NATIONAL ASSOCIATION OF
Community Health Centers

NACHC PAYMENT REFORM

READINESS ASSESSMENT TOOL

ABOUT

THE NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS (NACHC)

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.

JOHN SNOW, INC. (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: Ann Loeffler, MSPH; Jim Maxwell, PhD; Rachel Tobey, MS; and Ilana Webb, BA.

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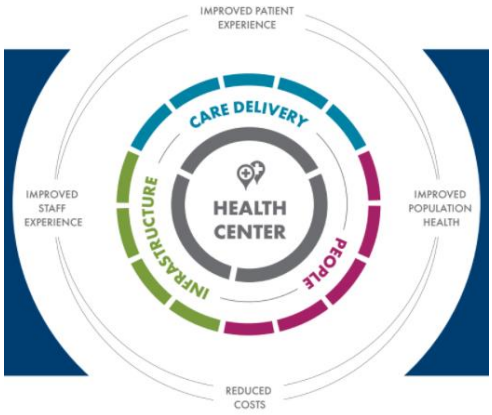
INTRODUCTION

The health care ecosystem is changing rapidly. Providers are interested in addressing the needs of the "whole person" in the context of their communities, and payers are changing from paying providers based on the number of services and tests provided (volume) to patient health outcomes. This shift "from volume to value" is intended to lead to the Quadruple Aim shown in the outer circle of Figure A.

Figure A. NACHC Value Transformation Framework



The shift to value-based care is requiring payers and providers to re-think how they deliver care in the context of the health care ecosystem and how they can thrive under new payment models. This is great news for providers suffering under volume-based, fragmented system that can often hinder "joy in practice" (staff engagement and satisfaction) and limit their abilities to address patient needs.

Community health centers are uniquely positioned to thrive under value-based care models, given their historic roots of addressing the "whole person" and the health of a population. Although primary care currently comprises only about 3% of the total cost of care, primary care providers influence 90% of overall health care costs. Transformation toward value will require the health care system to shift "upstream" to primary and preventive care services, the heart of health center services.

> "In the first years of the health centers, it wasn't rocket science to figure out that medical care alone was insufficient. What has happened now, and that is beginning to happen, is that community health centers and indeed hospitals and other health delivery organizations, are going to have to do this by collaborative efforts with other organizations – with public health agencies, with housing departments, with transportation departments, with county executives – to mount, in collaboration, the same kind of interventions."
>
> *Jack Geiger, We Are Public Health, March 10, 2014*

Despite this core intention to address the preventive and primary care needs of a population, not all health centers are currently prepared to engage in transformation from volume to value. Transformation efforts have critical implications for health centers' financial performance, sustainability, and their missions to provide high-quality, patient-centered care to underserved populations in an increasingly competitive market.

SUMMARY

If you are interested in transforming your services and payment toward value, this assessment may help you:

- Gain a common vocabulary on the various aspects of transformation toward value.
- Reduce anxiety and achieve clarity on what is needed to transform.
- Engage staff who use the assessment in determining where you stand on your capacities and abilities to transform.
- Contribute to your strategic plan as you explore potential strategies to take your organization to the "next level".
- Identify and communicate training and technical assistance needs to your state primary care association, health center controlled networks, and other professional practice networks.
- Connect to resources to move you forward in your journey to thrive in the changing health care ecosystem.

ASSESSMENT OVERVIEW

The preparedness assessment is designed to *begin the conversation* among health center leadership, staff, and key stakeholders/partners about successful engagement in payment reform models.

WHO

Before considering who will complete the assessment, gain clear agreement on *what* the assessment is assessing. For simplicity, the wording of the questions is geared toward assessing individual health centers. However, these questions can also be expanded to assess their broader community's system, a member network such as a Primary Care Association or Independent Practice Network (IPA). In the context of your assessment, we recommend that this assessment be completed by leadership, staff at multiple levels and areas of expertise, and other key stakeholders. Key stakeholders may include consumer/non-consumer members of the Board of Directors, payers, and others who are relevant to transformation goals.

WHEN

Often it is useful to decide ahead of time whether you just want a point-in-time assessment for a particular initiative, or if you intend to use the assessment to establish a baseline and complete it (or parts of it) at regular intervals thereafter to monitor progress. Many health centers have found it useful to complete the assessment as part of their environmental scans supporting strategic planning efforts.

Tips from the Health Center Community

Be inclusive: Get multidisciplinary and diverse perspectives throughout the organization and/or organizational ecosystem. Engage as many levels of staff as possible when completing the assessment, and consider including organizational partners if applicable.
Surface circumstances, not judgements: Use the assessment to see where you are and to develop your vision on where you want to be.
Foster open and creative discussion: Consider working with an objective facilitator or coach who understands health centers and can help respondents discuss and reconcile divergent scores.
Develop an action plan: Use what you learn from the assessment to move toward your vision through a plan with SMARTER (specific, measurable, achievable, realistic, time framed, evaluated, and reviewed) objectives, person responsible, and allocated resources to achieve the objectives.

WHAT

The assessment is organized by competency domain. The domains in this tool align with the Clinical Leadership Development Core Competencies. These are:

- General and Basic Operations
- Systems Orientation
- Cultural Sensitivity
- Interpersonal Communications and Teamwork
- Clinical Management
- Finance and Reimbursement
- Quality Management
- Health Information Technology
- Legal and Ethical Issues
- Advocacy

Each domain includes a series of statements to which respondents indicate, on a scale of 1-9, the most applicable rating in each competency area. A self-assessment of 1-3 indicates little or initial development of competency in the readiness area, 4-6 signals basic progress and competency, and 7-9 shows maturation and systematization of a competency. Table 1 illustrates the readiness levels applied throughout the assessment.

