HEALTH MANAGEMENT ASSOCIATES

ROADMAP TO INTEGRATED DELIVERY SYSTEMS FOR VULNERABLE POPULATIONS

HTI | HEALTHCARE TRANSFORMATION INSTITUTE

HMA

Health Management Associates

Health Management Associates (HMA) is an independent, national research and consulting firm specializing in publicly funded healthcare reform, policy, programs, and financing. We serve government, public and private providers, health systems, health plans, institutional investors, foundations, and associations. Every client matters. Every client gets our best. With over 20 offices and more than 200 multidisciplinary consultants coast to coast, our expertise, our services, and our team are always within client reach.

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Introduction and Purpose

As healthcare delivery in the United States advances value-based payment, transparency, quality and documentation of health outcomes, providers serving vulnerable populations must assess their clinical and organizational capacity and adapt. These populations not only present with complex clinical conditions, but also are often affected by behavioral and social issues that may limit the success of traditional medical regimens. To achieve the delivery of high quality care while constrained by requirements for greater accountability in the use of resources, providers will need to adopt seamlessly integrated models of care within and across health systems, supportive information technology and analytics capabilities, effective approaches to care management, and acknowledgement of the social determinants of health that will have an impact on treatment and flexible operational structures and strategies.

Providers at all levels must contend with this change, including public and private hospitals and health systems, safety net clinics and federally qualified health centers, and primary care and specialty physician groups. The role of public health departments and community-based organizations will also change and will need to be integrated into these new models. Payers will need to provide the right incentives to foster these historic changes.

This "Roadmap" provides a set of documents and tools that providers can use to ready themselves to integrate care and take on financial risk for populations who are the hardest to access and treat.

How to Use the Roadmap

The Roadmap is designed to accommodate providers at various stages of readiness for developing integrated delivery—either within their own systems or as a part of a network of multiple providers and organizations. The document encompasses the range of elements a provider should incorporate into restructuring the delivery of care to most effectively meet emerging mandates. The reader can review the Roadmap in full or access only the most relevant tools that HMA has developed to support this work.

Click on the links embedded within this document to access the various components of the Roadmap. Each section contains an introduction of the topic and most of the sections include a tool or other resource for download.

Who are the most vulnerable populations in our health system?

- Uninsured and under-insured people
- Insured individuals who lack ready access to comprehensive care
- Those who are homeless
- Incarcerated and formerly incarcerated populations
- Youth in foster care
- Those with multiple chronic conditions
- Those with behavioral health and substance use conditions
- Those whose health is complicated by social determinants

1. Integrated Delivery Structures

Experience has shown that systems that include the full range of services and provide integrated and coordinated care are more likely to succeed in meeting accountability requirements. Smaller healthcare organizations are less likely to be able to meet these delivery challenges alone and may have to join with other organizations to create a system that can provide comprehensive care. Regardless of their size, healthcare systems will also have to redesign their care model to provide proactive, continuous, and efficient care for patients and populations rather than provide reactive and episodic care designed for the individual. HMA has worked both with individual health systems and with multiple provider networks serving defined communities to move toward integrated care.

Based on this experience, HMA has found that the elements of restructuring would include:

- Identifying health services that best meet the needs of designated populations using demographics, health status and trends, health risks and patterns of utilization
- Developing strategies to transition providers away from volume-based reimbursement and toward payment based on quality and outcomes
- Integrating primary care and behavioral health services with financing and programmatic strategies
- Coordinating physical and behavioral healthcare with housing, employment, education, community social services and other vital support systems
- Implementing Patient-Centered Medical Homes (PCMH) and Health Homes that are built around team-based care
- Coordinating primary care with specialty outpatient, emergent, diagnostic, inpatient, behavioral health and long-term services and supports to both minimize duplication and fill gaps
- Implementing care management that includes risk assessment of patients and populations, self- management support, coordination of long-term care services and transitioning patients from inpatient and emergency care
- Designing and implementing effective team-based care, including training, mentoring and coaching of new workforce roles
- Using information technology to provide real time information about healthcare utilization and to assure coordination between care givers
- Assuring clinical and administrative leaders are supportive of and accountable for the transition of their areas of responsibility
- Implementing operational changes in health systems at the departmental levels to emphasize the principles of value-based care and integration with other components of the health system
- Identifying and implementing new ways to integrate services within health systems and across care settings, including with other providers
- Establishing an organizational and leadership structure that is responsible for the ongoing refinement of the integrated care model

RESOURCE

Components of an Integrated Delivery System

This manual presents an overview of, and approaches to, designing and implementing key components of integrated delivery systems (IDS) capable of providing accountable care. These approaches are based on HMA's experience in helping safety net healthcare organizations transform their delivery systems.

