NACHC PAYMENT REFORM

READINESS ASSESSMENT TOOL

ABOUT THE NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS

The National Association of Community Health Centers (NACHC) represents Community, Migrant, and Homeless Health Centers as well as Public Housing Health Centers and other Federally Qualified Health Centers. Founded in 1971, NACHC is a nonprofit organization providing advocacy, education, training, and technical assistance to health centers in support of their mission to provide quality health care to underserved populations.

ABOUT JSI

JSI is a health research and consulting organization committed to improving the health of individuals and communities worldwide, with a focus on vulnerable populations. JSI has a deep commitment to improving the capacity of the health-care safety net to deliver cost-effective, high quality care to underserved populations. JSI contributors to this paper include: Elena Thomas Faulkner, MA; Stacey Moody, MSW; Michelle Samplin-Salgado, MPH; and Morgan Anderson, BA.

This publication was supported by Grant/Cooperative Agreement Number U30CS16089 from the Health Resources and Services Administration, Bureau of Primary Health Care (HRSA/BPHC). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of HRSA/BPHC.

INTRODUCTION

Health care reform has elevated the importance of transforming the health delivery system to secure better health outcomes at lower cost. The implementation of the Affordable Care Act has resulted in nearly thirteen million individuals gaining access to insurance through March 2014; eight million through the Health Insurance Marketplace and 4.8 million in Medicaid and CHIP.[1] With increased access to health care, public and private insurers alike are increasingly turning their attention to the cost of health services. The Centers for Medicare and Medicaid Services (CMS), many states, and private insurers have adopted the Institute for Healthcare Improvement's Triple Aim—to improve patient experience (quality of care and satisfaction), improve population health, and reduce per capita costs—as the guiding framework for delivery system transformation and payment reform. Across the nation, public and private sector entities are recognizing payment reform as a pivotal catalyst and support for a transformed health care system,[2] and payment reform initiatives are emerging at an accelerating rate.[3, 4]

Health centers, through their mission, structure, and programmatic focus, have a unique ability to provide high-quality, cost-effective care that engages patients, and thus contributes substantially to the achievement of the Triple Aim. At the same time, payment reform and delivery system transformation efforts have critical implications for health centers' financial performance, sustainability, and their mission of providing high-quality, patient-centered care to underserved populations in an increasingly competitive market. However, not all health centers are currently prepared to effectively engage in payment reform activities. This tool is intended to help health centers assess their current readiness for engagement in payment reform activities, and to identify opportunities for improvement.

OVERVIEW

This Payment Reform Readiness Assessment Tool identifies key competency areas needed for successful health center engagement in the most prevalent and emerging payment reform models. It is designed to help health centers assess their current state of readiness, and to identify areas for improvement. The tool is not specific to one payer type or payment reform model. Rather, it is designed to capture core readiness areas that are needed for participation in a variety of payment reform models in use by both public and private payers. Because the majority of emerging payment reform initiatives are based on the establishment of a coordinated, patient- centered delivery system, the tool incorporates aspects of care coordination and patient centered managed care models. The competency areas and key questions within them were derived from a thorough review of current published and gray literature on payment reform and service delivery models (including existing readiness assessment tools for Accountable Care Organizations (ACOs), Patient-Centered Medical Home and other emerging payment and delivery system models), and JSI's own work with health centers in this arena[5] This assessment should not be used to replace readiness assessments for Patient Centered Medical Home certification or other specific certification/recognition programs, which address the specific requirements of those initiatives in much greater depth.

There are three domains consistently identified in the literature as being important to the success of service delivery redesign and payment reform initiatives. These are:

- **Organizational leadership** to pursue and guide payment reform efforts (including leadership in the development of partnerships);
- **Change management and service delivery transformation** with the ability to make **robust use of data and information** to support payment reform efforts (and related delivery system redesign); and
- **Financial and operational analysis** required for the successful participation in payment reform initatives.

HOW TO USE THIS TOOL

A series of statements are included within each readiness domain in order to help health centers identify their readiness, on a scale of 1-9, in each competency area. A self-assessment of 1-3 indicates little or initial development of competency in the readiness area, 4-6 signals substantial progress and competency, and 7-9 shows maturation and systematization of a competence. The table below describes the readiness levels applied throughout the tool. While the tool provides a description of what each level of readiness may include, individuals should use their own judgment and knowledge to determine where their organization falls within the 3 point scale for each level. For example, an organization that has established a basic level of readiness, staffing and experience, but is struggling to maintain core resources to engage in the activity might rank itself a 4 rather than a 6. Please note that the readiness levels build on one another. That is, an organization that has the basic requirements in place, or is at an advanced stage of readiness is also assumed to have accomplished the readiness described in the prior readiness level(s).

