Value Transformation Assessment (VTA)
Catholic Charities - Serving Central Washington

	Milestone	0	1	2	3	4	5	6	7	8	9	Score
1	**Practice has met its targets and has sustained improvements in practice-identified metrics for at least one year.**	Practice has identified the metrics it will track that are related to aims and has collected baseline information on these metrics. 0	Practice is monitoring the metrics related to aims but is not yet showing improvement in all metrics. 1	2	3	Practice has shown improvement in metrics related to aims but has not yet reached its targets or improvement is not sustained. 4	5	6	Practice has met at least 75% of its targets and sustained improvements in practice-identified metrics for at least one year. 7	8	9	
	Patient and Family Engagement											
2	**Patient care that is based on (or informed by) best practice evidence for BH/MH and primary care**	...does not exist in a systematic way 0	...depends on each provider's own use of the evidence; some shared evidence-based approaches occur in individual cases 1	2	3	. . .evidence-based guidelines available, but not systematically integrated into care delivery; use of evidence-based treatment depends on preferences of individual providers 4	5	6	...follow evidence-based guidelines for treatment and practices; is supported through provider education and reminders; is applied appropriately and consistently 7	8	9	
3	**Patient/family involvement in care plan**	...does not occur 0	...is passive; clinician or educator directs care with occasional patient/family input 1	2	3	...is sometimes included in decisions about integrated care; decisions about treatment are done collaboratively with some patients/families and their provider(s) 4	5	6	...is an integral part of the system of care; collaboration occurs among patient/family and team members and takes into account family, work or community barriers and resources 7	8	9	
4	**Communication with patients about integrated care**	...does not occur 0	...is passive; clinician or educator directs care with occasional patient/family input 1	2	3	...is sometimes included in decisions about integrated care; decisions about treatment are done collaboratively with some patients/families and their provider(s) 4	5	6	...is an integral part of the system of care; collaboration occurs among patient/family and team members and takes into account family, work or community barriers and resources 7	8	9	
	Team-based Relationships											
5	**Practice sets clear expectations for each team member's functions and responsibilities to optimize flexibility, outcomes and accountability.**	The practice has not established clear roles for each member of the care team or set clear expectations for each tem member's functions and responsibilities to optimize efficiency, outcomes, and accountability. 0	The practice has identified the work required before, during, and after patient visits and identifies the skills and credentials needed to perform that work. 1	2	3	The practice has matched the work that must be done with the team member who will do the work. 4	5	6	The practice has documented each team member's role and accountability lanes and each team member works to the maximum of his skill set and credentials in order to optimize efficiency and outcomes. 7	8	9	
	Population Health Management											
6	**Tracking of vulnerable patient groups that require additional monitoring and intervention**	...does not occur 0	... is passive; clinician may track individual patients based on circumstances 1	2	3	... patient lists exist and individual clinicians/care managers have varying approaches to outreach with no guiding protocols or systematic tracking 4	5	6	... patient lists (registries) with specified criteria and outreach protocols are monitored on a regular basis and outreach is performed consistently with information flowing back to the care team 7	8	9	
	Coordinated Care Delivery											
7	**Continuity of care between primary care and behavioral/mental health**	...does not exist 0	...is not always assured; patients with multiple needs are responsible for their own coordination and follow-up 1	2	3	...is achieved for some patients through the use of a care manager or other strategy for coordinating needed care; perhaps for a pilot group of patients only 4	5	6	...systems are in place to support continuity of care, to assure all patients are screened, assessed for treatment as needed, treatment scheduled, and follow-up maintained 7	8	9	

