Vermont Health Care Innovation Project: State Innovation Model (SIM) Evaluation Overview and Update

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Green Mountain Care Board
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AGENDA

- Overview

- Progress and Findings

- Discussion

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BRIEF HISTORY

State Innovation Model (SIM) Initiative within the Center for Medicare and Medicaid Innovation (CMMI) is testing the ability of state governments to accelerate statewide health care system transformation in service delivery, care coordination and value-based payment models.

- Federal evaluation (RTI), includes both state-specific and cross-state analyses.

- GMCB contracted with JSI to conduct State-led qualitative evaluation study of SIM investment in Vermont proposing to answer research questions in three topical areas:
    - Care Integration and Coordination
    - Use of Clinical and Economic Data to Promote Value-Based Care
    - Payment Reform and Incentive Structures

Visit Vermont Health Care Innovation Project website for more information

EVALUATION CONCEPTUAL FRAMEWORK

Program Effectiveness

Implementation Effectiveness

Context & VHCIP Inputs

VHCIP Inputs
- Payment model design and implementation
- Practice transformation
- Support for health data infrastructure
- Workgroups

Contextual Factors
- Blueprint for Health
- Payer initiatives/value-based payment
- Federal/state regulatory considerations
- Other federal/state/local health transformation initiatives

Community Characteristics
- Provider characteristics
- Demographics
- Population needs
- Geography

Delivery System Capabilities

Care Integration/Practice Transformation
- How is care integration defined?
- What is the range of approaches being tested/implemented?
- What are lessons learned/what evidence exists?
- What environmental and organizational factors enhance/inhibit care integration?

Use of Clinical & Economic Data to Promote Value-Based Care
- What data are being communicated, by whom, and for what purposes?
- How is data being used?
- What data is most helpful/least helpful?
- How could content or communication of data be modified to be more useful?

Payment Reform and Financial Incentive Structures
- What is range of incentive structures being used (financial and non-financial)?
- How do providers perceive incentive structures?
- Do incentive structures influence practice or services/does this vary based on provider setting or practice size?
- What adaptations at the practice and provider level are anticipated for the next generation of payment models?
- What level of support to providers require to make this transition?

Program Outcomes

Reach
- # of consumers/patients reached

Effectiveness
- Provider perceptions
- Consumer perceptions

Adoption
- # of participating provider orgs.
- Types of provider organizations
- Geographic spread
- Non-participation

Implementation
- Facilitating factors
- Inhibiting factors
- Contextual factors

Maintenance
- Facilitating factors
- Inhibiting factors
- Contextual factors

Long-term Outcomes

- **Improve population health**
- **Improve quality of care**
- **Reduce health care cost**

Sustainability/Replicability

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CARE COORDINATOR AND PROVIDER SURVEYS

- Care Coordinator Survey currently in field
  - 509 targeted, second reminder completed
  - 29 incomplete responses so far
  - 133 complete or 22% response rate to date

- Designated Agency distribution
  - Via VT Care Partners

- Provider Surveys
  - 1007 targeted: MD, DO, PA, NP
  - 2% response rate to date (less than one week fielded)

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SITE VISITS AND INTERVIEWS

- UCCs, Sub-grants, ACOs
  - Diverse scope of stakeholders selected for site visits
  - Geographic location, scope of project, partnerships, preliminary findings

- Approximately 25 additional interviews
  - Inclusion of consumers and consumer advocacy organizations

- Process to vet preliminary findings
  - Spring 2017

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FOCUS GROUPS

4 of 5 focus groups completed

- Persons with disabilities

- Integrated Family Services

- SASH

- Older Vermonters

- General care coordination population

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SUB-GRANTS

Analysis of sub-grant reports using the RE-AIM Framework

- Reach

- Effectiveness

- Adoption

- Implementation

- Maintenance

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LEARNING DISSEMINATION and DATA VISUALIZATION

- Learning Dissemination
    - Communication Channels (organizations and associations in VT)
    - Audiences (providers, consumers, agencies, etc.)
    - Methods (publication, webinar, training, email lists, newsletters, etc.)

- Data Visualization
    - Infographics
    - Story Board
    - Interactive Dashboard

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SELECT PRELIMINARY FINDINGS: CARE COORDINATION

- Statewide guidance, locally driven

- Increased capacity for quality improvement

- Further embedded care coordination infrastructure at the regional level
  - Strengthened leadership and local governance, expanded partnerships, more data availability, more data use for high-risk patient identification, better tools and enhanced knowledge

  - Advanced collective impact: tackling deeply entrenched and complex social and system problems to achieve significant and lasting change

- Significant amount of work focusing on social determinants.

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SELECT PRELIMINARY FINDINGS: CARE COORDINATION

- 98% of patients know who their care coordinator is and how to contact them.

- 97% of patients agree their care coordinator knows who else is helping with their care.

- Decrease in ED utilization and increase in QOL measures (sub-grants).

- 70% of patients have a complete shared care plan.

- 50% of care coordinators comfortable with running a shared plan conference.

- 38% of care coordinators confident in conducting Root Cause Analysis.

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SELECT PRELIMINARY FINDINGS: PAYMENT

- SIM sub-grant awards strengthened the capacity and infrastructure of the three ACOs, enabling them all to participate in shared savings program (SSP) within at least one payer sector
  - Enhanced infrastructure required for ACO functions: care coordination, quality improvement, data analytics, governance
  - Sub-grants to ACOs ensured that their membership providers were at the table (most notably independent practices)
  - Enabled ACOs to prepare their networks for participation in shared savings program

- Indirect benefits of shared savings program participation more important than actual shared savings
  - One ACO had shared savings for its Medicaid population
  - All ACOs had strong baseline quality scores overall
  - SSP Identified some clinical areas where improvement could occur
  - Lessons learned through participation enhanced policy makers, ACO, and ACO network participants' readiness for future alternative payment methodologies

- Broader understanding of panel management and population health management

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SELECT PRELIMINARY FINDINGS: PAYMENT

- Contributed to evolution of all-payer ACO model with accommodation of risk and non risk bearing organizations

- Need to figure out how to wrap behavioral health, LTSS, and non-medical services into payment reform (Medicaid Pathway as start to this discussion)

- Population health workgroup and plan informed by learnings of ACOs and SSP

- Models/evidence for shift from ED and inpatient to primary care and behavioral health service use

- What is the public private partnership between ACOs and the state – evolving roles of Blueprint, ACOs, Department of Health, VPQHC, etc.

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SELECT PRELIMINARY FINDINGS: DATA

- Expansion of EHRs
  - Beyond primary care
- Increased number of interfaces
- Data standardization efforts improved quality of data
- Statewide care coordination tool and pilot
- Focus on data infrastructure
- "Thirst" for data increased
    - Building capacity at multiple levels

SELECT PRELIMINARY FINDINGS: DATA

- Mental health data repository
  - Compatibility?

- Lack of ease of system integration
  - Patient ping and event notification

- Higher capability of ACO and individual practices to conduct analytics for high-risk patient identification

- Lack of funding model for increasing analytics capacity at practice level

- Struggle with data to understand risk-based contracting

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DISCUSSION

- What are some of the implications of the findings?

- What further exploration or questions does this incite?

- Surprises?

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