Accountable Care Organization Accelerated Development Session Pre-Meeting Registration and Planning Tool

Applicants are strongly encouraged to complete and submit this planning tool prior to arrival at the ADLS so as to enable them to take full advantage of the hands-on learning activities that will occur throughout the session. The purpose of the planning tool is (1) to guide the organizers of the conference to ensure the Accelerated Development Learning Session (ADLS) meets the needs of the participants, and (2) to facilitate an understanding of your organization's baseline capacity as it relates to ACO functions.

With the key capacities of a successful ACO in mind, the guidance for the development of this educational tool's content and rating scale was provided by consultation from a panel of provider peers and from a review of related assessment tools.

The information reported in this tool will not be considered by CMS in determining whether to approve or deny a registrant's subsequent application to participate in the Medicare Shared Savings Program or any other CMS initiative. Additionally, this pre-meeting planning tool is not intended to assess an entity's readiness for any particular CMS ACO program. Instead, it is designed to assess readiness to be an ACO generally and not as defined in section 1899 of the Act.

Please complete the following information about your organization and its plans to form an Accountable Care Organization (ACO).

Your name:

Date:

Organization & Address:

Names of the persons completing this assessment with you:

1.

2.

Your phone number:

Your e-mail address:

Please return the completed form by email to acoregister@rti.org or by fax to 312-456-5250
(Attention: ACO Planning Tool).

Directions for Completing this Tool

This planning tool, or self assessment, should be conducted by an internal team of staff who can provide an honest evaluation of how your organization is structured, and where it has strengths that can be leveraged and weaknesses that need to be addressed. Select the rating on the scale (1 to 4) that is closest to the description of your organization.

After completing this tool, the following guidelines will assist in determining your organization's best option for attendance at a CMS-sponsored ADLS:

- If your average score is a "1" or "2" for most domains in this assessment, consider viewing the webcast of ADLS Day 1 only and attending follow-up webinars.

- If your average score is a "2" or "3" for most domains in this assessment, consider sending a two-person team to an ADLS as an opportunity to identify additional resources for ACO development.

- If your average score is a "3" or "4" for most domains in this assessment, your organization may be positioned to most fully take advantage of the ADLS. Consider sending a team of four staff members to ADLS who will be ready to complete a comprehensive ACO implementation plan shortly after the ADLS.

- Note: Registration will be open to all organizations willing to commit the time of 2 executives (1 with clinical responsibility and 1 with financial/management responsibility), but will be on a first-come, first served basis.

For questions about how to complete this ACO planning tool, please contact: acoregister@rti.org

Accountable Care Organization Planning Tool
Draft

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Domain 1: Organizational Goals, Management, and Governance

Competency 1.1: The ACO understands the local health care market, including competition and collaboration between providers, prevalent diseases, attributed populations of patients, local health care cost drivers.

1.1.a. To what extent have you assessed the strengths and weaknesses of your potential ACO in light of your current health care market?

- ☐ 1: Some early, exploratory investigations have taken place among likely ACO partners, but there is no plan in place for a formal market analysis.
- ☐ 2: Likely ACO partners have identified the components of a market analysis, but no data has been collected or analyzed yet.
- ☐ 3: Some market analysis was conducted and reviewed by likely ACO entities, but additional market analysis is planned.
- ☐ 4: Full information about disease prevalence, local health care cost drivers, likely patient attribution models, and competition between providers was assessed before identifying ACO entities.

Competency 1.2: The ACO has conducted an ACO readiness assessment, and identified key weaknesses to be addressed during the ACO formation process.

1.2.a. To what extent has your ACO or likely ACO partners assessed readiness for becoming an ACO, including key weaknesses to address?

- ☐ 1: Our organization(s) have not yet identified a readiness assessment that meets our needs.
- ☐ 2: Our organization(s) are in the process of conducting a readiness assessment that includes a process for identifying key weaknesses in a potential ACO.
- ☐ 3: Our organization(s) have completed a readiness assessment and identified key weaknesses to address during our ACO formation process.
- ☐ 4: Our organization(s) are already operating as an ACO, and there are systems in place to identify and address weaknesses.

Competency 1.3: Multiple stakeholders are involved in goal-setting.

1.3.a. To what extent do your organization(s) involve multiple stakeholders in goal-setting?

- ☐ 1: Organization does not have documented goals or has goals created by upper management alone.
- ☐ 2: Organization has goals for different settings, specialties, or sub-populations that were developed with some input from clinicians practicing in those areas.
- ☐ 3: Organization has goals that were developed with extensive contribution and review by a broad group of clinicians and managers.
- ☐ 4: Organization has goals that were developed with extensive contribution and review by community members, patients, consumers, and other partners, in addition to clinicians and managers.

1.3.b. To what degree do your organization(s)' goals align with the three-part aim of better care for individuals, better health for populations, and lower costs through improvement in care?

- ☐ 1: Organization does not have any documented goals relating to care improvement, population health improvement, or slower growth in costs. May have internal goals primarily focused on organization's financial health.
- ☐ 2: Organization has documented goals related to one (but not all) of the three-part aim: care improvement, population health improvement, or slower growth in costs, but there are few or no metrics or benchmarks associated with those goals.
- ☐ 3: Organization has documented goals related to the three-part aim, with some metrics or benchmarks associated with those goals that are not monitored closely.
- ☐ 4: Organization has documented goals related to the three-part aim, with clear metrics and benchmarks that are monitored and reported on a regular basis.

1.3.c. To what degree are your goals used in plans for improvement?

- ☐ 1: Organization does not have any documented goals relating to care improvement, population health improvement, or slower growth in costs.
- ☐ 2: Organization has documented goals in one or more areas, but with no action plans for improving on those goals.
- ☐ 3: Organization has documented goals in one or more areas, and has some action plan for improving on those goals
- ☐ 4: Organization has documented goals in all areas, and incorporates them into plans for improvement.