TABLE 1. Readiness Level Descriptions

Health center has not yet addressed this area, or has just begun. Resources are not allocated or were just recently allocated. Experience in this area does not exist or is very limited.	Health center is addressing this area at a basic level. Resources are allocated. Experience in this area is consistent.	Health center is substantially addressing this area. Current and anticipated resources needed are fully in place, tailored and customized to the needs of the health center. Experience in this area is advanced and/or leading edge.
1 TO **3**	**4** TO **6**	**7** TO **9**
LITTLE OR INITIAL DEVELOPMENT	BASIC PROGRESS	MATURATION AND SYSTEMIZATION

HOW

For each domain, when assigning a category of readiness, respondents might also consider to what extent the required resources for transformation are in place, such as:

- **People:** leadership, workforce capacity, culture, patients, and partners
- **Services:** scope, delivery model, workflow, and performance metrics
- **Infrastructure:** equipment, information systems, funding mechanisms, and policies

While the assessment provides a description of what each level of readiness may include, respondents 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 the resources needed to engage in the activity might rank itself a 4 rather than a 6.

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).

Organizations can use the summary table following each competency area to compare the scores assigned by each respondent completing the assessment. Here is where you may note commonalities and differences in assessments for further exploration. Thus begins the conversation on transformation toward value.

A glossary of uncommon terms is provided at the end of this tool for the items underlined throughout.

NOTES ABOUT THE ASSESSMENT

This is a comprehensive assessment to provide a broad perspective across the key domains. Although a comprehensive view is preferable since the domains are interconnected, it may be more practical for respondents to customize the assessment to focus on a particular domain of interest. We encourage you to use the assessment as it best suits your needs.

In some cases, this assessment explores some areas that may be beyond the health center's current sphere of influence. These elements are included to provide the full picture of advanced transformation efforts, and health centers are encouraged to consider what they can and cannot control when creating priorities for action planning.

This assessment is not specific to one service transformation effort, payer type, or payment 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 most value-based efforts are aligned with the Quadruple Aim, the assessment incorporates these aspects of service delivery and payment. 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 assessments for Accountable Care Organizations (ACOs), Patient-Centered Medical Homes and other value-based payment and delivery system model(s), and JSI's own work with health centers in this arena.

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.

For further assistance with this assessment, please contact trainings@nachc.org.

TIPS FOR COMPLETING THE ONLINE ASSESSMENT

When completing the online assessment, these six simple steps will help make your efforts successful:

- Designate a **process lead:** to coordinate with respondents and submit the final response online.
- Organize a **team**: consider the domains and decide who will provide responses to the assessment.
- Complete the paper version **individually**: each respondent begins by reflecting their own perspective.
- Discuss **answers as a team**: set up meetings to share divergent and common views. As you go, be sure to keep a running list of comments including next steps and training/technical assistance needs when they arise.
- Identify **agreed upon answers**: determine which responses best reflect your organization.
- **Submit** your responses online.

ASSESSMENT QUESTIONS

COMPETENCY DOMAIN:
GENERAL AND BASIC OPERATIONS

1. Leadership and staff have a system to ensure that knowledge and expertise needed is sustained for current and future transformation efforts.

Health center relies on key leaders and staff to support transformation efforts based on their individual expertise and knowledge. Change and/or clinical practice transformation happen organically, led by department heads.	Leadership and key staff share a collective understanding of the vision and strategic plan for transforming services and payment. Health center has a written succession plan that will sustain and develop the organizational vision for transformation. The succession plan addresses not only leadership but also key staff managing transformation efforts.	Leadership remains focused on its vision and is not distracted by opportunities that do not align with that vision. Staff involved in transformation efforts can describe and explain organizational succession plans. The organization has documented processes and systems to manage and transfer knowledge related to transformation efforts. Staff responsible for implementing transformation efforts can ask for and receive the resources they need. Accountability mechanisms are in place and are systematically applied to BOD and staff strategic and operational planning.

2. 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 transformation programs, including how service delivery and payment reforms relate to current 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 can describe the relationship between payment reform and practice transformation efforts.	The BOD has prioritized preferred service delivery and payment models. The BOD can describe the organizational implications for engaging in them, including assessing desirability of risk-based arrangements.

3. The health center's governance requirements and structure facilitate any related governance role requirements of value-based initiatives.

Board of Directors (BOD) has analyzed requirements for representation in governance structure of initiatives.	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 the initiative. Health center is active member in PCA or other entities (e.g. Independent Practice Associations) facilitating health center involvement in initiatives.	Health center is represented (directly or through PCA) in governance and advisory body of service transformation and payment reform initiatives, including care integration, 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.

4. Behavioral health services are integrated with primary care services.

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 such as licensed clinical social workers are integrated into care team at some sites. Health center is reimbursed appropriately to cover costs associated with integrated services.	Behavioral health and substance use disorder services are provided through a team-based, multi-disciplinary, and comprehensive approach to patient-centered care. Integrated care teams include licensed behavioral health specialists (e.g. psychiatrists, psychologists, and psychiatric nurses). Integrated care teams share accountability for positive health outcomes, particularly in areas in which close coordination between medical and behavioral health care is required (e.g. schizophrenia). Health center is engaged in efforts to improve reimbursement models supporting integrated behavioral health care and substance use disorder services.

SUMMARY OF RESPONSES: GENERAL AND BASIC OPERATIONS

Use this table to compile scores from each respondent. Compare the scores and note any commonalities and differences in assessment among respondents which may need to be explored. Use your findings as a basis for developing an action plan to increase readiness level or maintain a high readiness level, as appropriate.

QUESTION	RESPONSE 1	RESPONSE 2	RESPONSE 3	RESPONSE 4	RESPONSE 5	AVERAGE
1. Leadership and staff have a system to ensure that knowledge and expertise needed is sustained for current and future transformation efforts.						
2. The BOD is knowledgeable about payment reform efforts and their implications for the health center's mission and services.						
3. The health center's governance requirements and structure facilitate any related governance role requirements of value-based initiatives.						
4. Behavioral health services are integrated with primary care services.						
TOTAL(S)						

Comments, Questions, and Priorities for Action Planning:

COMPETENCY DOMAIN:

B. SYSTEMS ORIENTATION

5. Leadership and staff share an organizational vision and plan to transform in alignment with mission and financial sustainability.

