Value-based Care (VBC) Participation Assessment Tool

Purpose

The American Academy of Family Physicians' (AAFP's) Value-based Care (VBC) Participation Assessment Tool is designed to enable independent family physicians to evaluate their practice's existing capabilities to help them succeed in VBC arrangements. The tool assesses three key capability areas you currently have in-house or access through vendors, partners or enablers.

Key capability areas to assess

- **Strategic:** Your practice's size, finances, experience with value-based contracts and relationships with insurance companies
- **Operational:** Your practice's ability to track patient data, use technology systems, engage with patients and measure the quality of care
- **Governance/organizational:** Your practice's experience with partners, support from leadership, staff capacity to take on new work and process for decision-making

Instructions

- For each question, select the option that best describes your practice's current capabilities. Consider your complete capability ecosystem and count capabilities as "available"—whether they are performed in-house or through current external relationships (e.g., tools, vendors, clinically integrated network/independent physician association [CIN/IPA], enablers/aggregators).
- When assessing areas you work with partners (e.g., CINs, IPAs, enablers), evaluate how effectively these relationships enhance your practice's VBC readiness.
- Use the tool regularly to reassess as your practice, partnerships and the VBC environment evolve.

Tips and tricks

Don't go it alone

The assessment tool includes strategic, operational and governance/organizational areas. No single person likely knows everything about your practice in these areas, so tap into members of your team, potentially forming a quick response work group that could include:

- Physician(s) or clinician lead(s)
- Operations or practice management team member(s)
- IT/data lead(s) (i.e., staff who manage EHR/data reports)
- Billing or finance team member(s)
- CIN/IPA representative(s) (if applicable)

Tap into your EHR and health IT systems

Use EHR-generated reports to discover answers about:

- Patient panel size and risk stratification
- Quality metrics and performance trends
- Data exchange capabilities (e.g., admit/discharge/transfer [ADT] alerts, payer data feeds)

If you're unsure what your EHR can report, ask your EHR vendor or the clinical informatics lead to walk you through the available dashboards.

Request a payer mix and attribution report

Ask your billing team or revenue cycle manager for a breakdown of payers and patient volume. Many payers also provide attribution reports that show:

- Number of attributed lives
- Participation in VBC models
- Quality measure performance
- Risk scores

If you're in a network or IPA, ask if they already have these reports consolidated.

Leverage past performance and previous contracts

If you have or are currently participating in any value-based arrangements, collect information relative to performance in these arrangements to assess financial or quality outcomes. If you haven't formally tracked this, contact your contracting office or any external vendor/enabler you worked with, as they may have archived scorecards.

SECTION 1. STRATEGIC CAPABILITIES

Practice overview

1.1 How many physicians are currently in your practice?

- 1 to 5 physicians
- 6 to 20 physicians
- 21-plus physicians

1.2 To what extent do your practice's goals tie to VBC success metrics (i.e., better quality of care, improved patient experiences and lower costs)?

- Our practice does not have clear practice goals related to VBC.
- Some of our practice's goals are related to VBC, but they are not well communicated throughout the practice.
- Our practice maintains well-defined VBC goals that are understood throughout the practice.

1.3 How would you describe your practice's current financial position related to VBC investment capacity?

Consider that typical VBC investments for small to mid-size primary care practices range from $10,000 to $50,000 annually for technology and staffing enhancements, with potential upfront costs from $25,000 to $100,000 for comprehensive capability development.

- Our practice has a constrained financial position with minimal reserves and limited investment capacity.
- Our practice has a stable financial position with limited reserves and some investment capacity.
- Our practice has a strong financial position with adequate reserves for investment, and we can afford the risk that VBC investments may not generate immediate returns (e.g., we can sustain the financial impact if the return on investment takes longer than expected or doesn't materialize as projected).

Market environment and payer relationships

1.4 How would you characterize VBC adoption among primary care practices in your immediate local area (i.e., neighboring practices, colleagues in your community)?

- We are unsure of local VBC adoption, or we have limited local engagement – Few, if any, primary care practices in our immediate community are actively participating in VBC models.
- We have a mixed local participation – Some neighboring practices have begun participating in VBC arrangements, while others remain focused on traditional fee-for-service.
- We have strong local activity – Several nearby primary care practices are actively engaged in VBC models and regularly discuss their experiences at local meetings.

1.5 What is the composition of your practice's payer mix?

- Our practice has a fragmented payer mix with many different payers and plans.
- Our practice has a moderately concentrated payer mix with several major payers.
- Our practice has a highly concentrated payer mix with one or two dominant payers.

1.6 Within your payer mix, to what extent is VBC participation required or incentivized?

Meaningful VBC opportunities include substantial financial incentives, such as shared savings percentages (typically from 25% to 50% of savings), primary care capitation adjusted for quality and cost performance, per member per month (PMPM) payments from $5 to $15 or requirements that affect a significant portion of your patient panel.