Competency 1.4: The ACO has established an organizational structure and relationships for coordinating care across multiple types of providers, sites of care, and payers.

1.4.a. To what extent have your organization(s) chosen an organizational model for becoming an ACO?

- ☐ 1: Some early, exploratory conversations have taken place between potential partners.
- ☐ 2: Potential partners have identified an organizational model, but have not taken formal steps to establish that model.
- ☐ 3: The selected ACO model has been in place for 1 year or less, or continues to encounter problems.
- ☐ 4: The selected ACO model has been in place for 1 year or more, or is high functioning.

1.4.b. Across the continuum of integration, ranging from loosely integrated to highly integrated, where does your organization fall?

- ☐ 1: Physicians are functioning together through an IPA or other structure for financial gain.
- ☐ 2: Primary care practices (PCPs), specialty practices, and hospitals are functioning together for financial gain.
- ☐ 3: Physicians and hospitals are working together through some organizational mechanisms to address all or most opportunities for slowing growth in costs or care improvement.
- ☐ 4: Physicians and hospitals are working jointly with public health and/or social service agencies to improve health outcomes for a very broad patient population in their community.

Competency 1.5: Partnerships and contracting arrangements are in place for coordinating care across providers, sites of care, and payers.

1.5.a. To what extent have the roles of different entities and providers within the ACO been defined?

- ☐ 1: Few initial discussions have taken place to begin to plan these partnerships across primary care physicians, specialists, hospitals, and other facilities.
- ☐ 2: One or more partnerships are set to begin in the near future, or are newly in place.
- ☐ 3: Partnerships are in place, such is an integrated delivery system, but have not yet contemplated an ACO.
- ☐ 4: Partnerships are in place and are already demonstrating improvements in quality and cost-reduction.

Competency 1.6: The ACO has established an effective governance structure and decision-making systems for clinical integration across provider organizations and for interactions with payers.

1.6.a. To what extent have your organization(s) defined a governance model for a potential ACO?

- ☐ 1: There is no single governing body overseeing all ACO stakeholders at this time, and no discussions have taken place yet about how that might look.
- ☐ 2: There is no single governing body overseeing the potential ACO, but some plans have been discussed, with clinical and management positions identified.
- ☐ 3: A single governing body has been established, but has not yet taken on clinical and management responsibilities, such as interaction with payers, setting policies for resource distribution, or establishing clinical guidelines and best practice information.
- ☐ 4: A single governing body has been established, and has taken on clinical and management responsibilities, such as interaction with payers, setting policies for resource distribution, or establishing clinical guidelines and best practice information.

Competency 1.7: The ACO effectively manages change in organizational and clinical processes.

1.7.a. To what extent have your organization(s) addressed issues of organizational culture necessary to meet ACO three-part aims?

- ☐ 1: Have not yet assessed existing provider culture or potential barriers to achieving three-part aims.
- ☐ 2: Have assessed provider culture and practice habits and identified several major barriers to address.
- ☐ 3: Have begun to address several identified aspects of provider culture that could limit the potential for the ACO to achieve its three-part aims.
- ☐ 4: Aspects of provider culture that limited the potential for the ACO to achieve its three-part aims have been addressed and resolved.

1.7.b. To what extent do the individual staff members and providers of your intended ACO know about and agree with the reasons for forming an ACO?

- ☐ 1: Reasons for ACO formation have not yet been established in a formal vision statement or communicated across the organization(s).
- ☐ 2: Organization-wide leadership has agreed upon a common vision for the ACO, but has not yet communicated it.
- ☐ 3: The vision for the ACO is documented and circulated to all levels of leadership.
- ☐ 4: The vision for the ACO is documented and communicated in multiple forums to the entire staff and network of providers.

Competency 1.8: Physicians are actively involved in the ACO Board of Directors and are active in senior management and operational roles in the provider organizations forming the ACO.

1.8.a. To what extent is physician leadership actively involved in management and operational roles?

- ☐ 1: A few physicians have been involved in forming or organizing the ACO, but are mostly busy with their day-to-day practice.
- ☐ 2: Physician group leaders have committed substantial time forming or organizing the ACO, but have not yet defined management, operational, or governance roles.
- ☐ 3: Physician group leaders have defined management, operational, and governance roles, but have not yet taken them on.
- ☐ 4: Physicians are actively involved in the existing ACO governance structure as well as senior management and operational roles.

Domain 2: Improving Care Delivery to Increase Quality and Reduce Costs

Competency 2.1: The ACO has primary care providers with the capacity to manage populations and coordinate care across all ACO provider organizations.

2.1.a. To what degree has your organization focused on primary care redesign and patient-centered care?

- ☐ 1: No primary care redesign or infrastructure to build care coordination capacity has been developed.
- ☐ 2: Primary care capacity to coordinate care and manage populations is being developed, but not yet showing demonstrable evidence of improved quality, reduced cost and improved patient experience.
- ☐ 3: Primary care capacity to coordinate care and manage populations in place.
- ☐ 4: Ability to coordinate care and manage populations exists across all primary care practices with demonstrable improvement in patient experience, quality, and cost; or, practices have obtained recognition for achieving patient-centered medical home criteria.

Competency 2.2: Delivery of specialty care is well coordinated with primary care.

2.2.a. To what degree are primary care and specialty care services integrated?

