

Rural & Frontier Healthcare Solutions Workgroup Charter

Workgroup Summary:

Co-Chairs: Patt Richesin, President, Kootenai Care Network and Larry Tisdale, VP Finance, Idaho Hospital Association

Bureau of Rural Health & Primary Care Staff Lead: Mary Sheridan

Workgroup Charge (from HTCI): Convene a workgroup to develop a sustainable value-based model for rural and frontier health systems, their hospitals, outpatient clinics, and other healthcare providers to optimize the value provided and sustained. The model will be submitted to the Center for Medicare and Medicaid Innovation as a demonstration project when the opportunity becomes available.

Function Alignment: Promote and support transformation by identifying opportunities for change and innovation that will help shape the future of healthcare.

Identify delivery system barriers that are preventing healthcare transformation and prioritize and recommend solutions.

Promote alignment of the delivery system and payment models to drive sustainable healthcare transformation.

Utilize accurate and timely data to identify strategies and drive decision making for healthcare transformation.

Help define and understand workforce and resource needs sufficient to test the proposed model.

Driver Alignment and Measurement:

HTCI Driver Alignment	Desired Outcome	Measurement	Workgroup Role
Finance	1. Rural and frontier health system value-based model developed.	Proposal accepted by HTCI.	Develop proposal.
Infrastructure development	2. Resources needed to support alignment with new value-based model identified.	Framework for necessary infrastructure changes addressed in proposal.	Identify changes needed for successful model adoption.

Planned Scope:

Deliverable 1:

Description:	Develop a value-based model for rural and frontier health systems and their primary care clinics.	
Timeframe:	<i>Anticipated Dates</i>	<i>Description</i>
	December 2019	Preliminary planning with co-chairs, staff, facilitator. Identify issues the workgroup will try to solve.
	January 2020	Review existing VBP models being deployed in rural and frontier communities. Develop a shared understanding about existing models that may help resolve or support the identified issues. Use existing models as the foundation for developing a proposed solution to meet the needs of Idaho CAHs.
	February 2020	Develop agreed-upon core concepts of a model, which may include waivers. Review state and federal regulations and policies that may create barriers to the proposed CAH value-based payment model.
	March 2020	Identify CAH resources and infrastructure needed to test and transition to the proposed value-based payment model. Identify data to describe current financial challenges and how the proposed model will facilitate improvement. Seek feedback from payers, HTCI, CAHs, and CAH community stakeholders about the proposed model.
	April 2020	Refine model based on feedback. Seek commitment from Idaho CAHs willing to test the new model.
Milestones:	<ul style="list-style-type: none"> • Core model concepts developed and agreed upon by workgroup members. • Model presentation to HTCI. • Finalize proposed model for inclusion in an application to CMMI as a demonstration project. 	

Deliverable 2:

Description:	Create training and educational models to support rural and frontier leadership, boards, communities, and staff to successfully transition to the proposed value-based payment model.	
Timeframe:	<i>Anticipated Dates</i>	<i>Description</i>
	February 2020	Develop a comprehensive list of stakeholders to educate about the proposed value-based payment model. Identify the type of education needed by each stakeholder group and the optimal delivery method.
	March 2020	Research existing educational modules that may address identified needs. Identify gaps in educational needs and develop solutions.

April 2020	Seek feedback from HTCI, CAHs, boards, and stakeholders regarding educational needs and solutions. Include the comprehensive list of educational needs and solutions in application to CMMI.
Milestones:	<ul style="list-style-type: none"> • Comprehensive list of education needs, gaps, and solutions developed. • Education addressed in application to CMMI.

Deliverable 3:

Description:	Create plausible, community-specific rural and frontier staffing and infrastructure changes needed to successfully implement proposed model.	
Timeframe:	<i>Anticipated Dates</i>	<i>Description</i>
	February 2020	Review repurposing efforts underway nationwide as it relates to value-based models in rural and frontier communities. Identify Idaho CAH infrastructure changes that must occur to support the proposed model.
	March 2020	Identify strategies and resources needed for infrastructure transition.
	April 2020	
Milestones:	<ul style="list-style-type: none"> • Idaho-specific repurposing scenarios developed. • Resource needs and strategies to support repurposing efforts identified. • Resource needs addressed in application to CMMI. 	