Health center regularly identifies and assesses needs of the population in its service area (including overall demographics, insured status, and health needs). Health center has analyzed degree to which current services meet identified service area needs. Leadership staff have discussed transformation opportunities, implications for the health center, and the relationship between transformation and mission.	The organization has a comprehensive strategic plan, including a shared vision with specific aims and written principles/priorities for engagement in transformation efforts. 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 generate new/additional resources (such as services and revenue. These criteria/principles/priorities are regularly shared and understood throughout all levels of the organization.	Health center vision reflects its role within the context of the delivery and payment system as a whole—recognizing interdependency and collaboration throughout the system.

6. The health center identifies and pursues strategic partnerships to achieve its transformation vision and foster financial sustainability.

Health center has informal relationships with other providers and payers. Health center participates in population-level community health assessments. Health center participates in community level health related coalitions, and committees.	Health center has formal partnerships to address specific needs of target population. Health center has established and articulated a negotiation /partnership strategy to guide its efforts. Health center is able to articulate its "value proposition" to potential and existing partners (e.g. the particular strengths and opportunities it brings to partnerships).	Health center leads partnership development efforts involving multiple partners to develop integrated service delivery and payment approaches. Health center is involved in multi-sectoral partnerships beyond health providers that focus on addressing community-level systems of care and payment. 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.

7. The health center is engaged with key partners (e.g. with local hospitals, specialists, payers) to meet care and payment transformation goals.

Health center is a member of community coalitions and other organizations addressing community-wide efforts addressing public health and health care. Staff participating in coalitions are primarily those leading health prevention and promotion efforts or communications staff.	Health center staff including senior-level clinical and administration help plan and implement efforts in population health assessments and coalitions.	Health center is part of a provider network that has analyzed utilization patterns and service delivery needs of the service area population. Health center has identified opportunities to address service delivery needs. Health center has formal partnerships in place, with rigorous Memoranda of Understanding/role definition to create new products/services in anticipation of target population needs or to take advantage of new payment reform opportunities.

■	■	■	■	■	■	■	■	■
1	2	3	4	5	6	7	8	9

8. Health center partnerships yield tangible benefits for the organization's transformation efforts, their patients, and the population served.

Health center has established positive working relationships with key partners such as hospitals, specialists, social service organizations, employers, law enforcement, and payers in the service area. Health center has a detailed understanding of the motivations and challenges driving partnerships in transformation initiatives.	Partnerships are yielding additional resources to support health center transformation efforts. Health center partnerships have improved quality and outcomes of care through focused collaborations with specific utilization and/or health outcome goals, such as hospital diversion programs, improving care transitions, or enhancing workflows for primary care. 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. Payers support health centers in identifying and addressing preventable high costs within the patient population.	Health center has analyzed and shared the cost-effectiveness and outcomes of partnership efforts. Through timely, actionable, and accurate reports or other mechanisms, payers support health centers in identifying and addressing preventable high costs within the patient population. Health center is a trusted resource working closely with payers and other partners to help shape new payment models supporting the health center's transformation vision.

■	■	■	■	■	■	■	■	■
1	2	3	4	5	6	7	8	9

9. The health center coordinates and manages care throughout the delivery system.

Health center focuses primarily on obtaining specialty, behavioral health, substance use disorders, and hospital care for patients needing follow-up care. Health center has referral relationships with community organizations addressing social determinants of health. Referrals are made and tracked, but there is not a system for determining whether referral is successfully completed.	Health center has established processes for establishing patient-driven care plans and ongoing follow-up and patient support for the plan, using motivational interviewing or other techniques. Health center has referral tracking and follow-up systems and a workforce with the ability to support those systems. Health center uses health coaches/ community health workers to support care coordination among other providers such as specialists and hospitals as well as other sources of support such as organizations addressing social determinants of health.	Health center care teams have the flexibility to coordinate with community services, particularly those addressing social determinants of health. Health center staff has the ability and systems needed to provide patients with a seamless care experience, coordinating health and social services addressing patients' preventive, primary care, oral health, pharmacy, vision, behavioral health and substance use disorder needs. Health center contracts with ACO/managed care organization to provide care management/ coordination for high utilizer patients in the service area, beyond its own patients.

SUMMARY OF RESPONSES: SYSTEMS ORIENTATION

Use this table to compile scores from each respondent. Compare the scores and note any commonalities and differences in assessment among respondents which may need to be explored. Use your findings as a basis for developing an action plan to increase readiness level or maintain a high readiness level, as appropriate.

QUESTION	RESPONSE 1	RESPONSE 2	RESPONSE 3	RESPONSE 4	RESPONSE 5	AVERAGE
5. Leadership and staff share an organizational vision and plan to transform in alignment with mission and financial sustainability.						
6. The health center identifies and pursues strategic partnerships to achieve its transformation vision and foster financial sustainability.						
7. The health center is engaged with key partners (e.g. with local hospitals, specialists, payers) to meet care and payment transformation goals.						
8. Health center partnerships yield tangible benefits for the organization's transformation efforts, their patients, and the population served.						
9. The health center coordinates and manages care throughout the delivery system.						
TOTAL(S)						

Comments, Questions, and Priorities for Action Planning:

COMPETENCY DOMAIN:

C. CULTURAL COMPETENCY

10. The health center provides patient-centered care.

Health center staff regularly receives training on cultural humility. Health center asks patients about their preferred language, pronouns, and modalities for communication.	Staff uses evidence-based techniques such as motivational interviewing to understand patient needs. Health center communicates with patients in a culturally appropriate manner and in the client's preferred language, pronouns, and modalities.	Health centers use every "touchpoint" with patients and the community to strengthen their relationships with current and future patients and their families. Through shared decision-making, patients are co-creators of their care plans and are provided with self-management support. Health center staff is recruited directly from the community served. Cultural humility is an established and recognized core value of the health center.

1	2	3	4	5	6	7	8	9

SUMMARY OF RESPONSES: CULTURAL COMPETENCY

Use this table to compile scores from each respondent. Compare the scores and note any commonalities and differences in assessment among respondents which may need to be explored. Use your findings as a basis for developing an action plan to increase readiness level or maintain a high readiness level, as appropriate.

QUESTION	RESPONSE 1	RESPONSE 2	RESPONSE 3	RESPONSE 4	RESPONSE 5	AVERAGE
10. The health center provides patient-centered care.						
TOTAL(S)						

Comments, Questions, and Priorities for Action Planning:

COMPETENCY DOMAIN:

D. INTERPERSONAL COMMUNICATIONS AND TEAMWORK

11. The organization appropriately and adaptively communicates and manages change to sustain current and future transformation efforts.