- ☐ 1: Communication between primary and specialty care is on an ad hoc basis, via fax or telephone.
- ☐ 2: Communication between primary and specialty care includes some mechanism for structure hand-offs and two-way communication.
- ☐ 3: Communication between primary and specialty care occurs mostly via connected Electronic Health Records (EHR) and electronic messaging, with structured hand-offs and two-way communication.
- ☐ 4: Primary and specialty care are integrated through connected infrastructure, such as interoperable EHRs or electronic health information exchange, as well as through a shared savings relationship.

2.2.b. To what extent are behavioral health programs integrated into primary or other specialty care?

- ☐ 1: Behavioral health care is separate from other types of health care.
- ☐ 2: Communication between behavioral health care and other types of health care occurs on a case-by-case basis.
- ☐ 3: There is some co-location and coordination across behavioral health care providers and other providers, or plans for similar coordination or integration.
- ☐ 4: Behavioral health programs are completely integrated with primary care.

Competency 2.3: Delivery of care is well coordinated across different settings of care and different provider organizations.

2.3.a. To what degree are your organization(s) prepared to manage care transitions and coordination across settings?

- ☐ 1: There is no formal mechanism in place to track patients as they transfer from one health care setting to another.
- ☐ 2: There are some data systems in place to provide a complete view of the covered care a patient receives, including care provided outside the organization, but there are no mechanisms for acting on that data.
- ☐ 3: There are data systems and clearly assigned responsibilities for following up with patients who have transferred across some settings, such as post-hospital discharge.
- ☐ 4: There are data systems and formal systems in place to assure smooth transitions of care across all practice settings, including hospitals, long-term care, home care, and palliative care, using established mechanisms such as care managers, protocols for medication reconciliation, or assessment and care planning.

2.3.b. To what extent are mechanisms in place to coordinate patients' outpatient care?

- ☐ 1: Patients are expected to make follow-up appointments when they need to at most locations.
- ☐ 2: Patients sometimes receive reminders for follow-up care or visit summaries at some locations.
- ☐ 3: Patients receive reminders and visit summaries. Follow-up visits and/or specialty referrals are schedules at the time of the initial encounter at most locations.
- ☐ 4: All locations have a documented policy for coordinating patients' care across outpatient visits, including providing follow-up reminders, visit summaries, and scheduling referral visits.

Competency 2.4: A systematic approach is in place for identifying patients at high risk for poor quality and high cost outcomes, such as those with multiple chronic diseases. Specialized care management is actively applied for high risk patients.

2.4.a. To what extent do your organization(s) have the ability to identify individual patients at risk for poor quality and high cost outcomes?

- ☐ 1: Little or no data are available about patients' clinical indicators or cost of care or service utilization.
- ☐ 2: High-risk patients are identified by monitoring their clinical indicators, but no information about cost of care or service utilization is available.
- ☐ 3: Some information about patients' risk for poor quality or resource use is available most of the time.
- ☐ 4: The organization uses predictive analytic tools to identify individual patients at high risk for poor quality and high cost outcomes.

2.4.b: To what extent do your organization(s) manage patients with complex chronic diseases or that have been identified as at risk for poor health outcomes or extraordinary resource use?

- ☐ 1: There are few or no services offered to patients with complex chronic diseases.
- ☐ 2: Some elements of the Chronic Care Model, PCMH, or care manager model have been implemented in some locations for some patients.
- ☐ 3: Specific high-risk patients are identified and assigned a care manager that works to improve health outcomes and reduce resource use.
- ☐ 4: Specific high-risk patients are identified, assigned a care manager, and there are demonstrable improvements in their health outcomes and resource use.

Competency 2.5: ACO providers have a population-based care management orientation.

2.5.a. To what extent are quality measures for specific health care conditions identified and monitored on a population basis within your organization(s)?

- ☐ 1: No clinical quality measures have been identified.
- ☐ 2: Some clinical quality measures have been identified and are being monitored.
- ☐ 3: The organization(s) are monitoring clinical quality measures required by an incentive program from a major purchaser.
- ☐ 4: The organization(s) have selected clinical quality measures that align with goals for care improvement and population health improvement.

2.5.b. To what extent are efficiency measures (episode-based resource use linked to quality measures for common conditions) identified and monitored on a population basis within your organization(s?)

- ☐ 1: Information about episode-based resource use is not available on a population basis.
- ☐ 2: Information about episode-based resource use is collected, but not analyzed.
- ☐ 3: Information about episode-based resource use is available, but not linked with quality data.
- ☐ 4: Information about episode-based resource use is linked with quality measure data for the population.

2.5.c. To what extent does your organization have the capability of comparing the performance of providers in the areas of quality and efficiency?

- ☐ 1: No quality and efficiency measures have been defined.
- ☐ 2: No capacity to compare quality and efficiency measures by provider, due to lack of attribution model, lack of information, lack of analytic capability, or some combination.
- ☐ 3: Some quality and efficiency measures are available by provider on an ad hoc basis.
- ☐ 4: Quality and efficiency measures have been defined and are regularly available on a provider-by-provider level.

2.5.d. To what extent does your organization(s) measure patients' satisfaction with their experience of care?

- ☐ 1: No patient satisfaction measures have been identified or collected.
- ☐ 2: Some patient satisfaction measures have been identified and are collected on an ad hoc basis organization-wide.
- ☐ 3: The organization(s) are monitoring patient satisfaction measures on a provider-level basis whenever data are collected.
- ☐ 4: The organization(s) have a regular schedule for collecting patient satisfaction data and monitor measures on a provider-by-provider basis that align with goals for care improvement.

2.5.e. To what extent does your organization(s) validate quality, efficiency, and patient satisfaction measures, ensuring that appropriate risk-adjustment, measurement period, and sample sizes have been applied?

- ☐ 1: No measure validation process is in place.
- ☐ 2: One or more (but not all) of the following are validated on an ad hoc basis by an internal group for some measures: risk-adjustment, measurement period, sample size, or attribution method.
- ☐ 3: Most measures are validated by an outside organization or independent group within our organization(s) on an ad hoc basis.
- ☐ 4: All measures are regularly validated.