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8	**Practice works with the primary care practices in its medical neighborhood to develop criteria for referrals for episodic care, co-management, and transfer of care/ return to primary care, processes for care transition, including communication with patients and family.**	Practice has developed its own criteria for appropriate referrals but has not discussed these with the primary care providers in the medical neighborhood. 0	Practice has started to reach out to primary care providers in the medical neighborhood to discuss referral criteria and how transitions should take place. 1 2 3			Practice has collaborated with the primary care practices in its medical neighborhood and has jointly developed criteria for referrals for episodic care, co-management and transfer of care but processes have not yet been implemented 4 5 6			Practice has collaborated with the primary care practices in its medical neighborhood and has jointly developed and implemented criteria for episodic care, co-management, and transfer of care/ return to primary care, processes for care transition, including communication with patients and family. 7 8 9			
9	**Practice identifies the primary care provider or care team of each patient seen and (where there is a primary care provider) communicates to the team about each visit/ encounter.**	Practice does not ask about primary care provider. 0	Practice queries patients about their primary care provider and records this information in the medical record. 1 2 3			Practice identifies the primary care provider of each patient but the communication with the primary care team is not consistent. 4 5 6			Practice has a reliable system in place to identify the primary care provider of each patient and to communicate with the primary care team about each visit or encounter. 7 8 9			
	Enhanced Access											
10	**Practice has a system in place for patient to access their care team 24/7.**	After hours, practice has an answering system with a recorded message. Message may tell patients to go to an ER or leave a message for a call back in the morning. 0	Practice uses a live answering service that takes messages from patients. Clinicians and care team members may call in for messages but timeframes are not standard. The service does not use any triage algorithms. 1 2 3			Practice uses a contract clinician or nurse triage service that provides algorithm-driven advice to patients after hours but the service or clinician does have any access to the patient's records. 4 5 6			Practice has a clinician available from the practice or on a contract basis who can speak to patients after hours while being able to access the patient's record. 7 8 9			
	Engaged and Committed Leadership											
11	**Practice has developed a vision and plan for transformation that includes specific clinical outcomes and utilization aims that are aligned with national TCPI aims and that are shared broadly with the practice.**	Practice has not yet begun developing its transformation vision and detailed plan. 0	Practice is beginning to develop a vision and plan that addresses goals of transformation but aims are not yet set. 1 2 3			Practice has developed a plan that addresses goals of transformation with specific aims but has not yet detailed how the aims will be addressed. 4 5 6			Practice has developed and shared a vision and detailed plan that addresses goals of transformation with specific clinical outcomes and utilization aims along with the detail on how each of the aims will be addressed. 7 8 9			
	Quality Improvement Strategy											
12	**Practice uses an organized approach (e.g. use of PDSAs, Model for Improvement, Lean, FMEA, Six Sigma) to identify and act on improvement opportunities.**	The practice does not incorporate standard improvement methodology to execute change ideas in the practice setting. 0	The practice has decided on a standard QI methodology and is planning the implementation process. 1 2 3			The practice is beginning to incorporate regular improvement methodology to execute change ideas in the practice setting but the methodology has not yet been implemented in all areas of the practice. 4 5 6			The practice fully incorporates regular improvement methodology to execute change ideas in the practice setting. 7 8 9			
13	**Practice builds QI capability in the practice and empowers staff to innovate and improve.**	Practice recognizes the need for QI capacity and has developed or identified training programs for staff in QI skills and tools. 0	A limited number of practice staff/providers have QI skills and are involved in the practice's QI initiatives. 1 2 3			Practice is building QI capability within the practice through approaches such as including QI skills in orientation for all new staff and ensures that all staff participate in QI training. 4 5 6			Practice has developed QI capability within the practice and empowers staff/ providers to participate in QI activities by allocating time for QI activities, including QI within defined job duties, recognizing and rewarding innovation and improvement. 7 8 9			

