ACCOUNTABLE CARE
LEARNING COLLABORATIVE
AT WESTERN GOVERNORS UNIVERSITY

Accountable Care Atlas: Work Area Checklists

GOVERNANCE CHECKLIST

PRE-CONTRACT

Commit to pursue Value Based Care

- [ ] G1 Align your organization's mission, vision, and strategy with value-based care and patient-centeredness objectives

Set objectives at the board level

- [ ] G2 Set clear goals and strategies for the board and organization to achieve within 12-18 month timeframes
- [ ] G3 Set cost, quality and risk migration targets for the portfolio of business
- [ ] G4 Include the quality improvement program in the strategic plan of the organization, including representation in the budgeting process
- [ ] G5 Align quality improvement initiatives with ethical obligations
- [ ] G6 Set meaningful and appropriate goals for your quality improvement efforts and monitor and communicate your progress towards achieving those goals

Identify value-oriented leaders

- [ ] G7 Identify leaders who have proven reputation and abilities among peers to achieve value outcomes, carry out quality-improvement initiatives, and manage risk
- [ ] G8 Invest in and monitor leadership development programs to build leaders who will propel risk-bearing/value -based provider strategy adoption

Design governance structure

- [ ] G9 Adjust board structure and bylaws to advance value-based agenda
- [ ] G10 Document decision-making processes that align with organization's value-based objectives
- [ ] G11 Drive high value outcomes by providing adequate resources, monitoring return on investments, and directing the flow of funds

Ensure multi-stakeholder input

- [ ] G12 Ensure that there is sufficient representation, through an advisory board or other means, of clinicians, community members, and patients throughout the governance structure of the organization
- [ ] G13 Ensure meaningful participation from providers currently practicing within the health system on steering committees
- [ ] G14 Select clinical and administrative champions that demonstrate a commitment to lead quality improvement efforts
- [ ] G15 Assign care provider champions to technology implementations
- [ ] G16 Ensure meaningful participation from patient representatives on steering committees
- [ ] G17 Establish formal policies related to patient rights and responsibilities
- [ ] G18 Ensure meaningful representation from representatives of local community health organizations on steering committees
- [ ] G19 Ensure meaningful participation from payer partners on steering committees

Identify and engage provider network

- [ ] G20 Develop strategy for provider membership and participation, including physician, hospital and service providers
- [ ] G21 Identify resources to support providers and health care professionals in offering value-driven care
- [ ] G22 Ensure internal communication strategy that effectively aligns with organizational values and optimize operational processes
- [ ] G23 Commit to a transparent organizational communication strategy related to improvement efforts for all stakeholders
- [ ] G24 Collaborate and communicate frequently and effectively with value-focused partners across the healthcare spectrum
- [ ] G25 Engage providers and health care leaders throughout all levels of the organization to carry out and drive value-based objectives
- [ ] G26 Articulate a specific strategy for supporting seriously ill patients

GOVERNANCE CHECKLIST

PHASE 1

Educate providers and staff

- [ ] G27 Offer care providers education concerning the aims and core characteristics of a value-based delivery system
- [ ] G28 Offer leadership training for care providers assigned to leadership roles
- [ ] G29 Offer patient experience training for providers and staff
- [ ] G30 Offer training on team-based care for care providers on multi-disciplinary teams
- [ ] G31 Train all types of providers and employees in improvement culture, improvement methodology, and their own role in quality
- [ ] G32 Develop leaders who are focused on patient-centered improvement efforts at all levels of the organization

Establish quality and leadership teams

- [ ] G33 Develop formal processes whereby interdisciplinary clinical and administrative teams integrate with one another
- [ ] G34 Establish the organizational framework with the staff necessary to manage quality programs and support improvement activities
- [ ] G35 Develop organizational expertise in a specific and actionable improvement model
- [ ] G36 Build a team of clinical quality improvement experts to guide the work of improvement teams in your organization

PHASE 3

Report system and provider performance

- [ ] G37 Capture and report data relevant to cost, processes of care delivery, health outcomes, and patient experience in a standard manner
- [ ] G38 Report quality performance to payers and other stakeholders

FINANCE CHECKLIST

PRE-CONTRACT

Assess financial requirements

- [ ] F1 Understand the financial investment required to support the transition to value-based payment models
- [ ] F2 Assess need for start-up financing and calculate burn rate and break-even point for contracts under consideration
- [ ] F3 Analyze and understand potential for short- and long-term return on investment for risk-bearing contracts