Competency 2.6: Adequate capacity is available in the ACO to deliver care, including inpatient, outpatient, post-acute, and behavioral health care.

2.6.a. To what degree are your organization(s)' primary care services equipped to ensure adequate access for patients?

- ☐ 1: The number of primary care providers is insufficient to meet demand, and there is no infrastructure in place to use other licensed practitioners to augment primary care availability.
- ☐ 2: The number of primary care providers may be sufficient, and there is some effort to use other licensed practitioners to augment primary care availability, but on an ad hoc basis.
- ☐ 3: The number of primary care providers is likely sufficient, and appropriate training and education in place to maximize ability of licensed practitioners to augment the practice team.
- ☐ 4: The number of primary care providers is sufficient due to strong practice teams to support primary care physicians.

2.6.b. To what degree are your organization(s)' specialty care services equipped to ensure adequate access for patients?

- ☐ 1: There has been no assessment about whether the number of specialty providers is under or over the number necessary to care efficiently for population being managed.
- ☐ 2: The number of specialty care providers is insufficient or overabundant to meet demand of population being managed, and there are no plans to address this.
- ☐ 3: The number of specialty care providers is likely sufficient based on currently available data.
- ☐ 4: The number of specialty care providers meets the organization's goals for providing highest-value care.

2.6.c. To what degree are your organization(s)' inpatient services equipped to ensure adequate access for patients?

- ☐ 1: There has been no assessment about whether the capacity if inpatient services is under or over the number necessary to efficiently care for population being managed.
- ☐ 2: The inpatient services capacity is insufficient or overabundant to meet demand of population being managed, and there are no plans to address this.
- ☐ 3: The capacity of inpatient services is likely sufficient based on currently available data.
- ☐ 4: The capacity of inpatient services is sufficient, and risk profiles, practice patterns, and other trends are routinely monitored to ensure efficient use of these resources.

Competency 2.7: Linkages have been established with community resources to promote ACO goals.

2.7.a. To what extent do providers within your ACO have relationships with community resources?

- ☐ 1: Providers interact with community-based resources on an ad hoc basis, with extraordinary patient cases.
- ☐ 2: Providers generally give information to patients about community-based resources.
- ☐ 3: Providers within the ACO have begun to participate in planning a health information exchange or are in the early stages of establishing referral relationships with community-based public health programs or local social service organizations.
- ☐ 4: Providers within the ACO have access to community resources in one or more ways: a community health information exchange; give and take referrals to community-based public health prevention programs; or have active relationships with local social service organizations.

Competency 2.8: A systematic approach to care process improvement is applied by all ACO providers.

2.8.a. To what extent are there quality improvement systems in place across the ACO to identify opportunities to improve care processes and increase value, plan and test small-scale interventions, study the impact, and implement change (e.g., using PDSA cycles or other systematic processes)?

- ☐ 1: Individual provider groups or entities in the potential ACO have staff address areas for quality improvement on an ad hoc basis.
- ☐ 2: Some provider groups or entities in the potential ACO regularly monitor performance and conduct PDSA cycles for quality improvement in all areas of their individual practices.
- ☐ 3: Provider groups or entities in the potential ACO regularly monitor performance and have worked jointly on PDSA cycles across settings to address population-wide opportunities for improvement.
- ☐ 4: Provider groups or entities in the potential ACO have demonstrated population-wide improvement based on a systematic approach to care process improvement that includes testing new models of care and new technologies.

2.8.b. To what extent are internal data used in a feedback loop to standardize care processes, continually improve performance, and measure and improve patient safety?

- ☐ 1: Patient data – either quality metrics or ad hoc analyses – are inaccessible or rarely used.
- ☐ 2: Patient data for quality improvement processes are available, but used only by some parts of the organization.
- ☐ 3: Patient data for quality improvement are used by most parts of the organization most of the time.
- ☐ 4: Patient data for quality improvement processes are regularly used in a feedback loop to all parts of the organization.

Competency 2.9: Evidence-based strategies to contain costs while maintaining or improving quality are systematically implemented by all ACO providers.

2.9.a. To what extent are there systems to research and disseminate evidence-based strategies to contain costs while maintaining or improving quality, which have been successful in other places or within the ACO?

- ☐ 1: Individual provider groups or entities in the potential ACO have staff address areas for cost containment on an ad hoc basis.
- ☐ 2: Some provider groups or entities in the potential ACO regularly monitor the latest research on cost containment and apply ideas in areas of their individual practices.
- ☐ 3: Provider groups or entities in the potential ACO regularly identify opportunities for cost containment and have worked jointly on implementing cross-setting evidence-based strategies.
- ☐ 4: Provider groups or entities in the potential ACO have demonstrated population-wide improvement in reducing costs based on a systematic approach to applying evidence-based cost containment strategies that maintain or improve quality.

Competency 2.10: Physicians, nurses, and other ACO providers actively using EHR tools for clinical decision support for evidence-based practice.

2.10.a. To what extent are providers actively using clinical decision support for evidence-based practice?

- ☐ 1: ACO leadership has not reviewed the degree to which evidence-based practice guidelines are used.
- ☐ 2: Some providers in the ACO or likely ACO have some adopted evidence-based practice guidelines on some topics, which may or may not be incorporated into all EHR used by all providers in the ACO.
- ☐ 3: There has been some physician involvement in selecting evidence-based practice guidelines to be incorporated in the EHR(s) used by providers in the ACO.
- ☐ 4: Physicians have bought-into adopted evidence-based practice guidelines, which were then incorporated into the EHR(s) used by providers in the ACO. Appropriate alerts for clinical decision support are turned on and monitored for use.