RESOURCE

Legal and Governance Structures of an ACO

This paper discusses legal and governance structures, including practical considerations for safety net providers, as well as legal issues that ACOs and other integrated delivery models should consider as they develop the foundation for this new structure.

2. Inpatient Transformation

More than most providers, hospitals are undergoing significant levels of change, both internally and externally, to adapt to and meet the demands of a marketplace focused on meeting the Triple Aim goals of improved health outcomes, reduced cost of care and improved patient experience. Despite the reforms that have been consistently projected as the future by federal initiatives—particularly focused on minimizing unnecessary inpatient utilization—hospitals still often judge their success by the number of "heads in the beds." The move from emergent and inpatient focus—often isolated from the care given before or after the hospitalization—to whole person, community-based care is a difficult transition to make, particularly before the financial incentives catch up to policy pronouncements.

The future role of hospitals must be tied to integrated delivery systems in which:

- Patient care "hand-offs" post discharge or between elements of the delivery system are seamless and non-duplicative
- Emergency departments are not utilized for primary care but are connected to appropriate providers to assure appropriate transitions
- Traditional approaches to utilization management extend beyond hospital boundaries and include robust care management and coordination with outpatient settings
- Hospitals address the whole health needs of their communities through innovative partnerships with other providers and organizations

TOOL

Operational Readiness Assessment

HMA offers a customized Integrated Delivery System Readiness Assessment Tool that includes self-assessment questionnaires and HMA consultants' analysis of your operational and strategic opportunities to identify transformation options that have support from your key constituencies and stakeholders. The assessment covers issues around governance, hospital/physician alignment, clinical integration, financial integration, information technology and more.

Contact
Sandra Sperry, **Warren Lyons** or **Ray Jankowski** for more information.

TOOL

Community Health Needs Assessment Data Tool

HMA's proprietary Community Health Needs Assessment data tool is designed to allow hospitals and other providers, including safety net providers, achieve the following goals:

+ Assess the demographics and health status of a provider service area, including variations in demographics and health status within/across the service area.
+ Identify community health needs within the designated service area.
+ Inform short-term and long-term strategic planning, including DSRIP project selections.

3. Long-Term Services and Supports

By 2020, an estimated 12 million older Americans – and millions more children and adults with chronic and disabling conditions – will be driving tremendous demand for long-term services and supports (LTSS). Medicaid and contracting managed care organizations have become second only to families and informal caregivers in providing the essential services and supports that enable older adults and people with disabilities to live, work, attend school and otherwise participate in their communities. As LTSS becomes managed, providers will need to integrate LTSS services into their day to day business practices. HMA's LTSS work parallels and helps to shape current system trends. We support improved outcomes for beneficiaries, sustainability for public purchasers and their managed care partners, and successful participation for the wide range of providers who offer critical services for those requiring long-term services and supports.

Specifically, for the LTSS population, providers will need to do the following to successfully integrate LTSS services into their business practice:

- **Models of Care:** Develop and promote person-centered, consumer-directed LTSS models of care
- **Quality Standards:** Develop LTSS quality standards and metrics, including achieving accreditation. HMA is currently developing a resource to assist organizations in achieving NCQA accreditation
- **Compliance:** Establish readiness and compliance with federal and state regulations, including home and community-based settings of care, Medicaid managed care, the Fair Labor Standards Act, and the Americans with Disabilities Act
- **LTSS Integration:** Implement care management models that promote integration of services across physical, behavioral and LTSS and between Medicare and Medicaid
- **Stakeholder Engagement:** Support effective community engagement by public policy makers, and empower advocacy organizations and other stakeholders in understanding, shaping and responding to change
- **Delivery and Payment Models:** Prepare and respond to payment and structural changes in LTSS (e.g., managed care, accountable care, value-based purchasing). HMA is developing a tool to support providers in embracing value-based payment in LTSS.
- **Social Determinants Design:** Design innovative approaches to addressing the social determinants of health, including improved strategies for affordable and accessible housing and competitive employment for persons with disabilities
- **Research and Evaluation:** Enable the use of data to uncover opportunities for improvement and to demonstrate value to ACOs, hospital systems, payers, and funders

TOOL

MLTSS Health Plan Business Appraisal and Advisory Services

This toolkit provides health plans with a behind-the-scenes review of its MLTSS operations to internalize, disseminate and sustain critical activities that drive success in the several domains, e.g., care coordination, provider network access and management, staff and provider training, quality improvement, and compliance and program integrity. Note: To be paired with advisory services and not self-administered.

Contact
Karen Brodsky
for more information.