TABLE 1. Readiness Level Descriptions

1 TO **3**	**4** TO **6**	**7** TO **9**
BEGINNING TO DEVELOP READINESS	BASIC REQUIREMENTS IN PLACE	FULLY DEVELOPED OR ADVANCED READINESS
The health center has not yet addressed this area, or is in the beginning stages of development. The health center has no or limited related experience. Required resources (staffing, equipment, technology, etc.) have not been identified, or have been identified but are not yet in place.	Health center has basic level of readiness. Core resources needed to engage in payment reform efforts are in place, including dedicated and trained staff, technology, and other infrastructure. The health center has some experience in the readiness area.	Health center has substantial experience in the readiness area. Resources needed are fully in place, tailored and customized to the needs of the health center. Readiness is spread throughout the organization.

The readiness assessment tool is designed to begin the conversation among health center leadership and staff about successful engagement in payment reform models. We recommend that this tool be completed by multiple members of the health center leadership and management staff, which may include consumer/non-consumer members of the Board of Directors and executive, clinical, and financial leadership (Chief Executive Officer, Chief Operating Officer, Chief Financial Officer, Chief Medical Officer, and Information Technology Director). Following each competency area, there is a table to compile the scores of all respondents. Organizations can use this table to compare the scores assigned by individuals for each competency area. Space is provided to note any commonalities and differences in assessment among respondents which may need to be explored. Respondents may also identify next steps to help the organization improve their readiness level or maintain a high readiness level, as appropirate.

COMPETENCY DOMAIN:
ORGANIZATIONAL LEADERSHIP AND PARTNERSHIP DEVELOPMENT

Organizational leadership, from the Board of Directors (BOD), administrative and clinical staff is critical to successful engagement in payment reform. Leadership must ensure that payment reform efforts are consistent with the organizational mission, that health center operations include resources to support payment reform, and provide support for new relationships with community partners and/or other provider entities. Administrative and clinical leaders must support and sustain staff during payment reform efforts.

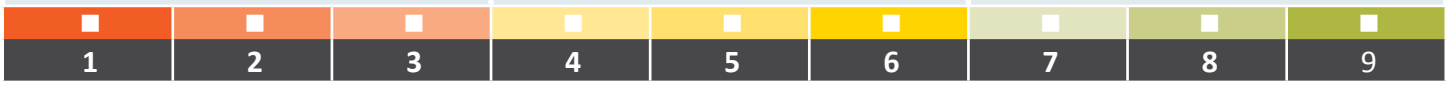
ORGANIZATIONAL LEADERSHIP

1. **The BOD is knowledgeable about payment reform efforts and their implications for the health center's mission and services.**

The BOD regularly receives information/training regarding local and state payment reform initiatives, including how payment reform relates to existing payment models (including health center prospective payment system [PPS] payment).	Payment reform and service delivery transformation are substantive components of BOD strategic planning processes and discussions. The BOD has explored the relationship between payment reform and practice transformation efforts.	The BOD has identified preferred payment reform models, and organizational implications for engaging in them, including assessing desirability of risk-based arrangements. The BOD supports policy efforts (including health center and Primary Care Association (PCA) activities) to shape state-level payment reform.

2. **The health center's governance requirements and structure facilitate governance role in payment reform initiatives.**

The BOD has analyzed requirements for representation in governance structure of payment reform initiative by certain types of providers and/or specific regions.	Bylaws, membership requirements and conflict of interest policies of health center have been reviewed and modified as needed to allow for incorporation of new BOD members if required by payment reform initiative. Health center is active member in PCA or other entities facilitating health center involvement in payment reform initiatives.	Health center is represented (directly or through PCA) in governance and advisory body of payment reform initiatives, including ACOs and Medicaid initiatives. Where the health center is the primary entity behind a multi-entity service delivery effort, the health center BOD serves as the governing body for the effort, incorporating representation from other organizations as appropriate and allowed for in the health center's by-laws.



3. **Administrative and clinical leadership have a shared organizational vision for and commitment to involvement in payment reform.**

Leadership staff have discussed payment reform opportunities, implications for health center, and relationship between payment reform and practice transformation.	Clinical and administrative leadership have established and shared written principles/priorities for engagement in payment reform.	Health center has an operational plan for engaging in payment reform initiatives. Health center has an articulated business case for engagement in payment reform.

1	2	3	4	5	6	7	8	9

4. **Administration and clinical leadership demonstrate commitment to payment reform model being pursued**

Clinical and administrative leaders regularly communicate and demonstrate their support for payment reform (and related practice transformation) initiatives.	Leadership supports dedication of staff time, training and organizational resources to payment reform initiatives. Leadership regularly communicates health center objectives and progress on payment reform initiatives with staff.	Payment reform capacity is institutionalized through job expectations and evaluations, and is systematically included in BOD and staff strategic and operational planning.