Competency 2.11: Patient engagement and activation is a focus of all ACO providers.

2.11.a. To what extent do your organization(s) communicate with patients in a manner that engages them as active partners in self-managing their care?

- ☐ 1: Providers or entities within the ACO have not changed any of their practice to enhance communication with patients or patient self-management.
- ☐ 2: Some providers or entities have strategies in place to engage patients for disease self-management, especially those with chronic conditions.
- ☐ 3: For some providers or entities within the ACO, patients have one or two of the following: access to their own health information online; visit summaries after all outpatient encounters; ability to email providers with follow-up questions; educational materials about their diagnosis and conditions; and participation in developing plans for disease self-management.
- ☐ 4: For all providers and entities within the ACO, patients have at least three of the following: access to their own health information online; visit summaries after all outpatient encounters; ability to email providers with follow-up questions; educational materials about their diagnosis and conditions; and participation in developing plans for disease self management.

Competency 2.12: Decision making is shared between patients and providers.

2.12.a. To what extent do the providers in your organization(s) communicate with patients in a manner that engages them to share in decision making regarding their care?

- ☐ 1: Providers within the ACO have not changed any of their practices to share decision making with patients.
- ☐ 2: Some providers in the ACO have strategies in place to share decision making with patients, especially those with chronic conditions.
- ☐ 3: For some providers within the ACO, patients have two or all three of the following: access to their own health information online; ability to email providers with follow-up questions; participation in decision making for developing care plans, and dialog with their primary care and specialty physicians guided by structured shared decision making tools.
- ☐ 4: For most providers within the ACO, patients have at least the following: access to their own health information online; ability to email providers with follow-up questions; and participation in developing care plans, and dialog with their primary care and specialty physicians guided by structured shared decision making tools.

Competency 2.13: Medication reconciliation is commonly practiced by all ACO providers.

2.13.a. To what extent do providers or entities in your potential ACO perform medication reconciliation for every patient?

- ☐ 1: Providers perform medication reconciliation when managing poly-pharmacy for chronically ill patients.
- ☐ 2: Providers perform medication reconciliation for every chronically ill patient and at every care transition.
- ☐ 3: Medication reconciliation is commonly practiced at most entities within the potential ACO, or will be when the ACO is formed.
- ☐ 4: Medication reconciliation is commonly practiced at every provider within the ACO.

Domain 3: Effective Use of Health Information Technology and Data Resources

Competency 3.1: The ACO has a comprehensive strategy for meaningful use of certified EHRs by all providers.

3.1.a. Across all providers in your organization, what is the rate of adoption and use of certified EHRs?

- ☐ 1: Fewer than half of clinical providers have access to an EHR.
- ☐ 2: All clinical providers have access to an EHR, but use of functions like e-prescribing, clinical decision support based on practice guidelines, patient registries, or health information exchange with other providers is sporadic.
- ☐ 3: All clinical providers have access to an EHR, and most use most functions most of the time.
- ☐ 4: All clinical providers use an EHR for all clinical documentation and all functions, and it is the primary source of internal communication for hand-offs and strong care coordination across settings or providers.

3.1.b. To what extent are providers within your organization(s) connected to each other or with other providers in the community via an EHR or health information exchange system?

- ☐ 1: There is sporadic use of EHRs across our organization(s) and in the community, with little interoperability.
- ☐ 2: There are more than one EHR systems across our organization(s) or in the community, but there is little exchange of information among providers in the community..
- ☐ 3: There are more than one EHR systems across our organization(s), and there is some interoperability (health information exchange) for some functions, such as laboratory and radiology reports, or summary records.
- ☐ 4: There is a common EHR or disparate EHR systems across our organization(s) with the ability to exchange health information with other providers in the community to support transitions in care and team based population care management.

Competency 3.2: EHRs provide capability for clinical decision support.

3.2.a. To what extent is clinical decision support incorporated into your organization(s) EHRs?

- ☐ 1: Few clinical providers have access to an EHR, so it is not the main source for clinical decision support.
- ☐ 2: All clinical providers have access to an EHR, but the EHRs have limited clinical decision support functionality, or the clinical decision support functionality is turned off by most providers or entities.
- ☐ 3: There has been some effort to turn on clinical decision support in the EHR used by most providers or entities.
- ☐ 4: The EHR(s) used within the ACO are fully loaded with a broad spectrum of clinical decision support tools, such as alerts and formularies, that are acceptable to all providers.

Competency 3.3: Registry functions are actively used to track the delivery of recommended care to patients.

3.3.a. To what extent are patient registries that aggregate information overtime and across settings used in your organization(s), either within your EHR or separately?

- ☐ 1: Few clinical providers populate or use patient registries.
- ☐ 2: Patient registries have been established in some (but not all) entities within the potential ACO, but are mostly out-of-date or limited to one providers data on a patient.
- ☐ 3: Patient registries are actively maintained by some (but not all) entities within the potential ACO.
- ☐ 4: Patient registries that maintain comprehensive patient and population level information across providers are actively used by all entities within the ACO to send reminders to patients for follow-up care; track whether all patients are receiving recommended care; and plan care for groups of patients.

Competency 3.4: Health IT and information exchange provides effective support for medication reconciliation.

3.4.a. To what extent does your organization(s)' Health IT to support medication reconciliation?

- ☐ 1: Few clinical providers have access to an EHR and electronic medication history, so it is not the main source for medication reconciliation.
- ☐ 2: Most clinical providers have access to an EHR and electronic medication history, but the EHRs have limited ability to support medication reconciliation.
- ☐ 3: There has been some effort to train providers to use the EHR and other electronic sources of medication history for medication reconciliation in some entities within the ACO.
- ☐ 4: All providers within the ACO have an EHR with access to up to date medication lists from treating providers that are widely used for medication reconciliation.