- There are a few payers in our practice's payer mix with VBC requirements or meaningful opportunities (e.g., optional programs with minimal upside potential, shared savings under 25%, PMPM under $3 or programs affecting less than 10% of the patient panel).
- Some major payers in our practice's payer mix offer VBC opportunities with moderate incentives (e.g., shared savings programs with 25% to 40% upside potential, PMPM payments from $5 to $10, primary care capitation with no upside adjustments for quality performance, quality bonuses from $10,000 to $50,000 annually or programs covering 25% to 50% of the patient volume).
- Multiple payers in our practice's payer mix require or strongly incentivize VBC participation (e.g., mandatory participation for continued network membership, shared savings exceeding 40%, PMPM payments from $10 to $15-plus, primary care capitation with performance adjustments, downside-risk arrangements or programs affecting 75%-plus of the patient panel).

1.7 Are you aware of organizations offering VBC aggregator/enabler services in your market?

- No, our practice is not aware of aggregators/enablers operating in our market.
- Yes, our practice is aware they exist, but we haven't been contacted by any aggregators/enablers.
- Yes, our practice is aware they exist, and we have been contacted by one or more aggregators/enablers.

1.8 Are you aware of state-level efforts supporting VBC adoption in your region?

- No, our practice is not aware of any state-level VBC support programs.
- Yes, our practice is aware of some voluntary state programs or initiatives.
- Yes, our practice is aware of comprehensive and/or required state-level VBC initiatives and support resources.

1.9 What is your practice's current level of participation in VBC arrangements?

- Our practice does not currently participate in any VBC arrangements.
- Our practice participates in upside-only VBC models (i.e., shared savings with no downside risk, receives PMPM payments).
- Our practice successfully participates in two-sided risk models (i.e., shared savings and losses).

1.10 Do you meet the minimum attributed lives or other patient volume criteria required by the payer to participate in their VBC program(s)?

Most upside-only VBC programs with no downside risk require a minimum of 100 to 500 attributed lives, whereas VBC programs with downside risk require a higher minimum (e.g., 5,000 beneficiaries for the Medicare Shared Savings Program), though this varies by payer and can be achieved through aggregation.

- Unsure/no. Our practice's current volume is insufficient to participate independently.
- Our practice is close to the required volume, but we may need to grow our panel or partner with others to meet participation thresholds.
- Yes, our patient population meets or exceeds the minimum thresholds required for participation.

SECTION 2: OPERATIONAL CAPABILITIES

Quality reporting and data infrastructure capabilities

2.1 How effectively does your practice monitor cost and utilization metrics to evaluate care delivery improvements?

- Our practice tracks clinical outcomes, but we haven't established processes to monitor cost and/or utilization impacts.
- Our practice monitors some cost/utilization metrics, but we have gaps in our measurement capabilities or data analysis (e.g., we track reduced readmission rates after targeted care coordination, but we are unable to quantify the financial impacts of discharge planning to different care settings).
- Our practice has robust financial analytics systems that consistently demonstrate and quantify the impact of care initiatives on outcomes, costs and utilization (e.g., we can use clinical and financial data to determine, for example, that "care coordination reduced 30-day readmissions by X percentage to save X amount of dollars").

2.2 Does your practice have experience using interim quality data to identify areas for improvement and inform workflow changes?

- Our practice rarely or never uses quality measures to guide workflow changes to improve outcomes.

- Our practice occasionally implements data-driven workflow changes with variable success (e.g., using diabetes control data to modify care protocols).
- Our practice routinely uses quality measures to identify opportunities and implement targeted workflow changes (e.g., modifying appointment scheduling based on no-show analytics).

2.3 How would you assess your practice's current EHR functionality and data infrastructure?

Advanced functionality includes population health dashboards, care gap identification, automated quality reporting and connection to regional health information exchanges (HIEs).

- Our practice has basic infrastructure with minimal EHR functionality and limited data capabilities (e.g., basic appointment scheduling and chart notes, manual chart reviews to identify patients with diabetes, and/or pulling reports requires IT support or vendor assistance).
- Our practice has moderate infrastructure, including adequate EHR capabilities and some basic data analytics tools (e.g., built-in clinical decision support alerts, ability to run patient lists by diagnosis or medication, basic quality measure tracking and/or some patient portal functionality).
- Our practice has robust infrastructure, including advanced EHR functionality, population health management systems and dedicated care coordination staff (e.g., integrated AI tools, automated care gap alerts, real-time quality dashboards, connections to regional HIEs and/or embedded care coordinators with direct EHR access).

2.4 How would you describe your practice's data analytics and IT support?

- Our practice has limited dedicated staff with a general understanding of health care analytics.
- Our practice has moderate staffing with some specialized roles, but gaps exist in advanced analytics expertise.
- Our practice has robust staffing, including dedicated data analysts and staff with health care analytics expertise.