TOOL

MLTSS State or Health Plan Audit Tools

This toolkit helps Managed Care Organizations manage their day-to-day LTSS care management load using the following tools: (1) service coordinator LTSS capacity tool, (2) service coordinator LTSS county coverage, (3) clinical staffing model, (4) daily health risk assessment and outreach calls tracking tool, (5) dashboard report, (6) staffing productivity and (7) sample health risk assessment.

Contact
Jeanine Davis
for more information.

4. Primary Care Transformation

Primary care practices are critical to the success of accountable care, but they need skills and infrastructure to fully participate. The transformation to a Patient-Centered Medical Home (PCMH) model of care is a foundational element in succeeding in taking on risk. This model focuses on six domains: patient-centered access, team-based care, population health management, care management, care coordination and transitions, performance measurement and quality improvement. If well designed, PCMHs and health homes have the potential to advance the Triple Aim of improving patient experience of care, improving population health outcomes, and reducing the cost of care. Strong leadership, a staffing model aligned with patient-centered care, and an information technology infrastructure are required to fully realize the model.

In addition to the strategy of building a PCMH foundation, there are supplemental key strategies that will support a primary care practice in improving its readiness to take on financial risk, including:

- Targeted interventions such as reduction of low value tests, emergency department diversion, post-hospital transition care, and the use of generic drugs
- A focus on developing an infrastructure to target high risk/costly populations, for example, individuals with behavioral health diagnoses may benefit from behavioral health/primary care integration
- Financial capacity and management control, which includes such things as utilization management, more advanced data analytics, and financial monitoring connected with patient-specific program intensity

TOOL

Risk-Ready Primary Care Model

Risk-Ready Primary Care is a model, developed and promoted by Health Management Associates, that creates a clear path to clinical and organizational excellence that prepares primary care entities to compete in the evolving world of value-based payments. Primary care practices must be ready to succeed at hitting quality targets to optimize pay for performance revenue, and similarly be ready to succeed in attracting and retaining patients. The model depicts and describes what it takes to get there.

TOOL

Achieving NCQA PCMH Recognition: A toolkit for practices seeking to apply

As part of a larger Children's Health Insurance Program Reauthorization Act (CHIPRA) initiative, HMA supported health centers in their transformation to a Patient-Centered Medical Home (PCMH) model of care. To assist those practices interested in applying for NCQA PCMH recognition, HMA designed and tested a tool kit that has subsequently been used nationally in major PCMH transformation initiatives. A key feature is a library of NCQA-required documentation for each standard, element, and factor in NCQA's 2014 PCMH program.

TOOL

Empanelment in an Accountable Care Environment: Implementation Guide

Empanelment is the process of creating and maintaining a relationship between each patient and a primary care provider (PCP). It is a critical and early step in the transformation of primary care delivery into a PCMH model of care. This guide details a step-by-step process of pre-empanelment work; and developing, refining and managing patient panels. An appendix includes panel management policy and procedure domains as well as scripts to use with patients and staff related to the empanelment.

5. Specialty Care Transformation

Specialty care in the safety net is often a pain point for patients, primary care providers, and the systems striving to create a rationally integrated value-based care continuum. Specialists drive, directly or indirectly, a significant portion of medical expenditures, particularly in concentrated high-dollar expenses for procedures and pharmaceuticals. Teaching and training expectations often compounds the complexity in safety net systems. Right-sized specialty care that is well-coordinated and timely is necessary to avoid ER visits, reduce inpatient utilization and provide optimal care, particularly with the increasing burden of chronic disease in vulnerable populations.

These steps optimize specialty care:

Assess

Define the population to be covered by specialty resources by coverage status, age, and gender, and estimate the number in the non-assigned population not yet accessing care that will likely seek care in the integrated system when they become ill. Measure access and latent capacity traditionally (the third next available appointment) and non-traditionally (percent of visits devoted to new patients per specialty). Apply safety net staff-to-client benchmarks (e.g. FTEs/100,000) to describe capacity.

Model

Develop models, methods and tools to decrease variability and overutilization in referral behavior and applying expertise in analyzing referral behavior and changing low value patterns through the use of tools, workflow changes and monitoring methods that optimize referrals. Incorporate delivery system changes needed for value-based payment, including risk sharing and episode of care payments.

Implement

Enhance primary care capabilities through support of co-management with a specialist and an enhanced relationship between PCP/team and specialist staff; fashion a single e-referral pathway with embedded, evidence-based decision supports designed for use by all providers seeking consultation; optimize specialty scheduling; introduce care coordination and care navigation, and use of care plans.

Innovate

Incorporate e-consults to enhance capacity and respond to patient and payer expectations for timelines, use telemedicine solutions to reach targets for retinal screens and to provide certain services; create specialty health homes for certain populations.