Competency 3.5: ACO providers actively use e-prescribing and related medication management functions in an EHR.

3.5.a. To what extent do providers within your ACO prescribe electronically and manage medications, either using an EHR or separate tool?

- ☐ 1: Few clinical providers actively e-prescribe.
- ☐ 2: E-prescribing and medication management functions are available to all clinical providers within the ACO, but are rarely used.
- ☐ 3: All clinical providers within the ACO send electronic prescriptions most of the time, but make limited use of other medication management functions.
- ☐ 4: All clinical providers within the ACO use an EHR or e-prescribing tool to send electronic prescriptions; check drug-drug and drug-allergy interactions; check formularies; and update active medication lists.

Competency 3.6: EHRs and Health Information Exchange support detailed quality measurement and performance reporting and feedback including the ability to retrieve information about individual provider performance.

3.6.a. To what extent is performance on quality, efficiency, and patient satisfaction measures routinely shared with all providers within your organization(s)?

- ☐ 1: No quality, efficiency, or patient satisfaction measures have been defined or there is little or no capacity to derive, report, and compare measures by provider.
- ☐ 2: Some quality, efficiency, or patient satisfaction measures are available and shared on an ad hoc basis with some providers.
- ☐ 3: Some quality, efficiency, or patient satisfaction measures are obtained from EHRs and/or HIE and shared with some providers on a routine basis. Some providers capture the structured data needed for HIT enabled quality measurement and reporting and can retrieve timely information about their own performance.
- ☐ 4: Quality, efficiency, and patient satisfaction measures are obtained from EHRs and/or HIE and routinely shared with all providers. Most providers capture the structured data needed for HIT enabled quality measurement and reporting and can retrieve timely information about their own performance.

3.6.b. To what extent is your organization(s) willing to publicly report comprehensive performance measures on health-related outcomes, care experience, and overall cost?

- ☐ 1: No measures are publicly reported.
- ☐ 2: Selected health-related, patient satisfaction, or total cost measures are available and shared with the public on an ad hoc basis.
- ☐ 3: Selected health-related, patient satisfaction, or total cost measures are shared with the public on a routine basis.
- ☐ 4: All health-related, patient satisfaction, or total cost measures that are aligned with goals are shared with the public on a routine basis.

Competency 3.7: Clinical and financial data are regularly updated, integrated, and maintained across clinical partners and from multiple sources.

3.7.a. To what extent has your organization conducted a gap analysis of information needed to meet analytic goals?

- ☐ 1: Few or none of the entities in the potential ACO have examined their current data sources or defined their data needs.
- ☐ 2: Some entities in the potential ACO have defined their data needs and identified current data sources, but have not conducted an in-depth gap analysis.
- ☐ 3: Most (but not all) entities in the potential ACO have determined that their current data sources are sufficiently reliable and robust, and have begun a gap analysis to determine what additional data systems or data integration are needed to maintain these sources of data.
- ☐ 4: All entities in the potential ACO have conducted a gap analysis of data sources and data integration needed to meet the ACO's objectives, and have begun to address identified gaps.

Competency 3.8: Information systems are in place to measure care process improvement, quality improvement, and costs of care.

3.8.a. To what degree does your organization have the administrative and clinical capabilities to implement programs aimed at managing health and costs for a population of patients?

- ☐ 1: Few or none of the entities in the potential ACO have data, capabilities or experience in identifying areas for clinical improvement, efficient utilization management, or cost reduction.
- ☐ 2: Some entities in the potential ACO have the administrative and clinical capabilities to used data to identify areas for clinical improvement, efficient utilization management, or cost reduction in their individual organizations or units.
- ☐ 3: Some entities in the potential ACO have experience working together to use data to identify areas for clinical improvement, efficient utilization management, or cost reduction, and have set up ad hoc data analyses to monitor improvements in these areas.
- ☐ 4: All entities in the potential ACO have worked together to analyze areas for clinical improvement, efficient utilization management, and cost reduction, and have incorporated the necessary data and analytic capacity to monitor improvements in these areas.

Competency 3.9: Physicians and other clinical staff have access to actionable, up-to-date, and accurate clinical data at the time of office visits, as needed.

3.9.a. To what extent do EHRs include information designed to help physicians and other staff plan a care visit, such as recent health care utilization information, clinical reminders for recommended care, or health information from other health care providers?

- ☐ 1: Clinical decision support, health care utilization data, or information from other health care providers is not integrated into current EHRs, or EHRs are not in place across the ACO.
- ☐ 2: Some clinical decision support, health care utilization data, or information from other health care providers is incorporated into the EHR, but are difficult for clinicians to access at the point of care.
- ☐ 3: Most providers within the ACO have access to clinical decision support, heath care utilization data, or information from other health care providers, but these data are used sporadically.
- ☐ 4: All providers within the ACO use up-to-date and accurate data on a patient's health care utilization, recommended care, and information from other health care providers in assessing and treating all patients.

Competency 3.10: Financial data systems are sufficient for assessing and managing financial risk, and are integrated with clinical data systems.

3.10.a. To what extent are systems in place to calculate the total cost of care for the population of patients served and by disease type and subpopulations (e.g., reports on actual costs, changing risk profile, high-cost claimants, case mix adjustment)?

- ☐ 1: Few or none of the entities in the potential ACO have experience in looking at actual costs for a population or within specific service categories over time.
- ☐ 2: Some entities in the potential ACO have access to cost information for their population of patients, but have not developed regular reporting mechanisms or benchmarks to monitor costs over time or by sub-population.
- ☐ 3: One or more (but not all) entities in the potential ACO have access to cost information on their combined patient population, and have the capacity to examine 3-month or 6-month rolling averages of cost as compared with benchmarks.
- ☐ 4: All entities involved in the potential ACO have extensive experience comparing ongoing 3-month or 6-month rolling averages of actual costs for various sub-populations as compared with benchmark costs.

