Patients/families are routinely interviewed during leadership 'walkarounds.'
10. In the past year, HCO has implemented new improvement programs in response to inpatient patient satisfactions surveys.
11. In the past year, HCO has implemented new improvement programs in response to outpatient patient satisfactions surveys.
12. Patients have web-based access to health education resources.
13. Patients have web-based access to their own medical records.
14. Patients have access to providers by email.
15. Providers use shared-decision making approaches for clinical conditions in which care can vary by patient preference.
16. HCO regularly acts upon patient/family satisfaction survey results.
17. HCO policies support patients/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. Senior leadership uses measureable performance data to drive strategic decision-making.
2. HCO measures per-capita payment by each payer.
3. HCO uses health care provider/team utilization data to support performance improvement.
4. HCO uses health care provider/team clinical quality data to support performance improvement.
5. HCO uses health care provider/team patient satisfaction data support performance improvement.
6. HCO tracks serious safety events.
7. Performance compared to benchmarks is widely shared within the HCO.
8. Clinical performance measures reflect evidence-based care.
9. Performance data presentation is tailored to the stake-holder such that the data are actionable.
10. HCO publicly reports a comprehensive summary of clinical care, patient experience, and cost performance.
11. Leadership discusses HCO VBC performance during most internal and public meetings.
12. HCO actively works to reduce potentially avoidable readmissions.
13. HCO actively works to reduce inappropriate emergency department utilization.
14. Internal feedback loops standardize care processes to reduce variation unrelated to unique patient needs/preferences.
15. Managers have been trained in continuous quality improvement techniques.
16. Managers use continuous quality improvement techniques to implement/evaluate performance improvement activities.
17. Providers and other stakeholders collaborate to improve performance.
18. 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. HCO has a comprehensive health information technology (HIT) strategy for achieving continually evolving stages of Meaningful Use.
2. HCO participates in at least one health information exchange.
3. All providers in the community use a common electronic health record (EHR), or different EHRs are interoperable.
4. 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. EHR alerts providers regarding recommended patient-specific care at point-of-service (e.g., inpatient bedside and office visit).
8. EHR supports medication reconciliation.
9. EHR supports patient registries.

10. HCO uses the e-prescribing function in its EHR.
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. HIT system (or EHR) provides regular population health reports.
14. HIT system (or EHR) provides regular utilization/financial reports.
15. HIT system (or EHR) integrates cost-of-care or utilization data from services provided outside of HCO.
16. HIT system (or EHR) extracts data from multiple sites to develop longitudinal performance reports.

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

1. HCO monitors outmigration data (market share) for different service lines.
2. HCO can develop a pro forma budget for a patient population.
3. HCO can develop a sensitivity analysis to predict profit/loss with alternate payment contracts (e.g., shared savings or bundled payment).
4. Actuarial support can validate payer-defined cost targets.
5. HCO has managed payment contracts or specific patient populations that require cost-of-care management (e.g., shared savings plans or bundled payments).
6. The HCO manages healthcare costs either with a self-insured employer or as a self-insured HCO.
7. HCO has partnered with a payer to control costs.
8. HCO has implemented efficiency strategies, such as Lean or Six Sigma.
9. Financial strength (profit margin and/or reserves) allows HCO to accept risk of spending greater than targets.
10. If executing financial risk contracts, stop-loss insurance or risk corridors are in place to mitigate risk.
11. HCO has access to capital to develop new value-based care initiatives.
12. HCO continuously monitors cost to deliver services compared to revenues.
13. HCO employs cost-accounting system capable of quantifying cost per encounter/service.
14. 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).
15. HCO can attribute cost-reduction investments to financial statements.
16. Provider contracts clearly define clinical accountabilities for patient care.
17. Provider contracts clearly define financial risks associated with patient care.
18. HCO has a legal plan to distribute shared savings or pay-forperformance bonuses.
19. If present, the HCO shared savings distribution plan does not induce providers to reduce or limit medically appropriate services.