6. Behavioral Health and Primary Care Integration

Integrating primary care and behavioral health is a central focus in healthcare delivery reform for many states and payers as they work towards addressing quality and cost containment. Significant research demonstrating the effect of co-morbid behavioral health conditions on overall health outcomes, and the subsequent cost increases, has led to an exploration of new models of care.

The development of an effective integrated care program requires careful attention to model design; the essential components of the system of care must deliver specific outcomes. Integration requires development of a clinical model, attention to change in organizational culture, and thoughtful implementation with operational support.

The key strategies for organizations and providers include:

Organizational Assessment

+
assessing
current workflows

+
analyzing utilization and
outcome data identifying gaps
and opportunities

+
creating action plans
and timelines

+
assessing staffing models
and hiring needs

Model Research and Selection

Team Development and Training

Hiring and staffing work plan

Population Health Management Tool Development

+ Registry development

+ Population selection

Financing Models for Maintenance and Sustainability

Billing and coding

Record Keeping and Information Sharing

Assessment of Technology Needs
(documentation, information sharing, tele-med)

RESOURCE

Collaborative Care Model

The Collaborative Care Model of integrated care was first tested at the University of Washington. With over 80 randomized controlled clinical trials showing robust results across multiple diagnoses, settings and payment groups, it has emerged as the predominant outcome changing model for treating mild to moderate behavioral health conditions in primary care settings. However, even with a remarkable evidence base and proven return on investment, widespread implementation has not occurred due to funding barriers, and implementation has languished despite being touted as a solution. Recently CMS announced three new CPT codes for reimbursing the Collaborative Care Model.

7. Clinical Leadership

The traditional leadership approach has focused more on a technical style of leading through change – changing processes, technologies, and training. The emerging transformation of healthcare delivery for safety net populations is forcing clinical and administrative leaders into unfamiliar territory. Successful leadership requires an enhanced set of skills, combining the traditional emphasis on clinical proficiency with the kind of non-traditional leadership qualities necessary to engage teams, have an impact on delivery system transformation, and respond to community, social, and clinical needs. Adaptive leadership skills are needed now more than ever; focusing on values and beliefs for change, and growing a new vision for a clinical team to adopt.

Key strategies for leaders in today's changing healthcare environment are:

Creating a broader vision and changing values

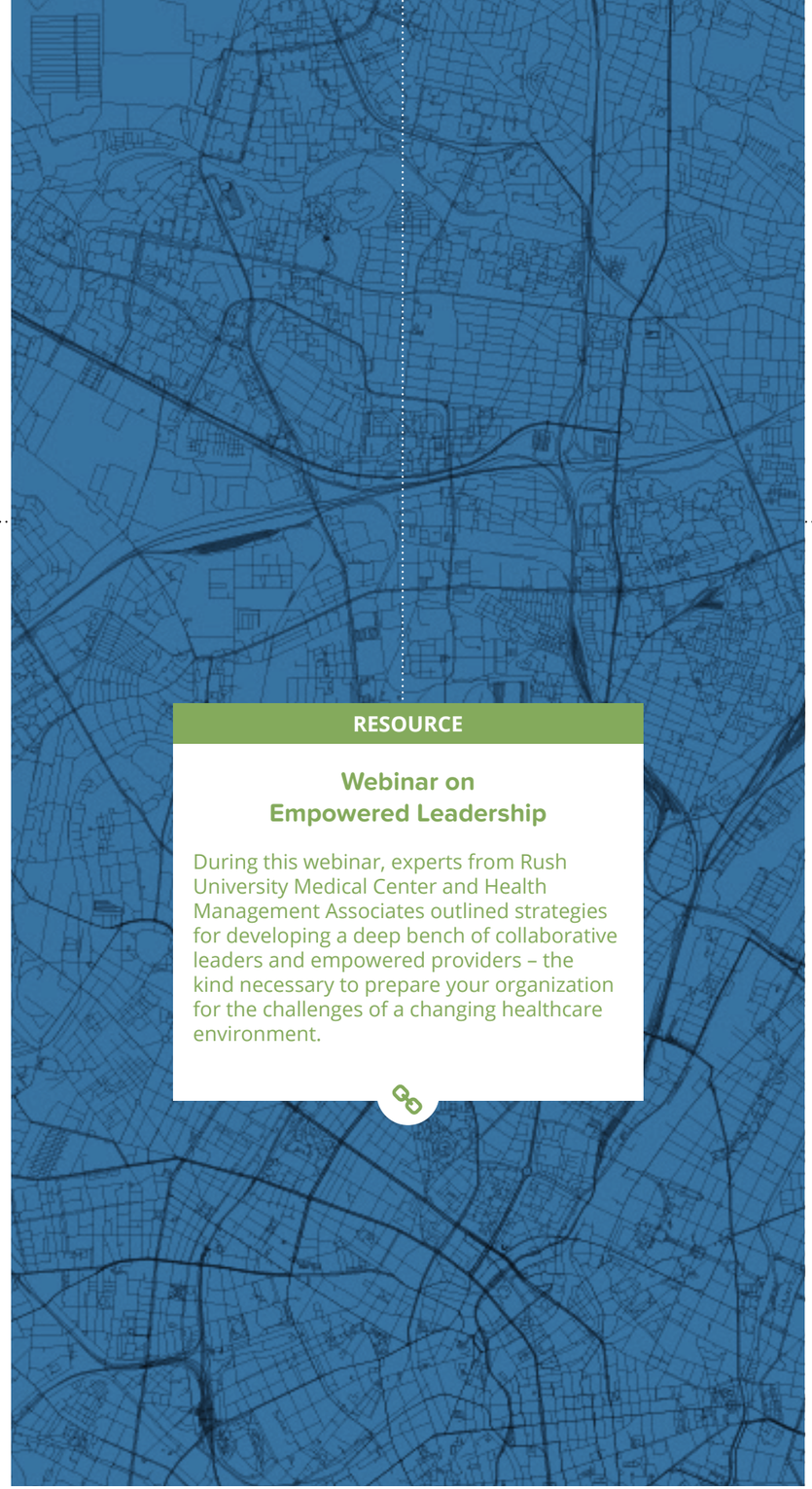
- Shared decisions
- Integrated clinical environments
- Team work
- Value versus volume
- Broader engagement of patients, consumers, and community