Domain 4: Ability to Assume and Manage Financial Risk

Competency 4.1: The ACO has the capacity to identify financial risk options, assess the financial risk of patient populations, and determine critical mass of providers and patients needed to assume financial risk.

4.1.a. To what extent does your organization have systems in place (e.g., analytic capacity; risk assessment models) for risk assessment and risk stratification of patient populations?

- ☐ 1: Few or none of the entities in the potential ACO have access or capacity to examine a population risk profile and/or the retrospective health care costs or utilization of a proposed patient population.
- ☐ 2: Some entities in the potential ACO have access to information about their population's health care cost or utilization, but have not developed a model for analyzing risk for future health care costs.
- ☐ 3: One or more (but not all) entities in the potential ACO have developed a model for analyzing the risk profile and/or predicting health care costs and utilization for their patient population, but it does not cover all anticipated ACO services or patients.
- ☐ 4: The organization has extensive experience refining a risk assessment model and applying it to patient populations for the purposes of risk stratification or planning.

4.1.b. To what extent does the size and scope of your potential ACO have a critical mass of beneficiaries and providers? [Numbers of beneficiaries noted below simply refer to the number that are seen by any of the ACO's providers in a given year, not based on any specific rule for patient attribution]

- ☐ 1: The size and scope of the potential ACO has been estimated by likely partners, but has not yet been verified with data.
- ☐ 2: The size and scope of the potential ACO is 10-100 physicians who have a significant portion of their patient population (20-80%) covered by payers that would participate in the ACO (including a minimum of 5000 Medicare beneficiaries).
- ☐ 3: The potential ACO is a moderate size multi-specialty group, physician hospital organization, and/or integrated delivery network (100-200 providers) who have a significant portion of their patient population (20-80%) covered by payers that would participate in the ACO (including a minimum of 10,000 Medicare beneficiaries).
- ☐ 4: The potential ACO is a large multi-specialty group, physician hospital organization, and/or integrated delivery network (over 200 providers) who have a significant portion of their patient population (20-80%) covered by payers that would participate in the ACO (including a minimum of 15,000 Medicare beneficiaries).

Competency 4.2: Provider contracting methods are established to clarify accountability for patient care and for distributing the financial risk of patient populations.

4.2.a. To what extent are contracting relationships in place that clearly spell out how all entities will be held accountable for patient care?

- ☐ 1: Entities have been identified, but no organizational structure is yet in place to create or enforce contracting mechanisms.
- ☐ 2: Elements of provider contracts have been discussed, such as accountability for cost and quality, but nothing has yet been formalized.
- ☐ 3: Provider contracts with clear lines of authority and accountability have been drafted and/or newly signed.
- ☐ 4: Provider contracts with clear lines of authority and accountability are in place and an organizational structure is in place to enforce those contracts.

4.2.b. To what extent is provider contracting in place that describes a shared savings model (e.g., savings threshold, model of risk)?

- ☐ 1: There is no organizational structure in place to from which to oversee or create contracting mechanisms.
- ☐ 2: Elements of a shared savings model have been discussed among entities that do or will form a partnership for an ACO, but nothing has been finalized.
- ☐ 3: A shared savings model has been drafted and agreed upon by some or all of the entities, but not yet implemented.
- ☐ 4: A shared savings model has been defined and implemented across all entities involved in the potential ACO.

Competency 4.3: Payment methods are established to communicate shared financial risks and rewards to all ACO providers.

4.3.a. To what extent is the payment model for incentives defined (e.g., shared savings to offset revenue reduction, shared savings for cost savings, incentives to investors)?

- ☐ 1: There have been few or no discussions of how the payment model of incentives would be defined across entities in the potential ACO.
- ☐ 2: The payment model for incentives has been discussed among entities that do or will form a partnership for an ACO, but nothing has been finalized.
- ☐ 3: A payment model for incentives has been drafted and agreed upon by some or all of the entities, but not yet implemented.
- ☐ 4: A payment model for incentives has been defined and implemented across all entities involved in the potential ACO.

Competency 4.4: The ACO has the ability to design, implement, distribute, and administer provider performance payment incentives.

4.4.a. To what degree does your organization have a legal structure allowing it to receive and distribute payments across partners in the potential ACO?

- ☐ 1: Multiple legal entities currently form the potential ACO, with no one entity with the experience or capability to receive and distribute payments across partners.
- ☐ 2: Multiple legal entities currently form the potential ACO, with one entity having the experience or capability to manage the financial transactions across partners.
- ☐ 3: The potential ACO is or will be comprised of a single legal entity, but that entity only has minimal experience/capability in managing financial transactions across partners or through the organization.
- ☐ 4: The potential ACO is comprised of a single legal entity, or with significant experience/capability in managing financial transactions throughout the organization.

4.4.b. At what level has your organization experienced allocation of bundled-payments or gain/risk sharing between providers?

- ☐ 1: The potential ACO is not comprised of any entities or provider groups with significant gain-sharing or risk-sharing experience.
- ☐ 2: The potential ACO is comprised of entities or provider groups with some experience in allocating payments or gain/risk sharing (e.g., within a multi-specialty group or within limited service lines at a hospital).
- ☐ 3: The potential ACO is comprised of at least one entity or provider group with extensive experience in allocating payments or in gain/risk sharing.
- ☐ 4: The potential ACO has an organizational lead with extensive experience in allocating bundled payments or gain/risk sharing across both physician groups and hospitals.