1	2	3	4	5	6	7	8	9

5. **The health center examines implications of specific payment reform opportunities in relationship to existing mission, service area, and scope of services.**

The health center regularly identifies and assesses needs of the population in its service area (including overall demographics, insured status, health needs). Health center has analyzed degree to which current services meet identified service area needs.	The health center has identified payment reform opportunities to better address specific needs of population (case management, hospital diversion, etc.). Health center has established criteria for involvement in payment reform that include ability to impact health center mission and focus, including willingness and ability to provide new services and/or serve new populations.	Health center has identified opportunities to meet its mission through involvement in system-level (ACO or MCO) service delivery organizations. The health center has conducted a detailed analysis of service area residents and patients who could be reached/served by specific reform models, and alignment of payment reform model service areas with health center service area.

1	2	3	4	5	6	7	8	9

Notes:

PARTNERSHIP

6. The health center has experience developing partnerships to address service area needs and take advantage of opportunities in the local health care marketplace.

The health center has established informal referral relationships with other service delivery providers. The health center is able to articulate its "competitive advantage" (e.g. the particular strengths and opportunities it brings to partnerships).	The health center has developed formalized partnerships with other service providers to address specific needs of target population. The health center has established and articulated a negotiation /partnership strategy to guide its efforts.	The health center has led partnership development efforts involving multiple partners to develop integrated service delivery approaches for meeting target population needs, and /or leveraging new funding opportunities. The health center is involved in partnerships that focus on developing community-level systems of care, including consolidation of redundant services.

7. The health center partners with local hospitals and specialists to meet the goals of the payment reform models.

The health center has established positive working relationships with hospitals and specialists in the service area. The health center has participated in community needs assessment activities conducted by not for profit hospitals. The health center has a detailed understanding of the motivations and challenges driving hospital and specialty practice partnership efforts and participation in payment reform initiatives.	The health center has participated in shared service delivery models including co-location of services, or other focused collaborations with specific utilization and/or health outcome goals, such as hospital diversion programs or service integration. The health center, hospital and /or specialty groups have together analyzed utilization patterns and service delivery needs of the service area population, and opportunities to address them.	The health center and hospital/specialty groups have developed new product/services to meet target population needs or to take advantage of new payment reform opportunities. The health center has analyzed the cost-effectiveness and outcomes of partnership efforts.

8. **The health center has established relationships with social services and/or other organizations in the community needed to support the payment reform model.**

The health center has an inventory of all organizations serving target area and specific populations (including public health, social service, justice, schools). The health center participates in community coalitions and/or stakeholder groups that extend beyond health care providers.	The health center has analyzed which partnerships are most critical for reaching payment reform goals. Health center staff are leaders of relevant community coalitions and/or stakeholder groups.	The health center has partnerships in place, with rigorous MOU/role definition, to develop new products/services which meet target population needs or take advantage of new payment reform opportunities. The health center has analyzed the cost-effectiveness and health outcomes of partnership efforts.

1	2	3	4	5	6	7	8	9

Notes:

SUMMARY OF RESPONSES:
Organizational Leadership and Partnership Development

Use this table to compile scores from your health center leadership and management staff. Compare the scores and note any commonalities and differences in assessment among respondents which may need to be explored. Indicate any activities and resources to help the health center increase their readiness level or maintain a high readiness level, as appropriate.

QUESTION	RESPONSE 1	RESPONSE 2	RESPONSE 3	RESPONSE 4	RESPONSE 5	AVERAGE
1. The BOD is knowledgeable about payment reform efforts and their implications for the health center's mission and services.						
2. The health center's governance requirements and structure facilitate governance role in payment reform initiatives.						
3. Administrative and clinical leadership have a shared organizational vision for and commitment to involvement in payment reform.						
4. Administration and clinical leadership demonstrate commitment to payment reform model being pursued						
5. The health center examines implications of specific payment reform opportunities in relationship to existing mission, service area, and scope of services.						
6. The health center has experience developing partnerships to address service area needs and take advantage of opportunities in the local health care marketplace.						
7. The health center partners with local hospitals and specialists to meet the goals of the payment reform models.						
8. The health center has established relationships with social services and/or other organizations in the community needed to support the payment reform model.						
TOTAL(S)						

Comments, Questions and Next Steps:

COMPETENCY DOMAIN:
CHANGE MANAGEMENT AND SERVICE DELIVERY TRANSFORMATION

As noted above, payment reform initiatives are not an end unto themselves, but a mechanism for moving toward the Triple Aim of improved patient experience and population health, with reduced total health system costs per capita. Thus, service delivery transformation is an important component of payment reform initiatives, and many emerging payment models are built on an expectation that primary care practices are operating as patient centered medical homes. Change management capacity is not only critical to practice transformation, but also to payment reform implementation, which also requires change processes.