Health center relies on key leaders and staff to decide on and support transformation efforts based on their individual expertise and knowledge. Change and/or clinical practice transformation happen organically, led by department heads.	Health center includes staff from multiple levels and disciplines when shaping a change initiative. The organization dedicates resources needed to build staff capacity for change management through training, coaching, and mentorship. Appropriate organizational resources (staff, technology, etc.) are dedicated to supporting the change process. Leaders have developed strategies to address past negative experience with change.	Staff can articulate the overarching vision for transformation and how a particular change initiative fits within the vision. Reflection and continuous learning are institutionalized within the organization and beyond. Change management processes are embedded in the organizational culture including job descriptions, performance review, and organizational benchmarks/score cards.

■	■	■	■	■	■	■	■	■
1	2	3	4	5	6	7	8	9

SUMMARY OF RESPONSES: INTERPERSONAL COMMUNICATIONS AND TEAMWORK

Use this table to compile scores from each respondent. Compare the scores and note any commonalities and differences in assessment among respondents which may need to be explored. Use your findings as a basis for developing an action plan to increase readiness level or maintain a high readiness level, as appropriate.

QUESTION	RESPONSE 1	RESPONSE 2	RESPONSE 3	RESPONSE 4	RESPONSE 5	AVERAGE
11. The organization appropriately and adaptively communicates and manages change to sustain current and future transformation efforts.						
TOTAL(S)						

Comments, Questions and Priorities for Action Planning:

COMPETENCY DOMAIN:

E. CLINICAL MANAGEMENT

12. The health center has systems to support timely access to care.

Health center offers some extended hours, including evenings and weekends.	Health center scheduling practices and operating hours are patient- and family-centered, including open/same-day/next-day scheduling as well as extended hours, as needed. Health center tracks and monitors indicators of patient experience and engagement. Health center provides a secure, electronic patient portal in appropriate languages for patients to access their records and schedule care.	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). Health center engages with patients by using a variety of modalities (e.g. non-face to face visits such as telehealth, e-mail, text-message, and phone; as well as face-to-face visits to hospitals, specialty centers, homes, and/or places of employment), that ensure high quality and patient satisfaction. Patients use the health center electronic patient portal for access to patient records, scheduling of care, visit summaries, interactions with care teams, and access to educational materials.

1	2	3	4	5	6	7	8	9

13. The health center uses formal, prospective empanelment.

Health center does not use patient empanelment (assigning patients to a specific provider or care team). Health center uses empanelment, but these assignments are not routinely analyzed for quality improvement (QI) or other purposes.	Health center prospectively and formally empanels patients to specific providers or care teams, and these assignments are routinely used for scheduling purposes. Empanelment is not by patient choice but may reflect their utilization history/patterns/care needs.	Patient choice is the initial method used to empanel patients. Panel assignments are routinely used for scheduling purposes and to monitor continuity of care.

1	2	3	4	5	6	7	8	9

SUMMARY OF RESPONSES: CLINICAL MANAGEMENT

Use this table to compile scores from each respondent. Compare the scores and note any commonalities and differences in assessment among respondents which may need to be explored. Use your findings as a basis for developing an action plan to increase readiness level or maintain a high readiness level, as appropriate.

QUESTION	RESPONSE 1	RESPONSE 2	RESPONSE 3	RESPONSE 4	RESPONSE 5	AVERAGE
12. The health center has systems to support timely access to care.						
13. The health center uses formal, prospective empanelment.						
TOTAL(S)						

Comments, Questions and Priorities for Action Planning:

COMPETENCY DOMAIN:

F. FINANCE AND REIMBURSEMENT

14. The health center has a solid understanding of its current financial performance under its existing service delivery and payment models.

Health center reports regularly on financial indicators for monitoring its overall operating margins and financial performance indicators required by UDS.	Health center monitors key performance indicators and their trends including but not limited to days cash on hand, days in accounts receivable, net collection rates, net income, payer mix, and utilization rates.	Health center compares its key performance indicators to relevant state and local benchmarks identify sand implement strategies for improvement. Health center uses key performance indicators to identify and implement strategies for improvement. Health center staff is able to describe health center financial health based on key performance indicators.

1	2	3	4	5	6	7	8	9

15. The health center addresses cost of care for patients with complex needs (e.g. chronic conditions) and utilization patterns.

Health center identifies complex and costly patients informally or through chart review. Health center has implemented a HRSA sponsored or similar disease collaborative at a minimum of one site.	Health center has a system to build organizational capacity to support accurate and specific diagnostic codes needed to characterize patient acuity/illness burden.	Health center has a system to build and account for organizational capacity to support accurate and specific diagnostic codes needed to characterize patient acuity. Health center uses practice management data to determine the most effective interventions that improve outcomes and lower costs for complex patients. Health center draws from external data sources (i.e. from payers, hospitals, specialists, etc.) to assess impact of interventions on cost and quality.

1	2	3	4	5	6	7	8	9

16. The health center addresses up-front costs of participation in care and payment transformation initiatives.

Health center uses historical costs to identify up-front costs associated with the payment reform initiative including staffing, space, and health information technology (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 can quantify return on investments related to care transformation initiatives.	When required, health center has developed per- member-per-month costs for the full scope of services to be offered. Health center has analyzed this cost in comparison to expected reimbursement.

1	2	3	4	5	6	7	8	9

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

Health center uses only internal data to track patient utilization and costs within the health center model.	Health center is reliant on partners and/or state agencies to provide data related to any patient outcomes or performance metrics tied to new payment models. Health center is reliant on partners and/or state agencies to provide data on system costs incurred by health center patients included in new payment models.	Health center care teams readily access both its own and system-level data regarding utilization and cost patterns (e.g. specialty, pharmacy, and hospital) of patients in the reform effort to establish high value referral networks.

1	2	3	4	5	6	7	8	9

18. The health center analyzes how payment timing and methodology for a proposed payment reform model relates to health center operating cash flow.