Project Reporting and Scope Changes:

Changes to scope must be approved by HTCI.

Version Information:

Version	Author	Summary	Date
1.0	Ann Watkins	Initial draft	10/25/19
1.1	Mary Sheridan	Revised	11/15/19
1.2	Mary Sheridan	Co-chair update	12/11/19
1.3	Matt Walker/Mary Sheridan	Incorporated feedback from workgroup members	2/3/2020

Final Acceptance:

Name/Signature	Title	Date	Approved via Email
HTCI approved on 12/17/19	HTCI advisory group	12/17/19	<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>

RURAL & FRONTIER HEALTHCARE SOLUTIONS WORKGROUP MEETING
MEETING SUMMARY
Thursday, January 23, 2020 | 9:00 a.m. – 4:00 p.m. MST
JRW Building, 700 W. State, Boise

Establishing the Work Group Framework

Patt Richesin, Kootenai Care Network, and Larry Tisdale, Idaho Hospital Association, provided a brief background and history of the value-based healthcare (VBHC) model in the state of Idaho. High-level discussions around the need to transition to a more sustainable budget model in Idaho began at the Value Based Healthcare Forum hosted at Boise State University in October 2019. Rural and frontier hospitals were identified as the most vulnerable to these changes. The communities these critical access hospitals serve also have the greatest need for enhanced services. The Healthcare Transformation Council of Idaho (HTCI) then decided to convene this workgroup to develop a potential pilot model that could be supported by funding from Centers for Medicare and Medicaid Innovation (CMMI). A grant announcement is possible sometime this spring.

Elizabeth Spaulding, facilitator, reviewed the charter with meeting participants, who identified some key changes to the scope of what they believe the work group can accomplish within the established timeframe, including how the work force training and capacity issues will be examined. These changes will be presented to HTCI for approval.

The group was then asked to share their expectations for the day. Participants were excited to learn more about new value-based models, including the global budget model, and share ideas and concerns about how a new model might impact their organizations and communities.

The Pennsylvania Model Presentation, Janice Walters

Janice Walters, Pennsylvania Department of Health, presented an overview of the development and implementation of Pennsylvania's pilot global budget model. This overview included the inception of the program, how global budgets were developed, how stakeholders were engaged, and the challenges and lessons that arose during the first year of implementation. Participants asked questions about the financial aspects of the model and how those changes might affect organizations with thin operating margins.

Key takeaways from the presentation included:

- Identify impactful, yet realistic targets.
- In order for a global budget model to work, organizations must focus equally on the opportunity for financial stabilization and the need to do what's best for their communities.
- Transformation plans for hospitals are critical to a successful implementation.
- Maintaining an accurate and up-to-date Healthcare Information Exchange is important for program monitoring. Pennsylvania also receives data from payers.
- Educating potential participants, their boards, and payers early in the process to manage misinformation and misconceptions can result in a more successful outcome.

Key questions included:

- How are waivers determined?
- Does the model inhibit the ability to grow?

- How do primary care conveners and disrupters influence the model?
- How are out of network patients impacted?
- What happens after year three?
- How do we establish a realistic baseline for hospitals that have already started implementing value-based services?
- How do investments in social determinants of health fit into the cost report?
- How do you calculate out of network savings?
- What was the level of provider support?
- What were the core staffing levels?