CHANGE MANAGEMENT

9. The health center has experience with and knowledge of change management practices.

The health center has had limited involvement in Human Resources and Services Administration (HRSA)-funded disease collaboratives, Patient Centered Medical Home transformation, achieving Meaningful Use standards, or other clinical practice transformation efforts. Continuous Quality Improvement (CQI) efforts are primarily focused on clinical processes. The health center uses structured CQI methods such as Plan, Do, Study Act (PDSA), lean production, six sigma, and related tools.	The health center has selected and implemented a formal model for CQI in both clinical and non-clinical arenas, engaging staff from all levels of the organization in defining and implementing initiatives. The health center has participated in multiple practice transformation initiatives and has spread successful practices throughout the organization. The health center consistently uses CQI methods such as PSDA, lean production, six sigma and related tools.	The health center has developed an identity as a "learning" or CQI organization. QI measures are regularly shared with team members, leadership and staff. The health center has institutionalized support for change management, such as robust data and information systems and analysis to inform change processes, expectations of leadership staff to lead and support change efforts, and coaching (external or internal) to address implementation barriers.

1	2	3	4	5	6	7	8	9

10. Clinical and administrative leaders support change processes in a systematic fashion.

The health center does not have an organizational approach to supporting change processes. Change and/or clinical practice transformation happen organically, led by department heads.	There is an organizational commitment to build staff capacity for change management through training and mentorship. Leaders have developed strategies to address past negative experience with change. Appropriate organizational resources (staff, technology, etc.) are dedicated to supporting the change process.	Change processes are imbedded in the organizational culture including job descriptions, performance review, and organizational benchmarks/score cards. There is regular communication, at all levels of the organization, regarding the purpose and objectives of change processes, their progress, and outcomes.

1	2	3	4	5	6	7	8	9

Notes:

SERVICE DELIVERY TRANSFORMATION

11. The health center has experience managing care for groups of patients and/or populations with chronic conditions.

The health center identifies high-risk patients informally or through chart review. Health center has implemented a HRSA sponsored or similar disease collaborative at a minimum of one site.	Disease registries are used to categorize subpopulations by clinical priorities. All service delivery sites participate in disease collaboratives. Lessons learned and best practices are shared across the organization. Specific disease conditions are included in CQI efforts on an ongoing basis.	The health center engages in regular and continuous management of patient visits for specific chronic conditions. Model of care includes systematic preventive, follow-up and planned visits for chronic care. Disease registries support automatic prompts and reminders about services.

1	2	3	4	5	6	7	8	9

12. The health center has experience managing high-utilizer/high cost patients.

The health center has not engaged in specific initiatives for high-utilizer/high cost patients. The health center systematically identifies its own patients who are high utilizers of health center and/or system resources.	The health center participates in Managed Care Organization (MCO) or hospital initiatives to address inappropriate utilization and prevent hospital re-admissions or admissions for ambulatory care sensitive conditions.	The health center has contract with ACO or MCO to conduct care management/coordination for its own high-utilizer patients. Health center has contract with ACO/MCO to provide care management/ coordination for high utilizer patients in the service area, beyond its own patients.

1	2	3	4	5	6	7	8	9

13. The health center provides robust care coordination.

The health center focuses primarily on obtaining specialty, behavioral health and hospital care for patients needing follow-up care. Referrals are made and tracked, but there is not a system for determining whether referral is successfully completed.	The health center has robust referral tracking and follow-up system. Care coordination includes motivational interviewing and efforts to address social determinants of health. Health center uses promotoras/community health workers to support care coordination. Health center coordinates care with major specialty and hospital groups. Health center is able to provide and/or receive information about care provided by specialty groups and hospitals.	The health center has systemic process for establishing patient-driven care plan, and ongoing follow-up and patient support for the plan, using motivational interviewing or other techniques. Health center is involved in partnerships to reduce hospital readmissions and to develop systems to coordinate behavioral and physical health care, or otherwise coordinate care across providers. Robust health information exchange allows health center to share information with other health care providers in real time.

1	2	3	4	5	6	7	8	9

14. **The health center is a Patient Centered Medical Home (PCMH)/Patient Centered Health Home (PCHH).**

The health center has not applied for PCMH/PCHH or similar state level recognition. The health center has begun implementing some aspects of patient centered medical home (team-based care, use of decision support tools, etc.).	The health center has implemented all aspects of medical home, and is actively preparing for certification/recognition. Staff receive ongoing training and support in implementing PCMH. The health center has attained recognition status (such as NCQA level one or two) by a national recognition/certification entity for at least one service delivery site.	The health center has achieved recognition status (such as NCQA level one or two) at all service sites. The health center has achieved advanced recognition status (such as NCQA level three) by a national recognition/certification entity at all service sites. PCMH standards are imbedded in organizational and staff expectations and resource allocation.

