ACLC Value-Based Readiness (VBRA) Program
System Transformation Initiative Charter Template

An essential step in clarifying the implementation initiative is to establish a program charter that outlines the job to be done. In doing so, all stakeholders will share a common understanding of the need for the program, the structure, the aim, the expected benefits, and key risks. The charter can include content describing all of the innovations in the program, or the organization might consider creating a separate charter for each innovation initiative.

The charter is adapted from the Institute for Healthcare Improvement charter template for quality improvement initiatives and aims to:

- Guide teams through a description of the program’s relationship to advancing the organization’s success under value-based performance incentives and payment models.
- Assist the team’s effort to highlight how the selected approach will be aligned and coordinated to advance value-based payment models.
- Help program teams examine whether the organization is considering key competencies in the program strategy and design.

The high-level process for completing the charter and preparing for implementation is below.

<table>
<thead>
<tr>
<th>Pre-Charter</th>
<th>Charter</th>
<th>Post-Charter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify executive sponsors and program leaders for the initiative</td>
<td>Host a “kick-off” session to initiate the program effort</td>
<td>Organize “implementation phase” team(s) to translate the charter and other essential data into an implementation plan</td>
</tr>
<tr>
<td>Organize all information captured in previous phases of work – strategic aims, innovation assessment and selection analysis, VBRA results, system performance opportunities</td>
<td>Complete each section in the charter as an entire program team or as smaller “break-out” teams</td>
<td>Launch plan and regularly monitor progress</td>
</tr>
<tr>
<td>Identify, engage and select partners in local market to who are aligned and committed to the VBP mission</td>
<td>Confirm target population and prioritize improvement opportunities</td>
<td></td>
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<tr>
<td>Confirm program planning team, send invitation to all team members</td>
<td>Each participating organization - or as a network - should evaluate the &quot;readiness&quot; capabilities listed in appendix and then summarizes the results in the form of a driver diagram</td>
<td></td>
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</table>
Program Charter Outline and Checklist

The charter contains five sections, detailed below, to help team members prepare for program implementation. We developed supporting resources (in appendixes) for each section to guide completion of the charter. These resources include additional questions and tools participating teams might use to complete the charter.

A. **Program Overview**
   **Description:** A brief description of the program, including the program leadership, team members and stakeholders.
   **Supporting Tools:**
   ☐ Key Program Design Considerations Assessment (Appendix A)

B. **What are we trying to accomplish?**
   **Description:** Clarify the problem, the need, aim(s) and benefits
   **Supporting Tools:**
   ☐ Patient Persona Template (Appendix B)

C. **How will we know change is an improvement?**
   **Description:** List the outcome, process and value measures as well as the "balancing measures" that will be used to ensure changing one part of the system won't negatively impact other parts of the system.

D. **What changes can we make that will result in an improvement?**
   **Description:** Change ideas that will lead to the desired results.
   **Supporting Tools:**
   ☐ Value-Based Performance Capability Assessment (Appendix C)

E. **Key Risks, Boundaries, and Assumptions**
   **Description:** The key risks, boundaries and assumptions that might prevent program success and the proposed mitigation approach for removing or limiting the risks.
   **Supporting Tools:**
   ☐ Health Policy Environment (Appendix D)

F. **Key changes that can enable success**
   **Description:** A high-level outline of the action plan that will advance the program aims and associated measures.
   **Supporting Tools:**
   ☐ Key Implementation Design Considerations (Appendix E)
   ☐ Logic model
   ☐ Driver Diagram (Appendix F)
A. Program Overview

**Description** – This section provides a summary of critical project management components.

**Supporting Documents** – Addressing questions in Appendix A can help team members consider the factors that support programmatic success.

Program Name:
Program Description:
Program Sponsor (Accountable Leader):
Program Lead (Responsible Leader(s)):
Anchor Delivery Sites:

**Key Program Team Members:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
<th>Title</th>
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</thead>
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</table>

**Key Stakeholders** (list non-team members whose input and support are critical to program success, and how will you engage these key stakeholders):

Budget:
Program Start Date:
Program Target End Date:
Timeline & Key Milestones:

**Validating Section A**
The checklist in Appendix A serves as a validation for the content in Section A (above), with the detailed answers captured noted under each bullet in the appendix.
B. What are we trying to accomplish?

**Description** -- The "care network" will not improve without a clear and firm intention to do so. In this section, briefly clarify the problem, the need, aim(s) and benefits.

**Supporting Tools** -- Creating patient personas using the template in Appendix B can help team members identify the key factors that will advance patient referred goals outcomes and program success.