Health center has understanding of how and when payments will be made, including any incentives, penalties, or wrap payments.	Health center understands the impact of anticipated payment flow and timing on operating cash flow projections.	Heath center has worked with payers to establish payment cycles that enhance the health center's ability to operate successfully in the reform initiative.

1	2	3	4	5	6	7	8	9

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

Health center has experience negotiating and managing fee for service volume-based and managed care contracts.	Health center has experience negotiating and managing pay-for-performance based contracts, and/or contracts with upside risk only.	Health center has (in house or contracted) experience negotiating downside risk-bearing contracts including experience analyzing the anticipated financial outcomes of such contracts. Health center is able to utilize its experiences under past contracts to inform current contracting strategies. Health center uses risk adjustment to support higher payments for higher need patients. Health center uses risk-related data to ensure that factors beyond the health center's influence do not result in lower quality scores.

1	2	3	4	5	6	7	8	9

20. The health center leverages value-based payment models to transform care and payment using either internal contracting expertise or expertise through service delivery networks such as IPAs or ACOs.

Health center relies on internal and external expertise to participate in value-based care models. Health center has a system for monitoring and tracking various incentive programs in place from each major payer with which it contracts.	Health center is able to discern, prioritize, and negotiate diverse transformation efforts and payment models with different payers and plans, particularly when incentives and durations are misaligned. 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, Centers for Medicare and Medicaid Services, or state entities.	Health center staff is adept at negotiating and implementing a variety of contracts supporting diverse transformation efforts and payment models with different payers and plans, particularly when incentives and durations are misaligned. Health center is involved (directly or through PCA, IPA, and/or ACO) in payment reform initiatives to employ quality and cost metrics consistent with reporting requirements under other existing initiatives or funders.

21. The health center has analyzed its financial capacity to engage in risk-based contracts.

Health center has limited its interest to up-side risk (sharing in cost savings or profit) only. Health center has not conducted an analysis of its ability to bear risk, other than identifying reserves available to cover risk.	Health center creates a financial model to anticipate the effects based on the identified size of its patient population that would be served and the potential for variation in cost and performance measures. Health center has analyzed its ability to benefit from up-side risk and absorb down-side risk on its own.	Health center has ability to be grouped with additional partners for performance assessment and risk sharing. Health center has established a reserve to support payment reform planning and implementation of new models, including risk-based reimbursement.

22. The health center has analyzed the relationship between payment reform models and FQHC PPS or FQHC 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 current payment (e.g. PPS, APM rate) is established, the costs, and services it includes, and how it relates to actual average per-visit costs.	Health center has analyzed the degree to which payment reform incentives/ payment mechanisms would result in revenue exceeding existing PPS and/or APM rates. Health center has experience navigating state rate setting, managed care reconciliation, and/or scope change processes for PPS or APM when applicable.	Health center has analyzed the impact of proposed APMs on health center revenues and operating cash flows.

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23. 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 performance/value.

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

Health center actively tracks grant and other funding opportunities that support service delivery transformation and payment reform initiatives.	Health center participates in local, state, and/or federal initiatives supporting service delivery and/or payment transformation (e.g. State Innovation Models, Transforming Clinical Practice Initiative, Comprehensive Primary Care Plus, etc.)	Health center partners with organizations such as behavioral health and social service organizations to help shape service delivery and payment transformation funding priorities at the state, local, and/or federal level Health center serves as the lead of state- and local-level payment initiatives that support efficiency and quality outcomes.

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SUMMARY OF RESPONSES: FINANCE AND REIMBURSEMENT

Use this table to compile scores from each respondent. Compare the scores and note any commonalities and differences in assessment among respondents which may need to be explored. Use your findings as a basis for developing an action plan to increase readiness level or maintain a high readiness level, as appropriate.

QUESTION	RESPONSE 1	RESPONSE 2	RESPONSE 3	RESPONSE 4	RESPONSE 5	AVERAGE
14. The health center has a solid understanding of its current financial performance under its existing service delivery and payment models.						
15. The health center addresses cost of care for patients with complex needs (e.g. chronic conditions) and utilization patterns.						
16. The health center addresses up-front costs of participation in care and payment transformation initiatives.						
17. The health center is able to track system-level utilization and cost data for its patients.						
18. The health center analyzes how payment timing and methodology for a proposed payment reform model relates to health center operating cash flow.						
19. The health center has experience and capacity to manage performance-based contracts.						
20. The health center leverages value-based payment models to transform care and payment using either internal contracting expertise or expertise through service delivery networks such as IPAs or ACOs.						
21. The health center has analyzed its financial capacity to engage in risk-based contracts.						
22. The health center has analyzed the relationship between payment reform models and FQHC PPS or FQHC alternate payment methodology (APM) payment for Medicaid.						
23. The health center has developed internal payment incentives based on quality and patient outcomes rather than volume.						
24. The health center is leveraging all the available state and local assistance and funding to support service delivery and payment transformation efforts.						
TOTAL(S)						

Comments, Questions and Priorities for Action Planning:

COMPETENCY DOMAIN:

G. QUALITY MANAGEMENT

25. The health center has knowledge and experience with quality improvement.

Health center has had limited involvement in Human Resources and Services Administration (HRSA)-funded disease collaboratives, Patient Centered Medical Home transformation, or other clinical practice transformation efforts. Continuous Quality Improvement (CQI) efforts are primarily focused on clinical processes.	Health center has goals and measurable objectives for quality improvement. Health center has selected and implemented a formal model for CQI (e.g. Plan, Do, Study, Act (PDSA), LEAN, Six Sigma, etc). The CQI model includes both clinical and non-clinical arenas and engages staff from all levels of the organization in defining and implementing initiatives.	Health center has developed an identity as a "learning" or CQI organization. QI measures are regularly shared with team members, leadership, and staff. Health center has institutionalized support for quality improvement, such as robust data and information systems and analysis to inform improvement processes, expectations of leadership staff to lead and support improvement efforts, and coaching (external or internal) to address implementation barriers.

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26. The health center has a clear understanding of its patient population.