Expanding the leadership role

- Understanding quality metrics and population health management
- Understanding contracting and payment methodology and how it drives clinical care
- Recruitment and retention of the right people for the change
- Developing skills for leadership without authority
- Engaging and developing staff in new change environments
- Implementing new technologies

Using adaptive change dimensions

- Leadership capacity for change and leading change
- Alignment of behaviors and beliefs
- Use of tools for shaping and supporting the new culture
  - Messaging and communications
  - Setting up clear expectations, new staff orientation, performance reviews
  - Hardwiring new ways through training, work redesign, ongoing metrics and feedback
- Change support by all formal and informal leaders



RESOURCE

Webinar on Empowered Leadership

During this webinar, experts from Rush University Medical Center and Health Management Associates outlined strategies for developing a deep bench of collaborative leaders and empowered providers – the kind necessary to prepare your organization for the challenges of a changing healthcare environment.

8. Care Management Strategies

Care management is taking center stage with healthcare providers taking on risk and seeking effective ways of improving patient outcomes while controlling costs. It is the strategy driving population health management outcomes and is critical to support a value-based payment model.

Key strategies for providers and practices creating program infrastructure for care management include:

- Identification of the patients with highest, most complex needs
- Development of a patient-centered health risk assessment
- Development of a customized, individualized care plan with patient/family and care team involvement
- Building rapport with the provider, team, and patient
- Embedding care managers in the practice and with access to the EMR
- Creating comprehensive transitions of care programs
- Building strong linkages with behavioral health and integrated whole-person care
- Building HIT supports, such as a care management registry to support population health activities, tracking and reminders
- Training care managers in patient engagement skills such as motivation interviewing, self-management, and behavioral activation
- Negotiation of fees and contracts to support care management and accept risk for the outcomes

RESOURCE

Care Management Essentials

During this webinar, HMA Managing Principal Nancy Jaeckels Kamp provides the key steps for designing and implementing a successful care management program – including the type of infrastructure and workflow redesign needed to ensure your organization's care management efforts deliver measureable results.

RESOURCE

Webinar on Targeting Readmissions

During this webinar, HMA experts outline the rationale for a collaborative approach to reducing readmissions, involving hospitals, health plans, community-based organizations, and other providers who can address cultural and community-related factors that impact healthcare outcomes.