I. Our commitment

II. Problem Description

A. Existing population health challenges

B. Key health improvement scenarios the program is intended to improve.

C. Population of Focus
III. Expected Outcomes and Benefits
   A. Patients and Communities

   B. Value-Based Readiness

IV. Aim(s)
   What outcome are we hoping to achieve for the overall program and each innovation? Specify how good, for whom, and by when (a specific date).
C. How will we know a change is an improvement?

Description -- In this section, provide operational definitions that specify unambiguously how to derive each measure, defining the numerators and denominators in measures such as percent or rates.

1. Outcome Measure(s)
   List the outcome measures the program will affect.

2. Utilization Measure(s)
   List the utilization measures the program will affect.
3. **Process Measure(s)**
List the measures that will indicate if the system change is having an effect on the outcome measure(s).

4. **Balancing Measure(s)**
List the measures that will indicate if the system change is having unanticipated outcomes.

5. **Value Measure(s)**
List the key measures that will be included when calculating the value (V=Quality / Cost) of the program once operational.
D. What changes can we make that will result in an improvement?

<table>
<thead>
<tr>
<th>Description</th>
<th>In this section, document the change ideas perceived to result in the performance changes defined in the previous sections.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supporting Tools</td>
<td>Evaluating the list of capabilities in Appendix C can help team members understand their &quot;readiness&quot; to successfully deliver the change ideas listed in this section (Section D) and the performance goals listed in Section C.</td>
</tr>
</tbody>
</table>

I. Change Ideas
### E. Key Risks, Boundaries and Assumptions

**Description** -- Document the key risks, boundaries and assumption that might prevent program success, the level of current risk (red, yellow, and green) and the proposed mitigation approach for removing or limiting the risks.

**Supporting Tools** – The responses to any of the topics covered within each Appendix might identify key risks, boundaries and/or assumptions the team should consider when designing and managing the implementation.

### II. Key Risks and Mitigation Approach

<table>
<thead>
<tr>
<th></th>
<th>Risk Description</th>
<th>Mitigation Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
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<td>2</td>
<td></td>
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<tr>
<td>3</td>
<td></td>
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</tr>
</tbody>
</table>

#### Boundaries
List any key limiting factors (e.g. hiring constraints, system procedures, regulations, technology considerations, what is out of scope)

#### Key Assumptions
List any events, complementary activities/actions or resources that are expected to occur or be available in order for the program to be successful.
F. Putting it all together: A pathway to success

In this section, translate the decisions, change ideas and capabilities analysis into either a logic model or driver diagram – depending on the preference and time allotted for the initiative. A sample driver diagram for reducing 30-day readmissions for a Medicare population with a principle diagnosis of pneumonia is in Appendix F. If completed previously, please include the results or comments from the “Value-Based Readiness Assessment (VBRA)” or other surveys to ensure workforce perceptions are considered in program planning.
Appendix A - Key Program Design Considerations Assessment

During our kick-off session (January 30) we identified several gaps in our current design, as well as confirmed our "readiness" to proceed for many key success factors. The team will work to complete the gaps over the coming sessions. A bullet with an "x" through a circle indicates a gap in the "key program design consideration"; a "checkmark" indicates we confirmed the "key program design consideration" is in place, and a "?" indicates we have not confirmed our state of "readiness."

- The program team has patients and patient representatives’ as part of the program strategy, design, and delivery.
- The program team has local community-based health organizations as part of the program strategy, design, and delivery.
- The program team has front-line care providers as part of the program strategy, design, and delivery.
- The program team has payers as part of the program strategy, design, and delivery.
- The program team has key service partners (DME, technology vendors, laboratory & imaging, etc.) as part of the program strategy, design, and delivery.
- The program sponsor has experience leading - or is trained to lead - healthcare teams through change initiatives.
- The program lead has experience leading - or is trained to lead - healthcare teams through change initiatives.
- The program sponsor and lead(s) have the sufficient authority to lead the program.
- All program team members have the time & funding necessary to participate in the program.
- All program team members have the "safety" (space for failure) they need to test the program objectives.
- All team members are trained on proven quality improvement (QI) methods.
- All team members are trained on the aims and characteristics of a value-based care delivery system.
- The guidelines for program communications are clearly defined based on all of the following attributes: timely, transparent, accurate and focused on problem-solving.
- The care teams participating in the change have previously displayed the key skills required to successfully operate the innovation in daily practice.
- The cultural values and norms we believe are essential for program success are currently exhibited by all team members.
Appendix B

Patient Personas

A key objective of the transformation effort is to establish a relationship-based, co-production health and social care solution service model that ensures "patients" and care providers share an understanding of the partnership required to jointly produce the best possible outcomes for each individual served in the acute to post-acute continuum.