Gain access to needed capital

- [ ] F4 Have access to the capital required to support the transition to value-based payment models

Create legal structure and for financial collaboration

- [ ] F5 Establish legal structures to receive and distribute shared savings payments to participating providers
- [ ] F6 Develop ability to distribute shared savings and performance-based payments to providers
- [ ] F7 Prepare for and mitigate insurance risk to protect against catastrophic claims or expenses
- [ ] F8 Align provider contracts with the aims of a value-based health system

PHASE 1

Build systems to track financial performance

- [ ] F9 Establish and maintain systems to track utilization, revenues, and costs when bearing financial risk
- [ ] F10 Track encounter data across the organization
- [ ] F11 Compare expected revenue to actual revenue from each source within, and outside of, the organization
- [ ] F12 Calculate spending at an individual patient level

Align incentives with value-based objectives

- [ ] F13 Create, evaluate, and modify operation metrics, including financial incentives for executive leadership and providers, to reflect your value-driven strategy
- [ ] F14 Design financial measures for a master population and important sub-populations using key clinical, socioeconomic and demographic factors
- [ ] F15 Incentivize attention to the patient's overall health care experience
- [ ] F16 Ensure all staff are in alignment with incentives to improve quality
- [ ] F17 Align executive compensation policies with value-based performance measures
- [ ] F18 Align care provider compensation and incentives with value-based performance measures
- [ ] F19 Reward quality improvement successes throughout the organization

Secure value-based contracts

- [ ] F20 Negotiate value-based contracts that are informed by quality and cost performance data with payers and employers

PHASE 3

Monitor performance of value-based contracts

- [ ] F21 Monitor performance in current value-based contracts
- [ ] F22 Evaluate provider referral patterns
- [ ] F23 Evaluate spending relative to quality performance
- [ ] F24 Provide feedback to care providers on value-based performance measures that are outlined in compensation agreements

CARE DELIVERY CHECKLIST

PHASE 1

Assess the needs of the covered population

- ☐ CD1 Adapt risk assessment models in response to patient need, business use, or payment incentives
- ☐ CD2 Support multiple levels of analysis, such as population, provider, and individual patient levels of analysis
- ☐ CD3 Anticipate the care needs of the entire population
- ☐ CD4 Understand the unique cultural characteristics of the population served to implement changes in the organization to provide high-value care

PHASE 2

Ensure access to care

- ☐ CD5 Provide convenient and timely access to care based on the needs of patients
- ☐ CD6 Increase access to primary care services (e.g., extended hours, nurse call lines, virtual visits, telehealth, and other non-visit based care and support)
- ☐ CD7 Provide 24/7 patient access to a clinician who can evaluate the patient's level of urgency and facilitate a timely and appropriate intervention
- ☐ CD8 Offer access to and integrate with behavioral health services
- ☐ CD9 Offer access to palliative and hospice care services
- ☐ CD10 Facilitate access to community resources and social support services
- ☐ CD11 Develop a process to leverage resources across the health care and social service spectrum based on the needs of your patient population
- ☐ CD12 Develop relationships on behalf of patients with community-based organizations and services

Develop patient risk assessment strategy

- ☐ CD13 Anticipate the care needs of individual patients
- ☐ CD14 Identify the purpose and goals of patient risk assessment and develop a strategy for support which incorporates multiple data types, including administrative, clinical, socio-economic, social determinant and patient-reported data
- ☐ CD15 Develop a strategy for effectively assessing patient risk and supporting stratified care management and care coordination
- ☐ CD16 Determine which patients are appropriate for risk assessment based on the patient's health and utilization history, behavioral or mental health history, functional status, cognitive and physical abilities
- ☐ CD17 Establish a single, formal coding methodology across all organizations in the system and accurately code clinical services provided

Identify individual patient needs

- ☐ CD18 Identify the rising risk index of patients and sub-populations on an on-going basis
- ☐ CD19 Identify diagnoses and patients' health care and social support needs that both drive spending and are modifiable
- ☐ CD20 Evaluate factors that may increase patient risk, such as functional, cultural, socioeconomic and behavioral determinants of health, as well as health literacy, emotional support, and family/caregiver burden
- ☐ CD21 Enable user-defined variable weights and models for multiple care models or programs to address the diversities of populations served
- ☐ CD22 Use patient assessment tools that are tailored to the capabilities of the patient