Idaho Needs and Success Factors Discussion & Key Questions for Next Steps

Participants discussed components of the Pennsylvania model that might be relevant to an Idaho model, as well as key distinctions. The group identified a list of considerations and questions to be answered in order to define clear outcomes and objectives:

Comments included:

- The settlement of cost reports will be an important issue to consider.
- An Idaho model will need to look at how to allow for capital improvements and future growth. Sustainability is the key need.
- There is a risk that a new model could hurt some hospitals. The model needs to be flexible to address the various needs of the different communities.
- Participation with Medicaid will be necessary.
- Community support and investment will be critical, from hospital boards to county commissioners. How we describe and promote a new model will need to be done carefully.
- Retaining access to care and economic stability should be the primary focus of any new model.
- ACOs/RCOs may offer an example or opportunity for partnership.

Questions included:

- Were there any services (mental health, OB, etc.) excluded in the Pennsylvania model?
- What data do we have? What data do we need?
 - Idaho-specific/baseline data.
- Are there other sources of data besides payers?
- Do we need to invite more payers to this discussion? At what point in the process will they be interested in participating?
- Do we have access to economic and community needs assessments?
- Does everyone at the table know what waivers they might want to request? Is this something CMMI can support?
- What are the first steps?
- How would DHW participate in this issue? How would this work support the health care systems?
- Does Idaho (legislature) have the appetite for supporting this?
- How can this new model align with the RCO/ACO model?
- How do we customize and scale?
- How do we communicate with the CAH's the outcome of this meeting? What's the elevator pitch?
- What problems are we trying to solve?

- What is our vision? What is our desired outcome?

Action Items

- Changes to the Workgroup Charter will sent to members and provided to HTCI.
- Lenne and Chris will develop a draft budget template relevant to their operating budgets in order to for the workgroup to have something to start building.
- Identify a decisionmaker in Pennsylvania to reach out to regarding the internal process for participation.
- Identify potential subject matter experts and other experts to bring to work group meetings.
- Identify what data is available through Medicaid.
- Provide information on the RCO/ACO models.





The Value-Based Care Tool – Prioritizing Capacities and Planning for Action

Dear Healthcare Organization Leader:

New health care payment alternatives, such as shared savings and bundled payments, demand that a health care organization (HCO) develop and deploy new organizational capacities to deliver *value-based care* (VBC). Value-based care improves clinical quality, satisfies patients and families, advances community health, and lowers per capita costs.

The web-based Value-Based Care Strategic Planning Tool (VBC Tool) will assess your HCO's *capacities* or *capabilities* (resources, processes, infrastructure, etc.) to deliver value-based care. The VBC Tool is designed to help you and your HCO be successful. The results can support HCO strategic planning and prioritize action plans that are responsive to a changing health care payment and delivery environment.

The Strategic Planning Tool has been developed by the Rural Policy Research Institute (RUPRI) Rural Health Value team through joint support from the Oregon Association of Hospitals and Health Systems (OAHHS) and the Federal Office of Rural Health Policy. After you complete the online VBC Tool, you will receive a Value-Based Care Readiness Report that you may use to assess your organization's readiness for value-based care and to develop value-based care action plans.

The Rural Health Value team suggests that you complete the Strategic Planning Tool with your senior leadership team to complement your strategic planning process. We anticipate the Strategic Planning Tool will require about two hours to complete.

Sincerely,

The Rural Health Value Team

Value-Based Health Care Strategic Planning Tool, V2



The Strategic Planning Tool will assess your health care organization (HCO) capacities (resources, processes, infrastructure, etc.) to deliver value-based care (VBC). Value-based care refers to health care that concurrently improves clinical quality/patient safety, advances community health, and lowers per capita cost.

The Strategic Planning Tool assesses 115 HCO capacities categorized under eight topic headings. The topic headings are interrelated and codependent; thus, capacities may fit under more than one topic heading.