Clearly understanding the needs, preferences and values of our patient population is essential to our success. A patient persona depicts the competencies, relationships, activities and goals required to generate optimal outcomes and well-being for patients at the appropriate place and level of utilization.

A patient persona encompasses the following attributes:

- Persona title based on primary condition
- Persona name (preferably a recognized change agent in the medical or public health field)
- Comorbidities
- Medications
- Health Scenario: Background information on the patient, including preferences and values, an overview of clinical history, psycho-social needs and social / family situation
- Persona interview notes: Each cohort member will interview a patient that closely matches the persona in order to confirm our interpretation of the persona accurately captures the patient voice. Note: The patient interview guide is in the "Persona Template" section.
- Optimal care path for the persona: The key care and outcome goals for the persona, the care team and care services required to optimize care and outcomes for the persona and the key activities and competencies required of each care team member and care service
- Clinical Value Compass: A "clinical value compass" is a means to help care teams see their patients from more than one angle; to see the whole-person, and the etiology of each person's current state of health and well-being. The "clinical value compass", named to reflect its similarity in layout to a navigational compass, has four cardinal points:
  - North: Functional status, risk status, and well-being
  - South: Cost of the care delivered, including medical expenses, lost days of work, and other non-health care costs incurred by the patient and his or her family
  - East: Whether the care provided matches the patient's preferences, needs and values, and whether the patient is satisfied with their care experience
  - West: Presenting clinical problems and their manifestations
Sample Person

Below is a patient persona developed by a member of the ACLC PAC 2018/2019 cohort depicting a patient with community acquired pneumonia.

**Community Acquired Pneumonia Persona**

*Persona Description*

**Name:** Elizabeth Blackwell*

**Age:** 68

**Gender:** Female

**Primary Condition:** Acute Illness Persona – Community-Acquired Pneumonia Episode

**Comorbidities:** COPD, CHF, HTN, DM

**Current Medications:** Lasix, Metoprolol, Glipizide, Advair, Proventil, and vitD. She uses O₂ at home.

**Health Scenario:** Ms. Blackwell is a 68-year-old female with a past medical history significant for COPD, CHF, HTN, and DM. She is admitted to the ICU intubated with respiratory failure due to multifocal pneumonia. She initially presented to the ED via EMS with complaints of SOB, worsening cough, fevers and chills. On arrival to the ED, oxygen saturation was noted to be 78% so she was placed on BiPAP. Prior to hospitalization S.M was homebound receiving home health services. She is a retired custodian who lives alone in an apartment on the 3rd floor. She has two adult children who share the role of primary caregiver.
**Patient Interview Notes**

**North: Functional status, risk status, and well-being**
I'm not very mobile any longer, so my well-being goals are simple - to remain safe from acute issues, to remain at home and to receive my care at home, and to have social time with my family. I'd also like to avoid being socially isolated, which is unlikely since my children are caring for me, but I worry I'm too much of a burden to them.

**South: Cost of the care delivered, including medical expenses, lost days of work, and other non-health care costs incurred by the patient and his or her family**
I don't want to go to the hospital and prefer to limit my interaction with the healthcare system. Although I have Medicare, I don't have much money, so I can't afford long hospital stays.

**East: Whether the care provided matches the patient's preferences, needs and values, and whether the patient is satisfied with their care experience**
Whenever I have to interact with a care provider, I want to make sure me and my children understand what they are talking about prior to having anything done to me. I want to make sure all of my care providers talk to my children about my condition and what they are recommending for me - that they are educated on the proposed plan and agree to any recommendations prior to moving ahead. When my time comes, I prefer to die at home with my children.

**West: Presenting clinical problems and their manifestations**
I hope I don't get pneumonia again. I also don't like always being cold, or hooked up to a machine. I wish I didn't have to take so many medications.
### Optimal Care Path

Ms. Blackwell’s care goals when in the hospital and post-hospital discharge are below, along with the care goals for the key care providers and support services required to optimize care and health outcomes for Ms. Blackwell.