Design systems to address patient needs

- ☐ CD23 Identify opportunities for intervention that target modifiable behaviors and interventions based on specific patient needs and the organization's program model(s)
- ☐ CD24 Integrate patient risk data with appropriate clinical evidence-based guidelines
- ☐ CD25 Design care management systems that address both medical and social determinants of health

CARE DELIVERY CHECKLIST

Establish and maintain use of care guidelines

- [ ] CD26 Use evidence-based care guidelines to manage patients based on clinical severity
- [ ] CD27 Use guidelines to avoid adverse drug events
- [ ] CD28 Use guidelines to avoid adverse impacts due to gaps in care
- [ ] CD29 Actively monitor whether clinical services correspond with nationally endorsed guidelines

Design care teams

- [ ] CD30 Develop care teams with well-defined roles and responsibilities for planning, coordinating, and assuming accountability for continuity of patient care across the continuum
- [ ] CD31 Ensure that the patient is at the center of the care team, which includes family/caregivers, multi-disciplinary health professionals, and community members who are focused on meeting the patient's goals
- [ ] CD32 Ensure members of the care team have the necessary communication skills and cultural competencies to understand and collaboratively establish the patient's/caregiver's medical or non-medical goals and priorities
- [ ] CD33 Designate a primary coordinator of care to assure continuity throughout the continuum of care
- [ ] CD34 Implement methods for the care team to receive reliable and timely feedback on the functioning of the team and achievement of the patient's goals
- [ ] CD35 Ensure that staff is adequately trained on the use of evidence-based care protocols
- [ ] CD36 Ensure that patients, families, providers, and care team members are involved in quality improvement activities
- [ ] CD37 Assess and Collaborate to reduce adverse events and prevent patient's functional decline, and preparation of a streamlined, evidence-based plan of care

Establish care team protocols

- [ ] CD38 Ensure coordinated and seamless care for patients across all sites and care events
- [ ] CD39 Develop care transition protocols to reduce unnecessary emergency room visits and hospital admissions
- [ ] CD40 Provide continuity of care in a way that organizes services around the patient's physical, emotional and social needs
- [ ] CD41 Provide culturally competent care
- [ ] CD42 Develop, document, and follow effective communication protocols within and across care teams and partnering organizations

Provide care team with data access and support

- [ ] CD43 Provide care teams with a single, comprehensive patient health record
- [ ] CD44 Integrate patient reported outcomes in clinical pathways
- [ ] CD45 Notify the care team of key patient activities (admission or discharge from a care setting, presents at ED, does not fill prescription, does not keep a referral)
- [ ] CD46 Provide point-of-care decision support tools for care providers
- [ ] CD47 Use up-to-date information on clinical findings, evidence-based research, and public health issues to guide interventions and activities
- [ ] CD48 Make risk assessment data available at the point of care (e.g. discrete, searchable fields and/or on the problem list in the EMR)

Implement shared care-planning and decision-making

- [ ] CD49 Assure the care plan is accessible by all stakeholders and contains the patient's most updated goals, preferences, advanced directives, results, and other relevant information
- [ ] CD50 Involve patients in all decisions relevant to their care
- [ ] CD51 Train the care team with the skills needed to clarify patient goals, preferences, needs, concerns and feedback, and incorporate these into all care

- [ ] CD52 Engage in a collaborative partnership approach for care decision-making and social support planning with patients and their family/caregivers
- [ ] CD53 Integrate appropriate legal procedures into operations (e.g. patient legal capacity for decision making, guardianship, consent, etc.)
- [ ] CD54 Identify gaps in patients' understanding of conditions and treatments and empower patients with tools and strategies (e.g. disease-specific patient support services) to promote self-management
- [ ] CD55 Educate patients on wise use of health care services before and after clinical encounters
- [ ] CD56 Provide patients with personally relevant health education materials
- [ ] CD57 Provide patients with all relevant cost and coverage information at appropriate decision points
- [ ] CD58 Provide a comprehensive care summary to patients

Conduct ongoing patient outreach

- [ ] CD59 Conduct ongoing patient outreach programs to improve the health of the targeted population
- [ ] CD60 Encourage and enable patients to carry out self-management by providing HIPAA compliant information and tools
- [ ] CD61 Ensure that patients have secure access to their personal health information and care plans
- [ ] CD62 Develop monitoring system to track patient out-of-network utilization
- [ ] CD63 Share information with patients about gaps in care suboptimal outcomes
- [ ] CD64 Offer or facilitate access to ongoing wellness classes and lifestyle change support groups
- [ ] CD65 Align with relevant public, community and employer health interventions to improve population health

