Accountable Care Atlas: Work Area Checklists
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
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

PHASE 3

Monitor performance of value-based contracts

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

☐ 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
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

Identify individual patient needs

- 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

Design systems to address patient needs

- CD18 Identify the rising risk index of patients and sub-populations on an ongoing 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
- 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
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
CARE DELIVERY CHECKLIST

□ 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
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.

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

accountablecareLC.org