<table>
<thead>
<tr>
<th>Persons</th>
<th>Admission/Discharge Planning</th>
<th>At Home</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Goal: 1. LOS aligned with diagnosis. 2. Avoid inpatient hospitalization complications. 3. Care provided is aligned with patient’s goals of care. 4. Patient and family stay informed of patient’s health status, options, and treatment plan. 5. Home care needs and follow-up appointments are arranged prior to discharge. 6. Avoid readmission and complications post-discharge.</td>
<td>Goal: 1. Patient and family have the support needed for patient to remain safe at home. 2. Avoid readmission and complications post-discharge. 3. Discharge instructions are followed and completed.</td>
</tr>
<tr>
<td>PCP</td>
<td>*Informed of hospitalization and discharge.</td>
<td>*Provided ordering support S.M.’s declining status (i.e., increase in oxygen DME, medication adjustments).</td>
</tr>
<tr>
<td>Hospital</td>
<td>*Donates information services in the ER.</td>
<td>Ambulatory Care Manager</td>
</tr>
<tr>
<td></td>
<td>*Collaborates with members of the healthcare team to ensure a timely and safe discharge.</td>
<td>*Medication reconciliation and education.</td>
</tr>
<tr>
<td></td>
<td>*Identifies and follows patient’s goals, care.</td>
<td>*Confirms and coordinates home health agency’s discharge plan.</td>
</tr>
<tr>
<td></td>
<td>*Begin discharge planning on the day of admission.</td>
<td>*Meets with patient, caregiver, and community agencies.</td>
</tr>
<tr>
<td></td>
<td>*Communicates discharge instructions.</td>
<td>*Engages in shared decision making, medication education, disease-specific education, etc.</td>
</tr>
<tr>
<td></td>
<td>*Schedules follow-up appointment.</td>
<td>*Coordinates appointment with bringing home visits.</td>
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<tr>
<td></td>
<td>*Orders resumption of home health services.</td>
<td>*Communicates transition for hospice to PCP.</td>
</tr>
<tr>
<td>Patient</td>
<td>*Communicates with patient and health care team.</td>
<td>Bridging Home Visits</td>
</tr>
<tr>
<td></td>
<td>*Engages with treatment planning. *Completes with health care team instructions.</td>
<td>*Home visits with S.M. within 7 days due to her inability to physically make her PCP appointment.</td>
</tr>
<tr>
<td></td>
<td>*Adheres to medication regimen.</td>
<td>*Communicates S.M. with transition to supportive care with home health and ambulatory care navigator.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>*Engages with PCP.</td>
<td>*Engages with home care agency.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>*Engages with hospice.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>*Collectively provide 24-hour care.</td>
</tr>
</tbody>
</table>
**Value Compass**

Ms. Blackwell’s care and well-being goals and preferences are depicted below in the “value compass.”

![Value Compass Diagram]

*Elizabeth Blackwell: Dr. Elizabeth Blackwell was the first woman to receive an M.D. degree from an American medical school. She supported medical education for women and helped many other women’s careers. By establishing the New York Infirmary in 1857, she offered a practical solution to one of the problems facing women who were rejected from internships elsewhere but determined to expand their skills as physicians. She also published several important books on the issue of women in medicine, including Medicine as a Profession For Women in 1860 and Address on the Medical Education of Women in 1864.*

**Persona Template**

Step 1: Start the persona by completing the fields below.

**Name:**
**Age:**
**Gender:**
**Primary Condition:**
**Comorbidities:**
**Current Medications:**
**Health Scenario:**
Step 2: Identify a patient with the target condition and interview the patient based on the questions below.

Step 2A: Below is an interview invitation script you might follow to invite a patient to a brief interview. You might contact the patient via email or by phone. We estimate the interview will last between 30 and 45 minutes.

******************************************************************************

Invitation script

Hi [patient name]. My name is [interviewer name]. I work for [organization name].

[organization Name] is persistently working to create the best system of care for all of our patients. One of our current improvement projects is focused on optimizing care and patient outcomes for patients discharged from the hospital.

We are writing you to request 45 minutes of your time for a brief discussion about your goals and outcomes as a patient who recently experienced [list the intervention or condition (hip surgery or AFib, for example)]. Your feedback is anonymous – your name or any personal details about you will not be used in our notes or shared with anyone.

We are sincerely grateful for your time. Your feedback will ensure we include the patient’s voice – your opinion – in how we design care.

Would you be willing to spend 45 minutes with us, so we can improve care for patients at [organization Name]? Please let me know if you are available at any of the following times:

Time 1, Time 2

Thank you for your time and consideration. Have a wonderful day.