PHASE 3

Monitor and report care delivery effectiveness

- [ ] CD66 Continually monitor care model effectiveness, leveraging data as well as feedback from care teams and patients
- [ ] CD67 Use clinical quality measures for performance management

HEALTH IT CHECKLIST

PHASE 1

Assess current IT strategy

- [ ] HIT1 Align health IT strategy with overall organizational goals and objectives
- [ ] HIT2 Assess the health IT strategy and infrastructure across the organization
- [ ] HIT3 Analyze and mitigate privacy and security risks

Identify gaps in IT infrastructure

- [ ] HIT4 Identify gaps in health IT infrastructure necessary to meet organizational goals and objectives
- [ ] HIT5 Identify data and data sources needed for clinical care, priority programs, and processes
- [ ] HIT6 Build appropriate staffing to maintain IT infrastructure
- [ ] HIT7 Define platform requirements to support value based objectives

Organize internal data assets

- [ ] HIT8 Aggregate and normalize internally available data and information to allow for the provision of useful information

PHASE 2

Aggregate external data assets

- [ ] HIT9 Develop strategy and plan to gather data and information from multiple sources, including structured and unstructured data
- [ ] HIT10 Develop and implement processes to acquire and ingest claims data from all relevant payers
- [ ] HIT11 Ensure access to critical data generated outside of the organization's network (e.g. hospital and commercial clinical laboratories, PH laboratories, and information on medications dispensed)
- [ ] HIT12 Develop and implement process to acquire and ingest multiple data types such as: SDH, PGDH, VS from monitoring devices, PH, Social services, etc.
- [ ] HIT13 Participate in data exchanges with local, state, and federal public health registries
- [ ] HIT14 Ensure data and information is shared in accordance with all applicable privacy and security laws and regulations
- [ ] HIT15 Ensure the data acquisition process continues uninterrupted
- [ ] HIT16 Monitor data integrity and conduct periodic data quality audits to ensure accurate data

Develop platforms to house and analyze data

- [ ] HIT17 Develop a stable platform for information systems that is consistent and aligned with the organization's health IT strategy
- [ ] HIT18 Establish a data repository that has timely clinical process and outcome data, cost data, and patient experience and safety data
- [ ] HIT19 Create capability to leverage the data repository for quality improvement activities

Enable data sharing and access by care team

- [ ] HIT20 Share patient specific data among authorized clinicians internal to the organization's network using any HIE, Direct messaging, shared screens, or any other available mechanism
- [ ] HIT21 Share patient specific data among authorized clinicians, both internal and external to the organization's network through various HIE structures or direct messaging
- [ ] HIT22 Ensure that all data use agreements and technical requirements are in place to enable sharing of patient specific health data between organization and external entities
- [ ] HIT23 Utilize secure e-communications effectively with authorized patient and family/caregivers when not co-located
- [ ] HIT24 Utilize secure e-communications effectively with the internal care team when not co-located
- [ ] HIT25 Utilize secure e-communications effectively with external partners and stakeholders when not co-located

PHASE 3

Enable reporting and feedback

- [ ] HIT26 Assess effectiveness of current reports and modify as deemed necessary by internal users
- [ ] HIT27 Identify key reports that various organizational stakeholders need to monitor the progress of their programs and processes
- [ ] HIT28 Develop internal reports to monitor key indicators of quality, utilization, and costs
- [ ] HIT29 Analyze data to create useful and/or actionable information that simultaneously supports performance improvement
- [ ] HIT30 Integrate cost, clinical data, and patient demographics into actionable reports
- [ ] HIT31 Create a user-friendly report profile which is interactive and easily modifiable
- [ ] HIT32 Allow segmentation by filters (e.g. payer, provider, health condition, psychosocial or behavioral health, etc.)
- [ ] HIT33 Provide role-based access to transparent risk reports
- [ ] HIT34 Share detailed reports, whether data and/or information at either a population, provider, or patient level, with authorized internal and external stakeholders
- [ ] HIT35 Develop or purchase a reporting tool, such as a dashboard, that captures appropriate deviations and benchmarks, and share reports with the care team, patients and public
- [ ] HIT36 Provide transparent cost, quality, and process data to internal and external stakeholders

Accountable Care Learning Collaborative

Managed by Leavitt Partners, LLC

Western Governors University

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