Competency 4.5: Partnerships are established with insurers and purchasers to share financial risks.

4.5.a. To what extent are insurers or purchasers aligning their financial risk and rewards with providers?

- ☐ 1: There is no alignment across different payers.
- ☐ 2: Relative compensation for all providers is mostly aligned across payers.
- ☐ 3: Compensation, some incentives, and some risk are in place by most providers to align providers around some (not all) specific goals.
- ☐ 4: All compensation, incentives, and risk are aligned across all payers for all specific goals.

Competency 4.6: The ACO has adequate capital sources and resources to assume financial risk for patient populations.

4.6.a. At what level has your organization participated in gain-sharing or risk-sharing arrangements in the recent 24 months?

- ☐ 1: All or most of the entities in the potential ACO have not had any significant experience in participating in risk-sharing or gain-sharing agreements.
- ☐ 2: Some of the entities in the potential ACO have had gain-sharing experience, but with no downside risk.
- ☐ 3: Most of the entities in the potential ACO have had risk-sharing experience, but for a subset of clinical services.
- ☐ 4: All or most of the entities in the potential ACO have extensive experience in bearing global risk.

4.6.b. To what extent does your organization have adequate capital sources and resources to assume risk?

- ☐ 1: The financial strength of entities in discussion to become an ACO has not been fully discussed.
- ☐ 2: Most of the entities in the potential ACO are over-leveraged (higher debt to equity ratio than recommended).
- ☐ 3: Some (but not all) of the entities in the potential ACO have a debt to equity ratio in line with responsible debt financing.
- ☐ 4: All entities in the potential ACO have a debt to equity ratio in line with responsible debt financing.

4.6.c. To what degree does your organization have sufficient financing capabilities to support ACO implementation?

- ☐ 1: There is no organizational mechanism yet in place to retain earnings, and instead funds (or plans to fund in the short-term) capital expenditures primarily through shareholder contributions or net income.
- ☐ 2: There is no organizational mechanism to retain earnings, and instead funds capital expenditures (or plans to fund capital expenditures) through a combination of shareholder contributions, net income, and debt financing.
- ☐ 3: The organization has the ability to retain earnings, have debt financing, and invest using net income, but has insufficient capacity to fund ACO implementation without the support of a capital-rich partner.
- ☐ 4: The organization has sufficient capacity to fund ACO implementation alone (without outside support).

Competency 4.7: Management and clinical capabilities are in place to understand and manage the costs of patient populations.

4.7.a. To what extent are systems in place to manage the total cost of care for the population of patients served (e.g., reports on actual costs, changing risk profile, high-cost claimants, case mix adjustment)?

- ☐ 1: Few or none of the entities in the potential ACO have experience in looking at actual costs for a population or within specific service categories over time.
- ☐ 2: Some entities in the potential ACO have access to cost information for their population of patients, but have not developed regular reporting mechanisms or benchmarks to monitor costs over time.
- ☐ 3: One or more (but not all) entities in the potential ACO regularly monitor costs and take retrospective action when costs exceed anticipated benchmarks.
- ☐ 4: All entities involved in the potential ACO have extensive experience in anticipating costs based on predictive risk modeling and addressing risks through changes in clinical care as necessary.

4.7.b. To what degree does your organization have the administrative and clinical capabilities to implement programs aimed at managing health and costs for a population of patients?

- ☐ 1: Few or none of the entities in the potential ACO have capabilities or experience in identifying areas for clinical improvement, efficient utilization management, or cost reduction.
- ☐ 2: Some entities in the potential ACO have the administrative and clinical capabilities to identify areas for clinical improvement, efficient utilization management, or cost reduction in their individual organizations or units, but have little experience in designing interventions to address those areas.
- ☐ 3: Some entities in the potential ACO have experience working together to identify areas for clinical improvement, efficient utilization management, or cost reduction, and have implemented one or two initiatives to address one or more of these areas.
- ☐ 4: All entities in the potential ACO have worked together to analyze areas for clinical improvement, efficient utilization management, and cost reduction, and have implemented interventions to address issues in all of these areas.

Competency 4.8: The ACO has adequate internal financial planning and budgeting systems to assess the financial risk of patient populations and to manage financial risk.

4.8.a. To what extent does your organization have systems in place (e.g., analytic capacity; available data on actual claims and patient characteristics) for projecting the budget of a potential ACO?

- ☐ 1: Few or none of the entities in the potential ACO have sufficient historical cost information on the anticipated patient population to build a projected ACO budget, identify areas for improvement, or set benchmarks for future budget years.
- ☐ 2: Some entities in the potential ACO have access to historical cost information, but do not have the analytic capacity to identify costs within specific service categories, ensure that reporting metrics are consistent from year to year, or develop trend estimates.
- ☐ 3: One or more (but not all) entities in the potential ACO have historical cost information and have completed requisite analyses (e.g., cost and utilization trend, service mix) to develop a baseline budget and trends.
- ☐ 4: The organization has extensive experience building a baseline budget, making trend projections, and adjusting for changes in the population risk profile over time.

4.8.b. To what extent has your organization developed a pro forma budget that details expected costs and savings from planned ACO interventions?

- ☐ 1: Few or none of the entities in the potential ACO have experience in developing expected costs and savings of an intervention to improve quality and reduce costs.
- ☐ 2: Some entities in the potential ACO have developed expected costs and savings of an intervention for one or more segments of their patient population.
- ☐ 3: One or more (but not all) entities in the potential ACO have developed a pro forma budget outlining the expected costs and savings of the ACO, based on planned interventions.
- ☐ 4: Most or all of the entities in the potential ACO has experience developing a pro forma budget for one or more interventions, and comparing actual costs and savings to the pro forma budget after the intervention was implemented.

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