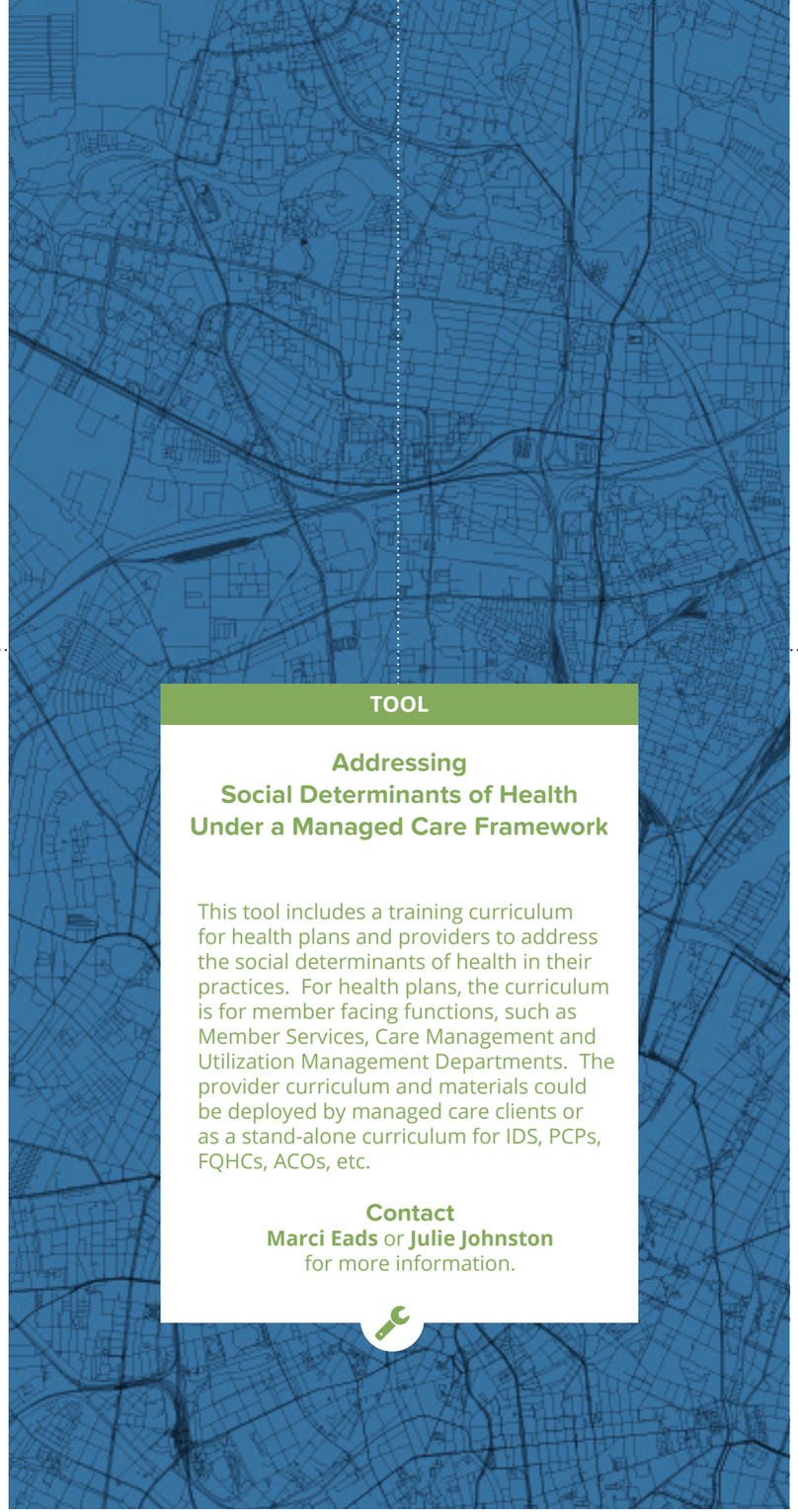
9. Social Determinants Of Health

There is growing recognition that the vision of healthier people and communities will require new attention to and dedication of resources for addressing the social determinants of health, including education, housing, environment, food, poverty, and safety. As the trend toward models of healthcare based in population health and focused on addressing social determinants of health intensifies, there is a need to expand the vision of what creates health and what constitutes healthcare. Increasingly, the basic necessities are considered key elements of healthcare as their absence leads to ill health.

Developing an understanding of how social determinants of health are related to health and healthcare, and developing strong relationships across communities and between broadly defined partners in health are increasingly becoming a cornerstone of successful models of care.

Health plans and providers will need to:

- Understand social determinants of health and their relationships to health
- Understand their role in addressing social determinants and partnering with community-based organizations to address those unmet needs
- Identify community-based providers with whom to partner
- Conduct strategic planning that includes partnership development, value-based purchasing and measuring the impact of social services on health outcomes



TOOL

Addressing Social Determinants of Health Under a Managed Care Framework

This tool includes a training curriculum for health plans and providers to address the social determinants of health in their practices. For health plans, the curriculum is for member facing functions, such as Member Services, Care Management and Utilization Management Departments. The provider curriculum and materials could be deployed by managed care clients or as a stand-alone curriculum for IDS, PCPs, FQHCs, ACOs, etc.