2.5 To what extent does your current health IT infrastructure support clinical decision-making for VBC?

- Our practice's current IT infrastructure has limited internal clinical decision support with basic systems that are unable to effectively guide our VBC decisions (e.g., standard alerts and reminders).
- Our practice's current IT infrastructure has adequate capabilities, but there are gaps in decision tools (e.g., rules-based clinical decision support).
- Our practice's current IT infrastructure has a strong clinical decision infrastructure with integrated analytics and workflows (e.g., predictive analytics and machine learning for risk identification).

2.6 How would you characterize your practice's data capabilities for monitoring VBC performance?

- Our practice has basic capabilities, with minimal reporting functionality and a limited ability to develop dashboards.
- Our practice has moderate capabilities, including standard reports and basic dashboards with some performance metrics.
- Our practice has advanced capabilities, including comprehensive dashboards, the ability to electronically send performance data to payers, and real-time performance monitoring and predictive analytics tools.

2.7 At what level is your practice able to share information with contracted payers and other health care delivery organizations?

- Our practice has minimal EHR integration and limited ability to exchange data beyond basic claims submission.
- Our practice has some established information exchange pathways with select partners (e.g., limited admit/discharge/transfer [ADT] alerts).
- Our practice has seamless bidirectional information flow (e.g., real-time ADT alerts, payer access to EHR and/or automated data exchange with robust security protocols).

2.8 How would you characterize your practice's access to actionable patient and claims data from contracted payers?

- Our practice receives basic claims data, but we have minimal visibility into payer-held patient information and risk scores.
- Our practice receives some useful payer data (e.g., periodic risk-stratification reports in current VBC contracts and select quality measure performance), but we experience delays or gaps in this information.
- Our practice has timely access to robust payer data, including risk scores, quality performance, care gaps and utilization patterns that directly inform our clinical decision-making.

Care management capabilities

2.9 How would you describe the level of understanding and engagement with VBC by the physicians in your practice?

- The physicians in our practice have a limited understanding of VBC requirements and incentives.
- The physicians in our practice understand basic VBC concepts, but they are not actively engaged in improvement initiatives.
- The physicians in our practice fully understand VBC goals and actively participate in improvement initiatives.

2.10 How would you characterize your practice's patient outreach and engagement capabilities?

- Our practice has minimal patient engagement resources or technology (e.g., appointment reminder calls are made manually by staff, paper handouts are provided during visits, and there is no systematic follow up for missed appointments or care gaps).
- Our practice has some patient engagement capabilities (e.g., automated appointment reminders via text or email, a basic patient portal for lab results and/or occasional health education mailings), but we lack a comprehensive strategy for coordinating outreach for chronic disease management and preventive care.
- Our practice has a comprehensive patient engagement strategy, including systematic identification of high-risk patients, multiple outreach channels, patient education resources and engagement tracking with supporting tools (e.g., automated care gap alerts trigger personalized outreach, multi-channel communication [e.g., text, email, phone, portal]), patient education materials tailored by condition, and language and/or tracking of patient response rates and engagement metrics.

2.11 How would you rate your practice's care management capabilities and resources?

- Our practice has a limited care management infrastructure with no dedicated care coordinators, no manual tracking for patients at increased risk and/or limited post-discharge follow-up systems.
- Our practice has some care management resources with coverage gaps, established but inconsistent use of risk stratification and/or basic care transition processes.
- Our practice has comprehensive care management, including dedicated care managers and established care transition processes.

2.12 How would you describe your practice's ability to manage and coordinate care with specialists?

- Our practice has limited ability to identify, coordinate or track referrals to other specialists.
- Our practice has some specialist coordination capabilities, but we lack comprehensive management.
- Our practice has a robust specialist network with performance tracking and coordinated care.

2.13 How comprehensively does your documentation of patient risk factors (i.e., clinical risk factors and social determinants of health) influence your personalized care planning decisions?

- Our practice's patient risk burden capture is inconsistent and/or incomplete, and it is not used to inform care delivery strategies.
- Our practice's patient risk burden is documented and partially influences care planning.
- Our practice has a standardized, consistent process for comprehensive risk capture, including accurate hierarchical condition category coding and documentation of clinical and non-clinical risk factors, which directly inform individualized care planning.

2.14 To what extent is your practice able to identify and risk stratify patients at increased risk?

- Our practice has limited ability to identify and stratify high-risk patients beyond basic clinical indicators.
- Our practice has basic risk-stratification capabilities using established clinical criteria and some data analytics.
- Our practice has advanced risk-stratification and/or predictive-analytics capabilities to proactively identify and manage high-risk patients.