Health center routinely assesses and analyzes its target population, as defined by its internal patient population data, payer/provider network attribution/assignment data, or other sources. Health center routinely collects patient input via patient satisfaction surveys conducted and analyzed at regular intervals.	Effective mechanisms are in place to reach out and help patients feel connected to the health center providers and/or other care team members if those relationships do not already exist. Health center has a robust system for assessing patient experience (i.e. patients are meaningful partners in providing feedback via advisory/focus groups, etc.).	Health center has an established feedback loop to incorporate patient input into CQI activities, and this loop is communicated with patients. Health center uses patient experience and engagement metrics such as the Patient Activation Measure and Consumer Assessment of Healthcare Providers and Systems (CAHPS) to improve care.

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27. The health center addresses quality of care for patients with complex needs (e.g. chronic conditions) and utilization patterns.

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. Health center identifies complex patients informally or through chart review.	Health center uses disease registries to categorize subpopulations by clinical priorities. Health center engages in regular and continuous management of patient visits for specific chronic conditions. Disease registries support automatic prompts and reminders about services.	Health center uses formal models including evidence-based practices to improve outcomes of complex patients. Model of care may include a team-based approach to systematic preventive, follow-up, planned, and group visits for chronic care.

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SUMMARY OF RESPONSES: QUALITY MANAGEMENT

Use this table to compile scores from each respondent. Compare the scores and note any commonalities and differences in assessment among respondents which may need to be explored. Use your findings as a basis for developing an action plan to increase readiness level or maintain a high readiness level, as appropriate.

QUESTION	RESPONSE 1	RESPONSE 2	RESPONSE 3	RESPONSE 4	RESPONSE 5	AVERAGE
25. The health center has knowledge and experience with quality improvement.						
26. The health center has a clear understanding of its patient population.						
27. The health center addresses quality of care for patients with complex needs (e.g. chronic conditions) and utilization patterns.						
TOTAL(S)						

Comments, Questions and Priorities for Action Planning:

COMPETENCY DOMAIN:

H. HEALTH INFORMATION TECHNOLOGY

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

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.	Health center has the workforce capacity to regularly examine both internal and external 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.	Health center staff regularly applies socio-economic data regarding the needs of populations targeted by specific payment reform efforts.

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

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

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

Health center regularly examines its penetration rate for its target market segments (i.e. low-income, uninsured). Health center has gathered data on other community providers serving the same patient population and their penetration rates.	Health center analyzes penetration into the service area/target population for a specific initiative. Health center understands the specialty and hospital referral patterns of its current and potential patients.	Health center is able to improve its market penetration in its service area using data. The health center understands its untapped demand within service area for specific services; for populations in the context of major competitors and their market share.

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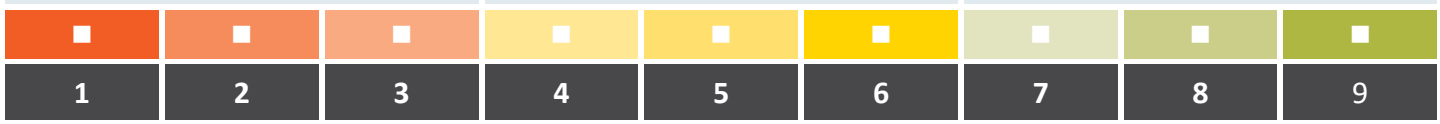
31. The health center uses data to understand its current capacity in terms of workforce and physical plant.

Health center uses practice management and health records data to quantify current capacity and the need for any additional capacity.	Health center applies practice management data to optimize existing capacity (using providers to full extent of license; expanding facility hours, etc.).	Health center uses practice management and health records data from internal and external sources to inform, plan, and engage in transformation efforts. These data may include potential impact on current demand, staffing mix or space needs that are different than those historically used.

32. The health center's health information technology (HIT) systems allow for tracking of client and service information needed to support care and payment transformation.

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 but it is not readily accessible in real-time. Health center is able to produce and submit accurate and timely reports reflecting performance indicators tied to quality or other funding.	Health center's systems are able to capture and report on unique encounters, services provided, utilization and health outcomes for specific groups of patients (e.g. age, lab results, chronic conditions, dual eligibles, high utilizers, etc.). 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 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. Health center information systems capture and report on non-traditional "touches" such as remote monitoring devices/wearables, virtual reality and/or other internet of things (iot) devices. Health center information systems enable care teams to securely exchange real-time tracking and service data such as event notification with delivery system partners (including hospitals, specialists, payers, public health, social services, law enforcement, emergency, and other health-related entities). Health center is able to leverage cost and utilization data available from partners for performance improvement.



33. The health center's health information technology (HIT) systems allow for use of internal and external data to support population health management.

Health center participates in some population-wide, information exchange networks such as those related to IPAs, MCOs, and/or health information exchanges.	Health center uses data exchanged via the information exchange networks to inform service model and payment transformation efforts.	Robust health information exchanges allow the health center to exchange data with other care providers and payers in realtime. Information exchange networks collectively assess aggregate data to address health disparities, support value/return on investment studies and inform other policy, payment, and system-wide transformation efforts to improve population health while reducing the total cost of care.

SUMMARY OF RESPONSES: HEALTH INFORMATION TECHNOLOGY

Use this table to compile scores from each respondent. Compare the scores and note any commonalities and differences in assessment among respondents which may need to be explored. Use your findings as a basis for developing an action plan to increase readiness level or maintain a high readiness level, as appropriate.

QUESTION	RESPONSE 1	RESPONSE 2	RESPONSE 3	RESPONSE 4	RESPONSE 5	AVERAGE
28. The health center regularly uses data to understand the socio-economic characteristics of population in service area						
29. The health center regularly uses data to understand the specific health needs of population in its service area.						
30. The health center uses data to understand its role within the broader health care marketplace and its market share.						
31. The health center uses data to understand its current capacity in terms of workforce and physical plant.						
32. The health center's health information technology (HIT) systems allow for tracking of client and service information needed to support care and payment transformation.						
33. The health center's health information technology (HIT) systems allow for use of internal and external data to support population health management.						
TOTAL(S)						

Comments, Questions and Priorities for Action Planning:

COMPETENCY DOMAIN:

I. LEGAL AND ETHICAL ISSUES

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

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

SUMMARY OF RESPONSES: LEGAL AND ETHICAL ISSUES

Use this table to compile scores from each respondent. Compare the scores and note any commonalities and differences in assessment among respondents which may need to be explored. Use your findings as a basis for developing an action plan to increase readiness level or maintain a high readiness level, as appropriate.