Contact
Marci Eads or **Julie Johnston**
for more information.

10. Information Technology

Once a healthcare organization commits to becoming or being part of an accountable care enterprise, achieving success in that endeavor depends heavily on its ability to execute an effective information management (IM) strategy and deploy the requisite information technology (IT) infrastructure.

For a healthcare organization to operate successfully as an accountable care enterprise it must have:

- Timely access to a rich stream of data to inform care management strategies
- Robust analytics and modeling capabilities that leverage a patient's profile, encounters, and experience
- The ability to collaborate in real-time, across and within health systems
- The ability to coordinate care across and within health systems
- The ability to engage and stay connected with patients between healthcare encounters, and
- The ability to aggregate, evaluate and report on clinical, operational and financial data

Our experience demonstrates that healthcare organization seeking to transform into an accountable care enterprise need a comprehensive, actionable accountable care IT plan that is built upon:

- **A thorough examination of the vital business processes underlying accountable care,**
- **An evaluation of existing IT assets against accountable care capability requirements in the context of the vast, sometimes daunting landscape of IT solutions and solution providers,**
- **The identification and prioritization of IT capability gaps,**
- **The identification of new IT solutions – or the need to optimize existing solutions – to address these gaps, and**
- **The prioritization and sequencing of investments in IT – new IT or improvements in existing IT – to build the requisite accountable care IT infrastructure.**

TOOL

Accountable Care IT Framework

The Accountable Care IT Framework (ACIF) is a methodology and toolset that enables healthcare organizations to align efforts to build up their IT infrastructure to meet the objectives of an accountable care enterprise. Designed to guide systematic IT requirements analysis and strategic planning, the ACIF offers an healthcare organization with concept diagrams and reference guides that illustrate and prioritize integrated business and IT functions necessary for successful transition to an accountable care enterprise, an IT capability assessment methodology and toolset that can be used to produce an IT capability blueprint, and an IT planning methodology and toolset that can be used to produce an accountable care IT plan.

Contact
Juan Montanez
for more information.

TOOL

Hot Spot Analyses

Hot spot analyses identify geographic patterns of statistically significant clusters of high and low rates. For example, this **linked** report includes maps that highlight zip codes in the Baton Rouge area with a high rate of calls regarding an emotionally disturbed person. Pairing this data with a map of the locations of behavioral health providers can highlight where resources may be lacking relative to need.

11. Workforce

Provider success in making the desired shift to value-based healthcare is contingent upon re-engineering workforce roles and accountabilities. This involves building competencies in population health management and team-based, integrated person-centered care. Across the broad continuum of ambulatory to acute care, primary care to specialty practices, institutional to community-based partners in integrated delivery systems, shared provider accountability for care management and care coordination for defined populations means that functioning effectively as a "team" takes on critical significance.

This "teamwork" includes:

- Using data to understand patient health risks
- Targeting interventions that span physical and behavioral health, as well as social and environmental domains
- Communicating around a shared care plan with a mix of clinical (physical medicine and behavioral health) and non-clinical team members (such as peer support and community health workers)
- Structuring protocols to ensure transitions and continuity of care applied across organizational settings
- Following processes of care and workflows led by a care manager, not a physician

This new integrated healthcare delivery paradigm requires a set of new healthcare skills and competencies, and revisiting workforce strategies overall. Organizations will need to:

- **Analyze and match populations with workforce:** Perform risk profiling and hot-spotting to refine understanding of the populations served and associated workforce needs.
- **Develop workforce and staffing models:** Define new team-based staffing models and key roles that must include care management, care coordination, physical medicine and behavioral health clinical roles, IT/data supports, and team administrative support. Include a plan to utilize all staff to the maximum of their training and experience.
- **Analyze current workforce assets and gaps to develop recruitment and training strategies:** Communication skills and aptitudes for collaboration are critical. Thoughtful evaluation of current staff is required to identify those not capable of transitioning into new care models and conversely, those who can provide leadership and mentoring. Training programs must be tailored to provide recruiting and training programs for the new workforce that take into account critical role-based skill sets.
- **Plan for ongoing workforce training and supports:** Workforce should build knowledge and competencies for working with high-risk populations with complex co-morbidities, as well as those with diverse cultural identities and needs. Key to this training are skills in quality improvement and team communication.
- **Develop performance management tools and processes:** Performance expectations and the tools and methods for evaluating performance must be developed in relation to new roles and accountabilities. Pathways for workforce and leadership development are also required as part of a commitment to transformation and in recognition of the need for a change management strategy.