Sincerely,
[cohort member name]

******************************************************************************
Step 2B: Conduct the interview. A proposed interview script is below. Prior to the interview, you might want to confirm the background – patient encounter details, background via your EMR. Please keep in mind, the example preferences and goals listed in the sample value compass (in the introduction section of this document) below should be modified according to the patient’s condition, comorbidities and intervention.

Patient Interview Script

Hi – [patient name]. Thank you again for your time. During our scheduled 45 minutes, we’ll walk through a series of questions that aim to capture your preferences and goals for the care you received and your health outcomes.

North: Functional status, risk status, and well-being
We’d like to begin by exploring your functional goals and quality of life. As you were going through your experience with [list the condition or intervention (AFib or hip surgery, for example)], what functional goals did you consider most important to you? We define functional goals as your ability to perform normal daily activities required to meet basic needs, fulfill usual roles, and maintain health and well-being.

The goals you might consider include being able to live independently as soon as possible, spending time with family, being able to exercise, going to church/synagogue, cooking, and other similar goals. Do these goals match your goals and preferences? Can you think of any others?

East: Whether the care provided matches the patient’s preferences, needs and values, and whether the patient is satisfied with their care experience

The second area we’d like to explore is called “patient-centered care.” When you were going through your experience, what were some of your goals and preferences for the care you received? A few goals and preferences we’ve heard other patients express are below. Do these goals match your goals and preferences? Can you think of any others?

a. Your home care needs and follow-up appointments are arranged prior to discharge.

b. You and your family stay informed of your health status, your care options, and your treatment plan.

c. Your care provider understands and is aligned with your care goals.

d. Your discharge instructions are clear.

 Others?
**South: Cost of the care delivered, including medical expenses, lost days of work, and other non-health care costs incurred by the patient and his or her family**

The third area we’d like to explore with you is cost. What are your primary concerns regarding cost? A few cost concerns we’ve heard from other patients are below. Do these goals match your goals and preferences? Can you think of any others?

a. Avoid hospitalization (or rehospitalization)
b. Short length of stay in the hospital (or any facility)
c. Minimal co-pays
d. Minimal Rx costs
e. Minimal medical device costs
f. No ED visits (or return ED visits)
g. Others?

**West: Presenting clinical problems and their manifestations**

We’d like to end with physical/biological – outcomes. What are your primary goals regarding clinical outcomes? A few goals we’ve heard from other patients are below. Do these goals match your goals and preferences? Can you think of any others?

a. Eliminate SOB, cough, fever and chills
b. Controlled CHF
c. Controlled HTN
d. Controlled COPD
e. Minimal polypharmacy
f. No complication from surgery
g. Others?

Lastly, please describe the type of self-management information or tools (e.g., mobile app) you need to confidently manage your care either on your own or with non-trained care providers such as family members.

Thank you sincerely for your time [patient name]. Your feedback will help us ensure we deliver high-quality care based on patient’s preferences and goals.

Have a wonderful day.

Sincerely,

[cohort member name]

**************************************************************************
Step 3: Optimal care path for the persona: The key care and outcome goals for the persona, the care team and care services required to optimize care and outcomes for the persona and the key activities and competencies required of each care team member and care service.

Please complete the table below to capture the "optimal care path" for the described persona. Feel free to add additional columns (phases of care or service locations) or rows (care providers, service providers or other "facilitators" of care). A "phase of care" might be "pre-admission" or "discharge."

<table>
<thead>
<tr>
<th>Provider / Microsystem</th>
<th>Phase / Service Location</th>
<th>Phase / Service Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP Team</td>
<td></td>
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<tr>
<td>Pharmacist</td>
<td></td>
<td></td>
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<tr>
<td>Discharge Team</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-professional caregiver(s)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient</td>
<td></td>
<td></td>
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<tr>
<td>Inpatient (acute) hospital</td>
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<tr>
<td>SNF</td>
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<td>etc...</td>
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</tbody>
</table>

Step 4 (if desired): Translate all of the findings into a compass diagram matching the image below.
Appendix C - Value-Based Performance Capabilities Assessment

Please answer the following questions when completing Section D to ensure the mechanisms supporting success under value-based payment models are considered.