SECTION 3: GOVERNANCE AND ENTERPRISE CAPABILITIES

Internal alignment for value-based participation

3.1 What is your practice's experience with leveraging external tools, vendors, aggregators or enablers to enhance VBC capabilities, whether strategic, operational or governance/organizational related?

- Our practice has no experience utilizing external tools, vendors or enablers/aggregators to address opportunities in VBC.
- Our practice has limited experience implementing external solutions, with challenges in data integration or achieving meaningful VBC improvements.
- Our practice has experience and established productive relationships with external solutions and we have successfully integrated tools that have enhanced one or more of our VBC capabilities.

3.2 What is your practice's preference when it comes to developing VBC capabilities?

- Buy/partner externally: Our practice prefers acquiring VBC solutions from external vendors, aggregators or enablers to access specialized expertise and accelerate our capabilities (e.g., contracting with population health management platforms, partnering with care management companies, purchasing analytics dashboards, and/or working with VBC enablers for contract negotiation and performance monitoring).
- Build in-house: Our practice prefers developing VBC capabilities internally using existing resources and infrastructure (e.g., training current staff on quality reporting, expanding EHR functionality with an existing vendor, hiring dedicated care coordinators and/or developing our own patient outreach protocols).

3.3 Does your practice have the administrative capacity (i.e., staff time, expertise and organizational systems) to effectively implement and monitor VBC initiatives with external tools, vendors, aggregators or enablers?

- Our practice has limited administrative infrastructure for VBC initiatives (i.e., insufficient staff time, limited expertise in managing vendor relationships, and/or inadequate systems for integrating external VBC tools and monitoring their performance).
- Our practice has some administrative capacity that could support external VBC initiatives, but we would need to reallocate significant resources or further invest to fully integrate an external tool and track outcomes.
- Our practice has a robust administrative infrastructure aligned to effectively implement and monitor VBC initiatives (i.e., dedicated staff, relevant expertise in external tool integration and/or comprehensive systems for monitoring performance improvements).

3.4 How would you describe your practice's governance structure in terms of its support for enhancing VBC capabilities?

- Our practice has a rigid governance structure that may pose challenges to advancing VBC capabilities.
- Our practice has governance that would require a compelling return on investment and a clear rationale with demonstrated successful outcomes to further develop VBC capabilities.
- Our practice has a highly flexible governance structure, enabling continuous enhancement and growth in VBC.

3.5 Is your practice part of a clinically integrated network/independent physician association (CIN/IPA)?

- Yes (proceed to next question)
- No (end assessment)

3.6 To what extent is your CIN/IPA supporting your practice's core capabilities needed to succeed in VBC arrangements?

Consider aspects like quality measurement and reporting, payer contract negotiations, care management, data analytics, technology infrastructure and performance feedback

- Our practice's CIN/IPA provides minimal or inadequate support across most core VBC capabilities (e.g., quality reporting, contracting,

care management, data analytics, etc.). The support provided does not effectively meet our practice's needs, creating gaps that impede our VBC performance.
- Our practice's CIN/IPA provides adequate support in some core VBC areas, but the support varies in quality and comprehensiveness, requiring our practice to supplement resources in certain areas.
- Our practice's CIN/IPA provides comprehensive, high-quality support across most core VBC capabilities that align well with our practice's needs. The support enhances our ability to succeed in VBC arrangements without requiring significant additional resources.

3.7 How does your relationship with your CIN/IPA impact your practice's autonomy to select and implement your own VBC solutions (e.g., vendors, enablers, technology platforms)?

- Our practice's CIN/IPA agreement limits our ability to independently select or implement VBC solutions. We are contractually required to use network-approved vendors/technologies with minimal exceptions and/or financial arrangements (e.g., shared-savings distribution methodology, required financial contributions), which constrains our resources for independent investments.
- Our practice's CIN/IPA relationship places some constraints on our technology and vendor selection. We have partial flexibility to supplement network solutions with our own choices, but we face either financial implications (e.g., reduced shared savings, additional fees) or operational challenges (e.g., data integration issues, duplicative reporting requirements and/or limited data access) when implementing independent solutions.
- Our practice's CIN/IPA relationship preserves our practice's autonomy to select and implement complementary VBC solutions. Network participation either provides financial resources to support our independent investments or imposes few restrictions on our technology decision-making while ensuring data-sharing compatibility with network systems.

3.8 How effectively does your CIN/IPA share VBC performance data and insights with your practice?

- Our practice receives minimal performance feedback or data sharing from our CIN/IPA, limiting our ability to understand our VBC performance or identify improvement opportunities.
- Our practice receives some performance reports and data from our CIN/IPA, but the information is often delayed, incomplete or difficult to use for practice improvement.
- Our practice receives timely, comprehensive performance data and actionable insights from our CIN/IPA that directly support our practice improvement efforts and VBC success.