QUESTION	RESPONSE 1	RESPONSE 2	RESPONSE 3	RESPONSE 4	RESPONSE 5	AVERAGE
34. The health center has secured appropriate legal and compliance expertise for payment reform activities.						
TOTAL(S)						

Comments, Questions and Priorities for Action Planning:

COMPETENCY DOMAIN:

J. ADVOCACY (WITHIN LEGAL LIMITS)

35. The Health Center understands the implications of policies that impact efforts regarding value-based payment and care.

Health Center is informally involved in tracking value-based care and payment-related policy through newsletter subscriptions, meetings, and other sources of information	Health Center is aware of policy efforts through formal channels such as PCA membership and formal participation in other organizations.	Health Center has a lead role in helping to shape state-level payment reform through participation in advisory groups, coalitions, and committees related to value-based care and payment. Health Center participates in national- and state-level efforts to gain a broader understanding of value-based care and payment reform efforts. The BOD supports policy efforts (including health center and PCA activities) to shape state-level payment reform.

1	2	3	4	5	6	7	8	9

SUMMARY OF RESPONSES: ADVOCACY (WITHIN LEGAL LIMITS)

Use this table to compile scores from each respondent. Compare the scores and note any commonalities and differences in assessment among respondents which may need to be explored. Use your findings as a basis for developing an action plan to increase readiness level or maintain a high readiness level, as appropriate.

QUESTION	RESPONSE 1	RESPONSE 2	RESPONSE 3	RESPONSE 4	RESPONSE 5	AVERAGE
35. The Health Center understands the implications of policies that impact efforts regarding value-based payment and care.						
TOTAL(S)						

Comments, Questions and Priorities for Action Planning:

GLOSSARY

Accountable Care Organizations (ACOs)
Groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their patients and share the financial risk of providing that care.

Change Management
Leading the process of transitioning from one way of delivering care to a different one.
Plan-Do-Study-Act (PDSA): an iterative, four-stage problem-solving model used for improving a process or carrying out change.

LEAN
An improvement model that focuses on maximizing customer value while minimizing waste.

FQHC Medicaid Prospective Payment System (PPS)
Under PPS, FQHCs receive a set payment for all primary and preventive care services delivered during each patient visit with a specific type of provider.

FQHC APM: Alternative Payment Methodology
Instead of PPS, states may work with health centers to develop a Medicaid Alternative Payment Methodology as long as the payments are not less than they would have been under PPS. FQHC APMs allow for increased flexibility in how a health center delivers care based on the specific needs of the patients and community they serve, including the use of integrated care teams and new visit types.

Health Information Technology (HIT)
A broad category encompassing technology that supports digital health information and systems, such as electronic health records, population health management systems, and health information exchanges.

Health Information Exchange (HIE)
A health information system—usually local or regional—that enables exchange and/or sharing of secure electronic health information among providers and community-based organizations.

Attribution or Assignment Data
These are data describing individuals for whom the health center is designated responsible for by a payer such as a managed care organization. Attributed members are often designated after having a health center visit. Assigned members are often designated in advance and may or may not have had a health center visit and may or may not be included in the health center's patient databases.

Independent Practice Association (IPA)
An association of independent physicians, or other organization that contracts with independent physicians, and provides services to managed care organizations on a negotiated per capita rate, flat retainer fee, or negotiated fee-for-service basis.

Social Determinants of Health (SDOH)
The conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. These might include things like access to safe housing, education, employment opportunities and adequate nutrition.

THANK YOU AND NEXT STEPS

Thank you for completing the assessment! We hope that the assessment enabled you to reflect not only on your current state but also where you would like to go next. Here are some ideas on what to do from here:

- If you are completing the tool individually, share your answers with your process lead and prepare for an interactive discussion on your responses.
- Agree on what responses best reflect your organization, and have your process lead submit your answers online.
- Identify areas in which you would like to improve and develop an action plan.
- Connect to resources such as training and technical assistance from your primary care association and/or health center controlled network to help you develop and implement your action plan.
- Check out these resources compiled by NACHC to support you on your journey.

REFERENCES

American Hospital Association Committee on Research. 2010. "Accountable Care Organizations AHA Research Synthesis Report." http://www.aha.org/research/cor/accountable/index.shtml.

Bachrach, A., D. Seith, and C. Bellrochs. 2011. "Pediatric Medical Homes Laying the Foundation of a Promising Model of Care." *National Center for Children in Poverty.* http://www.nccp.org/publications/pdf/text_1041.pdf.

Buxbaum, J. 2012. "Helping FQHCs Get Off the Treadmill." Web log. *State Reforum Weekly Insight*. Accessed December 17, 2017. https://www.statereforum.org/weekly-insight/helping-fqhcs-get-off-treadmill.

California Primary Care Association. 2017. "CP3 Readiness Assessment Tool for CPCA's Alternative Payment Methodologies Pilot Project."

Corrigan, J., and D. McNeill. 2009. "Building Organizational Capacity: A Cornerstone of Health System Reform." *Health Affairs* 28 (2): 205–15. doi:10.1377/hlthaff.28.2w205.

Edwards, S. T., M. K. Abrams, R. J. Berenson, E. C. Rich, G. E. Rosenthal, M. B. Rosenthal, and B. E. Landon. 2014. "Structuring Payment to Medical Homes After the Affordable Care Act." *Journal of General Internal Medicine* doi:10.1007/s11606-014-2848-3.

Fernald, D. H., N. Deaner, C. O'Neill, B. Jortbert, F. Verloin deGruy, and P. Dickinson. 2011. "Overcoming Early Barriers to PCHM Practice Improvement in Family Medicine Residencies." *Family Medicine* 43 (7): 503–9.

Guterman, S., K. Davis, C. Schoen, and K. Stremikis. 2009. "Reforming Provider Payment: Essential Building Block for Health Reform." *The Commonwealth Fund Commission on a High Performance Health System*. http://www.commonwealthfund.org/publica tions/fund-reports/2009/mar/reforming-provider-payment-essential-building-block-for-health-reform.

