Transition to Value Based Care Checklist

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CRITERIA	Development Required	Limited Capabilities	In-Place: Performance Evident
Structural Components			
• Change management capabilities and leadership commitment			
• Operations staff able to interface between user and IT staff			
• Dedicated business analyst(s) with good database and reporting skills			
• Physician leadership commitment including CMO, lead MDs in specialties, and Medical Directors (e.g. Regional)			
• Physician/Board approval and support for transition to value based performance			
• Ability to fund, staff, and train a care management division			
• EMR/EHR system with flexible query fields and the ability to build custom forms			
• Detailed processes related to clinical integration and management			
Population Health Management			
• Ability to attribute populations of patients by payer			
• Quality metrics system for tracking, reporting, reconciling, and managing results			
• Ability to classify patients by clinical episodes (e.g. registries)			
• Reporting system to analyze attributed payer populations by demographics, geography, and assigned providers			
• Ability to model attributed panel to understand risk and health needs of attributed population			
Registration and Allocation of Patients			
• Ability to identify and track patients by insurance class within the PM system			
• Protocols for front office and appointment scheduling for patients in assigned populations			
• Business processes to report patient treatment histories before allocating risk to physicians			
• Readiness to assign patients within the practice management system to distinct care teams or physicians & notify patients of assignment			
• Readiness to manage fluidity of patient panels and provider assignments			
Practice Team Model			
• Ability to team providers with clinical and clerical staffs			
• Establish current care model FTEs and configurations by practice site & compare/correct to benchmark/patient volume projections			
• Ability to normalize, correct and/or justify variances in staffing models within individual practice sites			
• Implement proactive scheduling plans, team huddles, and intra-team communication			
• Define and document best practices for each clinical team member for specific types of visits (e.g. intake, management, documentation, and discharge processes)			

CRITERIA (continued)	Development Required	Limited Capabilities	In-Place: Performance Evident
External Teams Configuration			
• Ability to establish case manager relationships for chronic conditions e.g. diabetes, end stage renal, etc.			
• Contracts/agreements with specialist, pharmacies, community service, and social workers			
• Established protocols and processes for patient referrals			
• Education of staff and providers with respect to referral guidelines			
• Support of transparent communication among providers to address changes in referral patterns and treatment variances			
• Tracking of adherence to referral guidelines at all levels			
Clinical Data Reporting			
• Established definitions and measurements related to key performance metrics and the processes to manage those metrics			
• Requirement of provider adherence to clinical best practices with allowance for variances where appropriate			
• Established system of reports to track adherence to overall metrics and take corrective actions as needed			
Financial Risk Management Program			
• Established system to track & report Medical Service Expense (MSE)			
• Organized system of cost accounting by care episodes			
• Established risk payment receipt and distribution methods			
Patient Education and Satisfaction Program			
• Education and encouragement of patient populations to engage in their healthcare management (e.g. educational handouts)			
• Technology put in place to enable patient communication and feedback (e.g. patient portals)			
• The creation of a patient-centric culture among provider teams at practice sites			
Physician Compensation Model			
• Established committees and board processes to build compensation models			
• Provider compensation aligned with quality measures and incentives			
• The analytic ability to generate compensation models which achieves provider acceptance			
• Ability to organize compensation models by different plans/payers			
• Distribution of compensation results early and often to increase trust and incent provider cooperation			