For each capacity, please rate the degree to which the capacity is developed and deployed in your HCO. Alternately, some capacities may be better assessed by degree of adoption (alternate response in parentheses). The six response options are:

- **Fully developed and deployed:** The VBC capacity is fully developed and deployed throughout the HCO. (The HCO has fully adopted this capacity.)
- **Developed, incompletely deployed:** The VBC capacity is developed, but incompletely deployed throughout the HCO. (The HCO has nearly adopted this capacity.)
- **In development:** The VBC capacity is in development, but has not been deployed in the HCO. (The HCO has partially adopted this capacity.)
- **In discussion:** The VBC capacity has been discussed within the last two years, but no development activity is occurring at the HCO. (The HCO is considering adopting this capacity.)
- **Not applicable:** The VBC capacity has been discussed by the HCO in the last two years, but was determined to be not applicable. (The HCO does not plan to adopt this capacity.)
- **Not considered:** The VBC capacity has not been considered by the HCO in the last two years. (The HCO has no plans for this capacity.)

Not all capacities will fit perfectly with the response choices. Please select the closest, or most appropriate, response.

What is your name?

What is your health care organization's name ("Doing business as...")?

What is your email address?



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

	Fully developed and deployed	Developed, incompletely deployed	In development	In discussion	Not applicable	Not considered
1. The HCO publicly identifies better patient care, improved community health, and lower per capita costs as priorities.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. The HCO strategic planning process determines priorities based on community needs.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. The governing body engages physicians in strategic decision-making.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Senior leadership engages clinicians in operational decision-making.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Senior leaders' performance evaluation and compensation are partly linked to value-based care performance.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. Senior leaders employ regular "walkarounds" of front-line care as a leadership practice.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Clinical employee job descriptions and/or performance evaluations specifically address competencies and/or performance linked to better care, improved health, and lower costs.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. Partnerships, joint ventures, or other contractual agreements facilitate resource (both investment and payment) allocation across multiple organizations that serve or support patients.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. The HCO has a specific strategy to address organizational affiliation or merger opportunities.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Do you have any other comments about your Health Care Organization's governance and leadership capacities?



B. 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.

	Fully developed and deployed	Developed, incompletely deployed	In development	In discussion	Not applicable	Not considered
1. The senior leadership team understands the role of care management in achieving cost and quality goals necessary for success in new payment models.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Partnerships, joint ventures, or other contractual agreements facilitate care coordination across multiple organizations that serve or support patients.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. The HCO has data and a system that assesses and identifies patients at high risk for poor outcomes or high resource utilization.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. The HCO assigns care managers to patients at high risk for poor outcomes or high resource utilization.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. The HCO offers chronic disease management services.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. The care management team (if established) is alerted when a patient uses services outside of the HCO.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. The HCO engages community resources (e.g., public health agencies, schools, human service agencies, community groups, faith-based organizations) to support care management.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. Non-traditional health care workers (e.g., community paramedics, community health workers, health coaches) are utilized as part of the care management team.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. The HCO provides or ensures the availability of palliative and/or hospice care.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Do you have any other comments about your Health Care Organization's Care Management capacities?

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

	Fully developed and deployed	Developed, incompletely deployed	In development	In discussion	Not applicable	Not considered
1. The senior leadership team understands the business case for clinical quality and patient safety.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. The HCO utilizes an objective assessment to determine the optimum number of primary and specialty care providers to serve the population.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. The HCO regularly measures access to care during office hours (e.g., wait time for routine appointment).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. An after-hours care system (e.g., practice call line, extended clinic hours) reduces emergency department use for non-emergent conditions.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. Primary care practices are accredited health homes (patient-centered medical homes).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. The HCO generates actions lists for clinicians of patients who are due/overdue for services.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. For non-urgent clinic visits, pre-visit planning occurs for complex patients.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. Clinical practices employ a team-based care model to best match patient needs with care team expertise.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. The clinician compensation system includes both volume and value-based incentives.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. Clinical practices offer group visits, e-visits, and other alternative patient encounters.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. Mental health professionals are integrated with primary care clinicians.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. Medication reconciliation occurs during each patient encounter within the HCO.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. Primary care clinicians have established a “referral network,” which prioritizes patient referrals to high-value specialists, ancillary services, and hospitals.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. The HCO incorporates evidence-based guidelines into clinical prompts, workflow, and practices.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. The HCO measures compliance with evidence-based care.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Do you have any other comments about your Health Care Organization's Clinical Care capacities?