1	2	3	4	5	6	7	8	9

15. **The health center provides patient-centered care.**

The health center conducts patient satisfaction surveys routinely. The health center uses patient feedback to inform CQI activities. The health center communicates with patients in a culturally appropriate manner and in the client's preferred language.	The health center has a robust system for assessing patient experience (using ongoing feedback mechanisms, focus groups, etc., in addition to satisfaction surveys). Enabling services are an integral component of care delivery, tailored to the needs of the patient.	Patients are fully engaged in care planning and care, and are provided with self-management support. The health center provides an electronic patient portal for access to patient records and scheduling of care.

1	2	3	4	5	6	7	8	9

16. **Behavioral health services are integrated with primary care services.**

The health center has strong referral relationships with behavioral health providers.	Behavioral health services are offered on site with warm hand-off. Behavioral health team members are integrated into care team at some sites, or partially.	Behavioral health services are integrated in care at all sites. Health Center has substantive partnerships/collaborations with behavioral health entities.

1	2	3	4	5	6	7	8	9

17. **The health center provides enhanced access to meet the needs of the target population.**

The health center offers extended weekday evening and weekend hours at a minimum of one service delivery site, and for some services.	The health center has implemented extended hours for all services and at most sites. Scheduling options are patient and family-centered and are accessible to all patients. Health center has implemented open access.	Patients have 24/7 access to care team via phone, email or in-person visits. Health center has collaboration with other providers for readily accessible urgent care (or provides care directly).

1	2	3	4	5	6	7	8	9

18. **The health center has linguistic and cultural competence to meet the target population's needs.**

The health center has assessed linguistic/cultural needs of the population(s) in the service area. The health center makes language translation and interpretation services available to meet the needs of its patient population.	The health center has identified any new cultural/linguistic groups that would be served under a payment reform initiative. The health center regularly conducts staff and provider linguistic/cultural competency training. The health center BOD composition is reflective of the community served.	The health center systematically develops relationships and partners with a variety of community groups. Care team regularly assesses and addresses language and communication barriers in care delivery. Expectations for cultural and linguistic competence are included in staff job descriptions and performance reviews, and in organization performance metrics.

1	2	3	4	5	6	7	8	9

19. **The health center engages in population health assessment and initiatives.**

The health center contributes to community-level population health assessments. The health center participates in community level health related coalitions, and committees. Participating staff are primarily those leading health prevention and promotion efforts or communications staff.	The health center actively participates in partnerships with public health, public schools, and social service providers. Health center staff participation includes senior-level clinical and administration, and includes planning and implementation of efforts.	The health center is the lead entity for community partnerships and coalitions addressing social determinants of health. The health center proactively develops multi-sector partnerships to address health conditions such as asthma, obesity, teen pregnancy, etc., that are strongly impacted by social and environmental factors.

1	2	3	4	5	6	7	8	9

Notes:

SUMMARY OF RESPONSES:
Change Management and Service Delivery Transformation

Use this table to compile scores from your health center leadership and management staff. Compare the scores and note any commonalities and differences in assessment among respondents which may need to be explored. Indicate any activities and resources to help the health center increase their readiness level or maintain a high readiness level, as appropriate.

QUESTION	RESPONSE 1	RESPONSE 2	RESPONSE 3	RESPONSE 4	RESPONSE 5	AVERAGE
9. The health center has experience with and knowledge of change management practices.						
10. Clinical and administrative leaders support change processes in a systematic fashion.						
11. The health center has experience managing care for groups of patients and/or populations with chronic conditions.						
12. The health center has experience managing high-utilizer/high cost patients.						
13. The health center provides robust care coordination.						
14. The health center is a Patient Centered Medical Home(PCMH)/ Patient Centered Health Home (PCHH).						
15. The health center provides patient-centered care.						
16. Behavioral health services are integrated with primary care services.						
17. The health center provides enhanced access to meet the needs of the target population.						
18. The health center has linguistic and cultural competence to meet the target population's needs.						
19. The health center engages in population health assessment and initiatives.						
TOTAL(S)						

Comments, Questions, and Next Steps:

COMPETENCY DOMAIN:
ROBUST USE OF DATA AND INFORMATION

Payment reform efforts are reliant on the availability of accurate and timely data. It is important to understand the appropriate incentive structures, support practice transformation associated with reform, and analyze financial impact of specific payment reform opportunities. Similarly, health centers need timely access to information about their patients' use of services, and about their own costs, in order to participate effectively in payment reform initiatives.

DATA TO INFORM PAYMENT REFORM FOCUS

20. The health center regularly uses data to understand the socio-economic characteristics of population in service area

The health center has aggregate data on the insurance and socio-economic status of its own population. This data is examined infrequently, typically in preparation for Uniform Data System (UDS) reporting.	The health center regularly examines data regarding the insurance and socio-economic status of both its own patients and residents of the service area, including an analysis of trends over time.	The health center has conducted an in-depth analysis of socio-economic needs of populations targeted by specific payment reform efforts.