Herald, L., R. Weech-Maldonado, and O. E. Asagbra. 2013. "Variations in Patient-Centered Medical Home Capacity: A Linear Growth Curve Analysis." *Medical Care Research and Review* 70 (6): 597–620. doi:10.1177/1077558713498117.

John Snow, Inc. 2016. "What is value-Based payment and why are health centers considering payment reform?" *HITEQ Center*. http://hiteqcenter.org/Resources/Value-Based-Payment/Value-Based-Payment-Basics/ArtMID/1063/ArticleID/229/Introduction-to-Value-Based-Payment-for-Health-Centers.

Ku, L., P. Shin, E. Jones, and B. Bruen. 2011. "Transforming Community Health Centers into Patient-Centered Medical Homes: The Role of Payment Reform." *The Commonwealth Fund*. http://www.commonwealthfund.org/publications/fund-reports/2011/sep/transforming-community-health-centers.

Leavitt Partners. "Accountable Care Learning Collaborative at Western Governors University (n.d.). Master Atlas and Work Area Checklists." Accessed January 10, 2018. https://www.accountablecarelc.org/sites/default/files/Master%20Atlas.pdf.

Leavitt Partners. "Accountable Care Learning Collaborative at Western Governors University. Value Based Readiness Assessment Model." Accessed January 10, 2018. https://www.accountablecarelc.org/sites/default/files/VBRA%20Introduction%20%28One%20Page%29.pdf.

Lee, H., L. Hill, and S. McConville. 2012. “Access to the Health Care Safety Net in California.” *Public Policy Institute of California*. http://www.ppic.org/content/pubs/report/R_1012HLR.pdf.

MacColl Center for Healthcare Innovation, Group Health Cooperative. “Patient Centered Medical Home Assessment.” 2014. *Safety Net Medical Home Initiative*. http://www.safetynetmedicalhome.org/sites/default/files/PCMH-A.pdf.

McClellan, M., and F. Mostashari. 2014. “Adopting Accountable Care: An Implementation Guide for Physician Practices.” *Brookings Institute Engleberg Center*. https://www.brookings.edu/wp-content/uploads/2016/06/ACO-Assessmentkit-Full-Version-Text.pdf.

Mostashari, F., and M. Munger. 2018. “New Models in Primary Care.” *Health Care Transformation Task Force Webinar*, 2018.

National Association of Community Health Centers. “Payment Reform Readiness Assessment Tool.” 2014. http://www.nachc.org/wp-content/uploads/2015/11/NACHC_PR_ReadinessAssessmentTool_Final_CORRECTED_8.5.2014-2.pdf.

National Association of Community Health Centers. “The FQHC Alternative Payment Methodology (APM) Toolkit: Fundamentals of Developing a Capitated FQHC APM.” 2017. http://www.nachc.org/wp-content/uploads/2017/08/NACHC_APMToolkit-1.pdf.

National Association of Community Health Centers. “Value Transformation Framework.” 2017. http://www.nachc.org/wp-content/uploads/2017/09/Value-Transformation-Framework_Steps.pdf.

National Rural Health Resource Center. “Rural Hospital Toolkit for Transitioning to Value-Based Systems.” Accessed December 12, 2017. https://www.ruralcenter.org/srht/rural-hospital-toolkit.

Riley, P., J. Berenson, and C. Dermody. "How the Affordable Care Act Supports a High-Performance Safety Net." The Common Wealth Fund Blog. 2012. http://www.commonwealthfund.org/publications/blog/2012/jan/affordable-care-act-safety-net.

Ryan, J., M. M. Doty, M. K. Abrams, and P. Riley. "The Adoption of Use of Health Information Technology by Community Health Centers, 2009- 2013.” The Commonwealth Fund. 2014. Issues Brief 10. http://www.commonwealthfund.org/publications/issue-briefs/2014/ may/adoption-and-use-of-hit-by-chcs.

Safety Net Clinic Coalition of Santa Cruz County. 2013. “Improving Access, Reducing Disparities in the Era of Health Care Reform.” http://www.hipscc.org/uploads/PDFs/Our_Work/SafetyNetClinicCoalition/SNCC%20Report%20to%20the%20Community%202012.pdf.

Safety Net Medical Home Initiative. "The Change Concepts for Practice Transformation: Overview." 2013. http://www.safetynetmedi calhome.org/sites/default/files/Change-Concepts-Overview.pdf.

Safety Net Medical Home Initiative. 2010. "Paying For the Medical Home: Payment Models to Support Patient-Centered Medical Home Transformation in the Safety Net." http://www.safetynetmedicalhome.org/sites/default/files/Policy-Brief-1.pdf.

Shortell, S. M., and S. Weinberger. "Safety Net Accountable Care Organization (ACO) Readiness Assessment." 2012. http://www.law.berkeley.edu/files/bclbe/Mar6_FINAL_combined.pdf.

The MITRE Corporation. “Accelerating and Aligning Primary Care Payment Models.” 2017. *Health Care Payment Learning and Action Network (HCP-LAN)*. https://hcp-lan.org/workproducts/pm-whitepaper-final.pdf.

The MITRE Corporation. “Alternative Payment Model Framework and Progress Tracking Work Group. APM Framework Final White Paper.” 2016. *Health Care Payment Learning and Action Network (HCP-LAN)*. https://hcp-lan.org/workproducts/apm-whitepaper.pdf.

True, G., A. E. Butler, B. G. Lamparska, L. M. Lempa, A. J. Shea, A. D. Asch, and R. M. Werner. 2012. "Open Access in the Patient-Centered Medical Home: Lessons from the Veterans Health Administration." *Journal of General Internal Medicine* 28 (4):539-45 doi:10.1007/s11606-012- 2279-y.

Witgert, K., and C. Hess. "Issues and Policy Options in Sustaining a Safety Net Infrastructure to Meet the Health Care Needs of Vulnerable Populations." National Academy for State Health Policy. 2012. http://www.nashp.org/sites/default/files/sustaining.SN_.infrastructure.pdf.