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

	Fully developed and deployed	Developed, incompletely deployed	In development	In discussion	Not applicable	Not considered
1. The HCO can define and regularly update the population size and demographic characteristics within its service area.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. The HCO can identify and regularly update the population health needs within its service area.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. The HCO has implemented programs in response to needs identified in a Community Health Needs Assessment survey (or similar assessment).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. The HCO works with other community organizations and services to identify and prioritize shared goals and initiatives for high priority community health needs.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. The HCO has identified a champion specifically tasked with accountability for community health improvement.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. The HCO has the staff expertise and internal resources to support population health initiatives.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Senior leadership understands the relationship between community health improvement and emerging payment and care delivery models.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. Clinicians understand the relationship between community health improvement and emerging payment and care delivery models.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. The HCO has implemented community preventive health programs in addition to those that directly promote current HCO services.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. The HCO offers wellness programs, benefits, and/or incentives to its employees.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Do you have any other comments about your Health Care Organization's Community Health capacities?

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

	Fully developed and deployed	Developed, incompletely deployed	In development	In discussion	Not applicable	Not considered
1. The HCO visibly states its commitment to patient and family partnerships in healthcare decision-making.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Leadership includes a position with responsibilities specifically tasked to oversee and develop patient and family engagement activities.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Specific strategic programs with measurable objectives focus on improving patient and family engagement.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Prior to each planned hospital admission, the HCO staff provides and discusses a planning checklist with the patient and/or family.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. The HCO collects data regarding patient and family cultural/language preferences.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. The HCO modifies care based on patient and family cultural/language preferences.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. The HCO generates reminders for patients who are due/overdue for preventive and follow-up services and acts on them.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. The HCO has a patient/family advisory council (or equivalent).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Leadership routinely interacts with patients/families during leadership "walkarounds" With attention to confidentiality.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. The HCO provides patients with web-based access to health education resources specific to the patient's condition(s) and needs(s).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. Patients have web-based access to their own medical records.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. Patients have secure electronic access to clinicians (e.g., email, EHR portal).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. The HCO policies and actions support patients and families following error or harm.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Do you have any other comments about your Health Care Organization's Patient and Family Engagement capacities?

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

	Fully developed and deployed	Developed, incompletely deployed	In development	In discussion	Not applicable	Not considered
1. The senior leadership uses measurable performance data to drive strategic decision-making.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. The HCO measures per-capita costs and payment by each payer.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. The HCO uses health care provider/team utilization data to support performance improvement efforts.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. The HCO uses health care provider/team clinical quality data to support performance improvement efforts.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. The HCO uses health care provider/team patient experience data to support performance improvement efforts.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. The HCO tracks serious safety events.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Performance compared to benchmarks is widely shared within the HCO.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. The HCO's clinical performance measures reflect evidence-based care.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Performance data presentation is tailored to the stakeholder such that the data are actionable.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. The HCO publicly reports a comprehensive summary of clinical care, patient experience, and cost performance.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. The HCO management and leadership team discusses HCO VBC performance during most internal and public meetings.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. The HCO actively works to reduce potentially avoidable readmissions.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. Internal feedback loops standardize care processes to reduce variation unrelated to unique patient needs and preferences.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. Managers have been trained in continuous quality improvement techniques.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. Managers use continuous quality improvement techniques to implement and evaluate performance improvement activities.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. Clinicians and other stakeholders collaborate to improve performance.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. The HCO proactively participates in improvement initiatives and campaigns offered by external organizations which align with internal quality improvement goals and needs.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Do you have any other comments about your Health Care Organization's Performance Improvement and Reporting capacities?

G. Health Information Technology - Electronic systems (hardware, software, and supporting processes) that collect, collate, integrate, and disseminate performance data.