21. The health center regularly uses data to understand the specific health needs of population in its service area.

The health center has data on the primary health conditions of its own patient population. The health center has analyzed health needs of specific populations (age, gender and race/ethnic groups) within its patient population.	The health center is aware of broader health needs in service area, including behavioral and oral health needs, comorbidities and primary prevention needs (e.g. smoking and obesity rates, etc.)	The health center has a thorough understanding of specific health status and health needs of the population targeted by health reform, based on its own data serving the patient population and information available from other provider groups and/or published literature.

22. The health center uses data to understand its role within the broader health care marketplace, and its market share.

The health center regularly examines its penetration rate for low-income and uninsured populations in its service area. The health center has gathered data on other safety net providers serving the same patient population and their penetration rate.	The health center analyzes penetration into the service area/target population for a specific initiative. Understanding of other providers seen by own patient population: has mapped out specialty and hospital referral patterns.	Knows penetration in service area population, untapped demand within service area for specific services and/or populations; major competitors and how much of market they capture.

23. **The health center has assessed the capacity of its current providers and facilities, and the need for additional staffing or space to support the services to be provided under a specific payment reform model.**

The health center has quantified current capacity and the need for any additional capacity.	The health center has identified specific strategies for maximizing current capacity (using providers to full extent of license; expanding facility hours, etc.), and/or for expanding capacity.	The health center has identified the specific staffing needed for proposed payment reform initiative, including potential impact on current demand, staffing mix or space needs that are different than those historically used.

1 2 3 4 5 6 7 8 9

INFORMATION SYSTEMS

24. **The health center's health information technology (HIT) systems allow for tracking of client and service information needed to inform payment/service delivery models.**

The health center's systems are able to capture unique encounters, services provided, utilization and diagnosis. The system readily produces reports on encounters, utilization and diagnoses in the aggregate.	The health center's systems are able to capture and report on unique encounters, services provided, utilization and health outcomes for specific groups of patients (age, chronic conditions, dual eligibles, high utilizers, etc.).	The health center's systems capture and produce reports on patient social determinants of health, including environmental factors (health habits; mental health; patient perspective and preferences for issues such as involvement in decision making and communication modalities; risk assessments). Health center information systems capture and report on non-traditional "touches" such as email, phone call, group visits for diabetes management and prenatal care, etc. and enabling services.

1 2 3 4 5 6 7 8 9

25. **The health center's electronic health record (EHR) supports clinical practice and care management of client populations.**

The health center has separate health records and practice management systems. The EHR captures visit-level data and diagnosis, but is not integrated with lab, pharmaceutical, or case management data.	The EHR includes patient and provider reminder functionality, e-prescribing, and clinical decision support components. The EHR facilitates reporting on Meaningful Use, UDS, and Medicare Shared Savings Program quality measures.	Health center systems facilitate analysis of both clinical and cost data for specific groups of patients. The health center uses existing data to analyze potential impact of specific initiatives on patient care and access.

1 2 3 4 5 6 7 8 9

26. **The health center has robust Health Information Exchange (HIE) with providers/partners of proposed payment reform effort.**

The health center obtains data on hospitalizations of its patients through a manual process. Data is claims based and not available "real time. "	Payment reform partners exchange data on patient medication, lab results, health status assessment, and behavioral health assessments through manual or request- based processes. The partners have a shared referral tracking and follow-up system. The health center participates in state or regional- level all-payer claims data efforts.	Data is exchanged among partners in real-time using HIE. The health center is able to leverage cost and utilization data available from partners for advanced data analysis and management.

1	2	3	4	5	6	7	8	9

Notes:

SUMMARY OF RESPONSES:
Robust Use of Data and Information

Use this table to compile scores from your health center leadership and management staff. Compare the scores and note any commonalities and differences in assessment among respondents which may need to be explored. Indicate any activities and resources to help the health center increase their readiness level or maintain a high readiness level, as appropriate.

QUESTION	RESPONSE 1	RESPONSE 2	RESPONSE 3	RESPONSE 4	RESPONSE 5	AVERAGE
20. The health center regularly uses data to understand the socio-economic characteristics of population in service area						
21. The health center regularly uses data to understand the specific health needs of population in its service area.						
22. The health center uses data to understand its role within the broader health care marketplace, and its market share.						
23. The health center has assessed the capacity of its current providers and facilities, and the need for additional staffing or space to support the services to be provided under a specific payment reform model.						
24. The health center's health information technology (HIT) systems allow for tracking of client and service information needed to inform payment/service delivery models.						
25. The health center's electronic health record (EHR) supports clinical practice and care management of client populations.						
26. The health center has robust Health Information Exchange (HIE) with providers/partners of proposed payment reform effort.						
TOTAL(S)						

Comments, Questions, and Next Steps:

COMPETENCY DOMAIN:
FINANCIAL AND OPERATIONAL ANALYSIS, MANAGEMENT AND STRATEGY

The above three domains outline the competencies that comprise the core leadership, service delivery and informational infrastructure necessary for successful engagement in any payment reform initiative. In addition to these foundational competencies, health centers must be ready to conduct financial and operational analysis of specific reform opportunities, and to manage the fiscal and operational components of the payment reform model itself.