☐ The organization(s) can calculate spending at an individual patient level.
☐ The organization(s) can calculate spending for the target population(s).
☐ The organization(s) can calculate quality measures at an individual patient level.
☐ The organization(s) can calculate quality measures for the target population(s).
☐ The organization can evaluate spending relative to quality performance for the target population(s).
☐ The organization can evaluate spending relative to quality performance for the target population(s).
☐ The organization can anticipate the health and well-being needs of individual patients in the target population.
☐ The organization can anticipate the health and well-being needs of the entire target population.
☐ The organization can match the type and volume of care providers to the needs of the target population.
☐ The organization can match the type and volume of care settings to the needs of the target population.
☐ The organization integrates patient reported data across all healthcare services included in the program.
☐ The organization actively monitors whether clinical services correspond with nationally endorsed guidelines and recommendations.
☐ The organization uses clinical quality measures for performance management.
☐ The organization can evaluate front-line care provider referral patterns.
☐ The organization can provide timely access to primary care.
☐ The organization has guidelines to assure proper patient transitions between care teams.
☐ The organization has guidelines to avoid adverse drug events.
☐ The organization has guidelines to avoid adverse impacts to gaps in care.
☐ The organization has evidence-based guidelines to manage patients based on clinical severity?
☐ The organization embeds shared decision-making (SDM) strategies, such as decision-aids, across all healthcare services included in the program.
☐ The organization provides a comprehensive care summary for each patient in the target population.
☐ The organization provides a comprehensive care summary for each patient in the target population.
☐ The organization provides each patient in the target population with personally relevant health education information.
☐ The organization facilitates access to community-based health services for each patient in the target population.
☐ The change expected by the innovation is clearly aligned with organizational objectives.
The following questions are related to the “Health Policy Environment” domain in the “Accountable Care Framework” (below).

☐ The organization clearly understands the political climate within the organization that might positively or negatively influence the success of the program.

☐ The organization clearly understands the political climate outside of the organization (e.g., partners, competitors, state agencies, etc.) that might positively or negatively influence the success of the program.

☐ The organization clearly understands the workforce regulations that might positively or negatively influence the success of the program.

☐ The organization clearly understands how the ability to exchange timely health information with partners might positively or negatively influence the success of the program.

☐ The organization clearly understands if the workforce needed to successfully deliver the program either currently exists within the organization and partners or is accessible for the program.

☐ The organization clearly understands if the target population(s) has the ability to access the “innovation.”

☐ The organization already has good standing relationships with each of the partner entities required for program success.
Appendix E - Key Implementation Design Considerations

The following content offers a few points the program team might consider when translating the charter notes into a driver diagram (Section F) the team will use to frame the "change pathway."

Domain I: Setting Direction

1. Confirm the teams understand the current system can remain as-is and the program clearly outlines superior alternatives to the current way of working
2. Confirm the team can clearly articulate the differences between the new business model aims and characteristics and the current business model
3. Confirm the implications of the innovation (including its subsequent effects) have been fully assessed and anticipated, and communicated to all team members

Domain II: Establish the Foundation

1. Provide tools and training that ensures all staff can adapt current knowledge and processes to new program performance expectations.
2. Build trusted relationships and respect between team members
3. Confirm the program team’s values and ways of working are compatible with value-based care principles
4. Assess whether all assigned leaders have the ability to successfully lead initiatives and teams
5. Assign appropriately skilled front-line care providers as champions of care redesign and technology strategy and implementation phases.
6. Assign appropriately skilled front-line care providers as leaders of quality improvement teams.
7. Ensure the governing body is "balanced" with care delivery institutions, patients and caregivers, social services organizations and community-based organizations
8. Train all care teams on quality improvement methods
9. Provide patient experience training for all care teams

Domain III: Building the Will

1. Map current processes in detail using tools such as process and value stream maps, run charts, staff and patient surveys, Pareto analysis, etc. Sequence the implementation strategy according to the program team’s perceived ability to successfully perform the competencies required for success.
2. Collaborate with all team members to break down the implementation plan into manageable parts.
3. Co-design the innovation implementation approach in a manner that permits the workforce to visibly observe the benefits of the innovation early in the implementation cycle.
4. Establish a communication plan that supports the regular and timely sharing of key program lessons within and across the program teams.
5. Develop a communication plan that ensures all staff understand the expected impact of proposed changes on the organization’s pathway to success under value-based payment models.
6. Establish accountability measures for the overall team and each team member.
7. Collaborate with the team members to ensure all staff understand how their performance goals relate to other team's performance goals, the program goals and organizational goals overall.
8. Establish a measurement system to share timely results of the implementation with the all team members and key stakeholders
Appendix F – Sample Driver Diagram

Below is a sample driver diagram used by a PAC cohort to reduce 30-day readmissions for a Medicare population with a principle diagnosis of pneumonia. The team translated the decisions, change ideas and capabilities analysis captured in this charter into the displayed driver diagram.