	Fully developed and deployed	Developed, incompletely deployed	In development	In discussion	Not applicable	Not considered
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.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. The HCO electronically exchanges information with other clinical care organizations as needed to serve patient needs.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. The HCO has developed a master patient index (across all care sites) that includes important patient-specific demographic, clinical, and payer data.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Care teams across settings and organizations receive alerts regarding patient status change (e.g., ED visit, hospital admission, hospital discharge).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Clinical practice guidelines imbedded within the EHR provide clinical decision support.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. The HCO EHR alerts clinicians regarding recommended patient-specific care at point-of-service (e.g., inpatient bedside and office visit).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. The HCO EHR supports medication reconciliation.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. The HCO EHR supports patient registries.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. The HCO clinicians use e-prescribing.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. Clinical data sharing between providers (e.g., between primary and specialty care) is concurrent.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. Predictive analytic tool(s) identify patients at high risk for poor outcomes or high resource utilization.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. The HIT system (or EHR) provides regular population health reports.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. The HIT system (or EHR) provides regular utilization/financial reports.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Do you have any other comments about your Health Care Organization's Health Information Technology capacities?

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

	Fully developed and deployed	Developed, incompletely deployed	In development	In discussion	Not applicable	Not considered
1. The HCO monitors outmigration data (market share) for different service lines.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. The HCO can forecast profit and loss when assessing alternative payment contracts (e.g., shared savings or bundled payment).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. The HCO can validate payer-defined cost targets and risk-adjustment methodologies.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. The HCO gains direct experience managing both financial and medical risk by self-insuring or contracting with a self-insured employer.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. The HCO has implemented efficiency strategies, such as Lean or Six Sigma.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Financial strength (profit margin and/or reserves) allows the HCO to accept risk of spending greater than targets.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. If the HCO participates in risk contracts, stop-loss insurance, or risk corridors are in place to mitigate risk.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. The HCO has access to capital to develop new value-based care initiatives.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. The HCO continuously monitors cost to deliver services compared to revenues.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. The HCO employs a cost-accounting system capable of quantifying cost per encounter/service.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. Clinician contracts define clinical accountabilities for patient care, such as quality improvement participation, patient confidentiality maintenance, and/or board certification.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. Clinician contracts define financial rewards and incentives related to patient care.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. If present, the HCO shared savings distribution plan does not induce providers to reduce or limit medically appropriate services.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Do you have any other comments about your Health Care Organization's Financial Risk Management capacities?

Value-Based Health Care Strategic Planning Tool



Please take a few minutes and answer these last few demographic questions. This information is necessary to create reports that will be beneficial to your organization.

In which of the following is your health care organization located?

- Metropolitan Statistical Area (urban)
- non-Metropolitan Statistical area (rural)
- unknown

Is your health care organization located in a HRSA-designated Frontier area?

- no
- yes
- unknown

Please select the choice that most accurately describes your health care organization:

- Hospital
 - Critical Access Hospital
 - Inpatient Prospective Payment System Hospital
 - Other (please indicate hospital type below)
- Outpatient clinic _____
 - Independent
 - Hospital- or health system-owned
- Rural Health Clinic
- Community Health Center or Federally Qualified Health Center
- Other (please indicate health care organization type below)

Which of the following best describes your health care organization's affiliations status?

- Independent
- Owned by a health system
- Managed by a health system
- Other affiliation arrangement (please indicate below)

What was your health care organization's net patient revenue last fiscal year (patient revenue after contractual allowances)?

- <\$10 million
- \$10 million - \$30 million
- \$30 million - \$50 million
- \$50 million - \$70 million
- >\$70 million
- Unknown

Thank you. You have completed the Value-Based Health Care Strategic Planning Tool.

Would you like to see a summary report of all of your responses to the Planning Tool?

- Yes
- No

Would you like to be added to the email distribution list for announcements from the RUPRI Center for Rural Health Research and the Rural Health Value project?

- Yes
- No