FINANCIAL AND OPERATIONAL ANALYSIS AND MANAGEMENT

27. **The health center has identified the up-front costs of participation in the proposed payment model.**

The health center has used historical costs to identify up-front costs associated with the payment reform initiative including staffing, space and HIT costs. Cost estimates for service delivery are based on historical health center per-visit costs.	Cost estimates have been adjusted to account for patient population to be served (vis-à-vis average health center patient) and specific health needs and/or utilization patterns they experience.	Health center has developed a per-member-per-month cost for the full scope of services to be offered. Health center has analyzed this cost in comparison to expected reimbursement.

28. **The health center is able to track system-level utilization and cost data for its patients.**

Health center will not have access to data on utilization or costs other than its own experience.	Health center is reliant on partners and/or state agencies to provide data on system costs incurred by health center patients included in the payment reform initiative.	Health center has ready access to both its own and system-level data regarding utilization and costs for patients in the reform effort.

29. **The health center has analyzed how payment timing and methodology for a proposed payment reform model relates to health center revenue cycle management needs.**

Health center has understanding of how payments will be made, and timing of payments, including any incentives, penalties, or wrap payments.	Health center has mapped payment flow and timing against revenue cycle and fiscal year.	Heath center has worked with Insurer or MCO to establish payment cycles that meet its revenue cycle management needs.

30. **The health center has experience and capacity to manage performance-based contracts.**

The health center has experience negotiating and managing fee for service volume-based and managed care contracts.	The health center has experience negotiating and managing pay-for-performance based contract, and/or contracts with upside risk only.	The health center has (in house or contracted) experience negotiating risk-bearing contracts. The health center has analyzed its success under past contracts to inform current contracting strategies.

1	2	3	4	5	6	7	8	9

31. **The health center has secured appropriate legal and compliance expertise for payment reform activities.**

The health center has not independently analyzed legal and/or compliance implications of specific payment reform initiatives. Any analysis has been provided by partners and/or sponsors of payment reform initiatives.	Health center has identified legal/compliance issues related to specific payment reform initiatives, including anti-trust issues, governance requirements, maintenance of PPS payment protections, organizational liability and FTCA issues.	Health center has ensured internal expertise is adequate to address identified issues, or has contracted with external expertise as needed.

1	2	3	4	5	6	7	8	9

FINANCIAL AND OPERATIONAL STRATEGY

32. **The health center has developed a business case for linking reimbursement to utilization and social complexity of health center patients and health center cost structure.**

The health center is able to identify data on its cost, patient utilization rates, and enabling service needs for its overall patient population.	The health center is able to identify data on its cost, patient utilization rates, and enabling service needs of specific group(s) of patients to be involved in payment reform.	The health center has data comparing its patients to the patient population, and is able to demonstrate how its robust services lead to better outcomes/costs. The health center can clearly articulate how enabling services will contribute to achievement of clinical and cost goals of specific payment reform efforts.

1	2	3	4	5	6	7	8	9

33. **The health center has analyzed its ability to engage in risk-based contracts.**

The health center has not conducted an analysis of its ability to bear risk, other than identifying reserves available to cover risk. The health center has limited its interest to up-side risk (sharing in cost savings or profit) only.	The health center has identified the size of its patient population that would be served, and the potential for variation in cost and performance measures. The health center has analyzed its ability to benefit from up-side risk and absorb down-side risk on its own.	The health center has ability to be grouped with additional partners for performance assessment and risk sharing. Health center is able to set aside revenues from existing reimbursement methodologies to prepare for risk-based reimbursement.

1 2 3 4 5 6 7 8 9

34. **The health center has an established strategy for coordination of performance-based incentives and payment reform strategies across payer types.**

The health center has a system for monitoring and tracking various incentive programs in place from each major payer with which it contracts.	The health center actively negotiates, during contract process, pay for performance or other incentive metrics that are consistent with quality and process measures already reported by health centers to HRSA, CMS, or state entities.	The health center is involved (directly or through PCA) in payment reform initiatives to employ quality and cost metrics consistent with reporting requirements under other initiatives or funders.