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	Transparent Measurement and Monitoring											
14	**Practice regularly produces and shares reports on performance at both the organization and provider/care team levels, including progress over time and how performance compares to goals. Practice has a system in place to assure follow up action where appropriate.**	Practice does not produce reports on how providers and/or care teams are meeting quality goals. 0	Practice produces some reports on organizational or provider/ care team performance and how they are meeting quality goals but the reports are not shared in a fully transparent manner. 1 2 3			Practice is regularly producing reports on how providers and/or care teams are performing or meeting quality goals but distribution of the reports is limited or there is inconsistent follow up on the reports. 4 5 6			Practice regularly produces reports on how providers and/or care teams are performing and meeting quality goals, transparently shares them within the organization, and has an effective system for follow up. 7 8 9			
	Optimal Use of HIT											
15	**Data systems/patient records**	...are based on paper records only; separate records used by each provider 0	...are shared among providers on an ad hoc basis; multiple records exist for each patient; no aggregate data used to identify trends or gaps 1 2 3			...use a data system (paper or EMR) shared among the patient care team, who all have access to the shared medical record, treatment plan and lab/test results; team uses aggregated data to identify trends and launches QI projects to achieve measurable goals 4 5 6			...has a full EMR accessible to all providers; team uses a registry or EMR to routinely track key indicators of patient outcomes and integration outcomes; indicators reported regularly to management; team uses data to support a continuous QI process 7 8 9			
	Staff Vitality and Joy in Work											
16	**Practice has effective strategies in place to cultivate joy in work and can document results.**	Practice has no proactive strategies aimed at creating joy in work. 0	Practice has developed strategies to improve the experience of staff and create joy in work but implementation of these initiatives is limited. 1 2 3			Practice has strategies in place to promote joy in work (e.g. reward and recognition programs, staff development, social activities) but has no mechanism for determining whether the programs initiated are successful. 4 5 6			Practice has implemented strategies to support joy in work and can demonstrate the results through metrics such as staff survey results, high retention rates, or low turnover rates. 7 8 9			
	Capability to Analyze and Document Value											
17	**Practice shares its financial data in a transparent manner within the practice and has developed the business capabilities to use business practices and tools to analyze and document the value the organization brings to various types of alternative payment models.**	Practice, or the larger system in which it may belong, has not developed business acumen in the various types of alternative payment models. Financial skills development is limited to financial staff. 0	Practice has identified resources for educating staff at all levels in principles of business management, commensurate with their roles in contracting and analysis of alternative payment arrangements that a practice might consider. 1 2 3			Practice is providing education and practice data on business metrics to staff at all levels across the organization. Specialized training is being provided to those at the practice level that may be involved in analysis of alternative payment arrangements and in contracting for services. 4 5 6			Practice share financial data in a transparent manner within the practice and has developed the business capabilities to use business practices and tools to analyze and document the value the organization brings to various types of alternative payment models. 7 8 9			
18	**Practice considers itself ready for migrating into an alternative based payment arrangement.**	Practice not yet considering alternative payment approaches. 0	Practice is participating in performance-based incentive programs but is not yet ready for alternative payment approaches. 1 2 3			Practice is developing its internal capabilities to succeed in an alternative payment system and a date has been set for this migration within the TCPI timeframe. 4 5 6			Practice is confident is confident of its readiness for migrating into alternative payment approaches. 7 8 9			

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Efficiency of Operations												
19	**Practice uses a formal approach to understanding its work processes, eliminating waste in the processes, and increasing the value of all processing steps.**	Practice has not started working on systematically streamlining its processes. 0	Practice has identified processes that it intends to study and streamline but the improvement work has not yet begun. 1	2	3	Practice has worked to streamline a number of its work flows by reviewing the steps and eliminating waste and rework, but the concept of value is not consistently considered during these efforts. 4	5	6	Practice uses an organized approach (e.g.. lean process mapping) to reviewing its processes, eliminating waste in the process, and understanding the value of each process step to the patient and other customers. 7	8	9	
Strategic Use of Practice Revenue												
20	**Funding sources and resources**	...a single grant or funding source; no shared resource streams 0	...separate PC/MH/BH funding streams, but all contribute to costs of integrated care; few resources from participating organizations/agencies 1	2	3	...separate funding streams, but some sharing of on-site expenses, e.g., for some staffing or infrastructure; available billing codes used for new services; agencies contribute some resources to support change to integration, such as in-kind staff or expenses of provider training 4	5	6	...fully integrated funding, with resources shared across providers; maximization of billing for all types of treatment; resources and staffing used flexibly 7	8	9	

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