TOOL

Workforce Optimization Tools

HMA has tools and resources to help support re-engineering of workforce roles and accountabilities in light of the shift to value-based care, such as:

+ Sample job/role descriptions
+ Competency definitions and evaluation modules
+ Staffing models for integrated care in various settings
+ Sample training curriculum for teams, care managers, organizational management, and leadership

For access to these tools, contact Lynn Dierker or Pat Dennehy

12. Financing and Value-Based Payment

The development and implementation of an integrated delivery system that provides access to quality, accountable care requires the design and development of payment models that focus on value instead of volume. Successful practice transformation is not sustainable without a financial model. Fortunately, value-based payment (VBP) is an emerging type of payment approach that pays for value for attributed patients rather than paying for volume for patients based upon the numbers of visits, procedures or other indicators that solely reflect activity rather than outcomes. Because it facilitates and incentivizes better care, better outcomes, and reduced costs, VBP increasingly will become the dominant payment method for healthcare providers.

Steps to improving the financing of care through VBP include:

Organizational Readiness:
Key areas leaders, providers, staff and governing boards must understand are (1) knowing what VBP is and its likely forms and timing, (2) the level of preparation required to make the transition, (3) what their roles will be, and (4) what the new performance expectations are.

Partnerships:
Partnerships with other healthcare providers along the continuum of care are becoming increasingly critical to managing the care, outcomes, and costs of patients and populations for whom an organization will be responsible. Examples include formal agreement with a wide range of healthcare and social services providers to identify where patients currently seek care and who can support outcomes and/ or cost reductions. True collaboration requires the reciprocal sharing of data among the partners.

Care Delivery, HIT, and HIE Readiness:
As noted in a previous section, having the advanced analytic and informatics capacity to know what drives performance across the continuum of care is paramount. Also critical is having systematic processes to act on that data and information. This includes employing multiple methods for engaging attributed populations and managing their health outcomes and costs of populations with different levels of risk, including through care coordination, clinical care management, support with care transitions, and integrating services and care.

Financial and Operational Readiness:
Prior to participation in VBP, providers and payers need to ensure a strong financial and operational foundation under the current payment models as well as data systems that provide timely and actionable information on what is driving performance related to clinical and cost targets. It also requires being able to transition to manage costs per patient as, ultimately, the total cost of care for attributed populations.

RESOURCE

Finance - A Guide to Safety Net Provider Reimbursement

Because of the deficiencies of the current system, there is increasing recognition of the need to move to integrated care and reimbursement systems that reward providers on the basis of value provided, measured by quality and cost effectiveness. The purpose of this guide is to explore the implications of such changes for safety net providers. The guide begins by discussing the current reimbursement systems and their effects, and then explores the options for redesign that promise better performance.

TOOL

Value-Based Payment Readiness Assessment Tool

The purpose of this tool is to give primary care and behavioral health providers, health centers, and primary care practices actionable information on readiness to succeed under value-based payment and to identify critical gaps that need to be addressed.

The assessment focuses on the following readiness domains:

+ Organizational readiness
+ Partnership readiness
+ Care delivery and health information technology/health information exchange readiness
+ Financial and operational readiness
+ Organizational concerns

Upon completing the assessment the organization receives a custom readiness report and one hour consultation.

New Tools for the Roads Ahead

Our experts at the Healthcare Transformation Institute are continually developing new tools to help organizations navigate the changing healthcare landscape and drive innovation.

TOOL

Health Plan and Provider Collaboration Readiness Assessment Tool

CMS and CMMI are using their substantial influence to transition the U.S. healthcare system away from fee-for-service and towards shared risk and population-based payment. There are increasing expectations from state Medicaid agencies that Medicaid managed care plans will adopt similar strategies. This self-assessment tool will help those plans evaluate their readiness to comply by probing seven domains required to successfully partner with healthcare providers and implement alternative payment methodologies (APM) including strategic readiness, member attribution, delegation of some aspects of care coordination and care management, choice of appropriate quality metrics, ability to share timely and actionable information, construct of a range of APMs and ability to measure the impact of this payment strategy.

Contact
Art Jones
for more information.

TOOL

Relationship Centered Primary Care Assessment Tool

While many reforms have led to improved outcomes, the "heart" of healthcare, namely the therapeutic, personal relationship between two people has been either assumed to exist or neglected entirely. Relationship Centered Care (RCC) is a concept that emphasizes the relationships that underscore all of healthcare delivery. HMA is in the process of developing a tool to assess the ability of primary care to address four critical domains: social supports for patients, longitudinal care team relationships, team-based care, and the provider-community connection. The tool is complementary to the primary care transformation efforts spearheaded through HMA's Risk-Ready Primary Care development and will soon be posted on our website.

Contact
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for more information.

HMA

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