1 2 3 4 5 6 7 8 9

35. **The health center has analyzed the relationship between payment reform models and health center PPS or alternate payment methodology (APM) payment for Medicaid.**

Health center finance, administrative and clinical staff have a thorough understanding of basis upon which the health center's PPS or APM rate is established, the costs and services it includes, and how it relates to actual average per-visit costs.	The health center has analyzed the degree to which payment reform incentives/ payment mechanisms would result in revenue exceeding existing PPS and APM rates. Health center has experience negotiating state rate setting and/or scope change processes for PPS or APM.	Health center has analyzed the impact of proposed APMs on health center revenue and flexibility of operations. Health centers have analyzed the advantages and disadvantages of receiving FQHC (Federally Qualified Health Center) payment as a capitated per-member-per-month (PMPM) (later reconciled to PPS) as compared with current payment methodologies.

1 2 3 4 5 6 7 8 9

36. **The health center has developed internal payment incentives based on quality and patient outcomes rather than volume.**

Providers paid on salary basis.	Provider and/or team bonuses are offered for meeting productivity or quality process benchmarks.	The full care team receives financial incentives based on quality, patient experience, or appropriate utilization.

1	2	3	4	5	6	7	8	9

37. **The health center is leveraging all the available state and local assistance and funding to support payment reform and service delivery transformation efforts.**

The health center actively tracks grant and other funding opportunities that support service delivery transformation and payment reform initiatives.	Health center has applied for and received local, state, and/or federal funds and/or technical assistance for service delivery transformation (including HRSA PCMHH Initiative). The health center (directly or through the PCA) has kept abreast of State and Federal payment reform opportunities such as CMS State Innovation Model funding and the Medicare Shared Savings Program.	Health center has cultivated relationships with local and regional health care and behavioral health entities that are eligible to apply for payment reform funding. The health center serves as the lead of an ACO for state-level Medicaid ACO initiatives.

1	2	3	4	5	6	7	8	9

Notes:

SUMMARY OF RESPONSES:
Financial and Operational Analysis, Management and Strategy

Use this table to compile scores from your health center leadership and management staff. Compare the scores and note any commonalities and differences in assessment among respondents which may need to be explored. Indicate any activities and resources to help the health center increase their readiness level or maintain a high readiness level, as appropriate.

QUESTION	RESPONSE 1	RESPONSE 2	RESPONSE 3	RESPONSE 4	RESPONSE 5	AVERAGE
27. The health center has identified the up-front costs of participation in the proposed payment model.						
28. The health center is able to track system-level utilization and cost data for its patients.						
29. The health center has analyzed how payment timing and methodology for a proposed payment reform model relates to health center revenue cycle management needs.						
30. The health center has experience and capacity to manage performance-based contracts.						
31. The health center has secured appropriate legal and compliance expertise for payment reform activities.						
32. The health center has developed a business case for linking reimbursement to utilization and social complexity of health center patients and health center cost structure.						
33. The health center has analyzed its ability to engage in risk-based contracts.						
34. The health center has an established strategy for coordination of performance-based incentives and payment reform strategies across payer types.						
35. The health center has analyzed the relationship between payment reform models and health center PPS or alternate payment methodology (APM) payment for Medicaid.						
36. The health center has developed internal payment incentives based on quality and patient outcomes rather than volume.						
37. The health center is leveraging all the available state and local assistance and funding to support payment reform and service delivery transformation efforts.						
TOTAL(S)						

Comments, Questions, and Next Steps:

ENDNOTES

1. Press Release. *Enrollment in the Health Insurance Marketplace totals over 8 million people.* U.S. Department of Health & Human Services. May 1, 2014. http://www.hhs.gov/news/press/2014pres/05/20140501a.html

2. While early innovation in payment methodology and delivery system design were led by the private sector, efforts in the public sector have increased over the past several years. In particular, CMS has undertaken substantive initiatives in both Medicare and Medicaid to support payment reform as a mechanism for transforming the delivery system. These include development of Patient-Centered Medical Homes (PCMHs), and dual eligible demonstration programs. It also includes clarification to states that they can use existing flexibility to better integrate and coordinate care, i.e., through 1115 waivers and Affordable Care Act Section 2703 funding to support new models of care and payment.

3. The growth of Accountable Care Organizations (ACOs) provides a good example. In 2009 the ACO was a new concept, with only a handful being developed in the private sector. Currently there are around 400 ACO initiatives, including ACOs focusing on Medicaid and/or CHP+ programs in 14 states.

4. The Engelberg Center for Health Care Reform & the Dartmouth Institute. (June 2013). Opening Plenary Session of the Fourth National Accountable Care Organization Summit, Washington, DC.

5. Including the NACHC emerging issues document Health Centers and Payment Reform: A Primer released in October of 2013 and available at: http://www.nachc.com/client/Health%20Centers%20and%20Payment%20Reform.pdf

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