Furthering Community Health Accountable Care – 03410-1295-15
Bi-State Primary Care Association

Final Report for VHCIP Provider Sub-grant Program

August 5, 2016

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Acknowledgments

Funding for this report was provided by the State of Vermont, Vermont Health Care Innovation Project, under Vermont's State Innovation Model (SIM) grant, awarded by the Center for Medicare and Medicaid Services (CMS) Innovation Center (CFDA Number 93.624) Federal Grant #1G1CMS331181-03-01.

Executive Summary

Community Health Accountable Care (CHAC) is a shared savings Accountable Care Organization with a mission to improve the ability of our participant organizations to provide the right health care for their patients based on the medical and social needs of each individual patient. CHAC fully supports the Patient Centered Medical Home principles of individualized, self-directed treatment plans, an orientation toward whole health, and ongoing relationships between patients and their care teams. The VHCIP Provider Grant funding, coupled with our second VHCIP grant, has truly been the backbone of Community Health Accountable Care (CHAC) as it has funded basic infrastructure including core staffing, facility costs, meeting costs, professional services, and IT support.

The project “Furthering Community Health Accountable Care” had the primary goal of increasing provider collaboration across the continuum of care in local communities by growing and strengthening CHAC as an organization. Accomplishments include implementation of CHAC’s standing committees; development, adoption of, and implementation of clinical recommendations for COPD, CHF, Falls Risk Assessment, Diabetes, and Depression; implementation of a telemonitoring pilot; implementation of

Patient Ping for all attributed lives; development of care management, operational, and compliance standards with successful execution of training programs; support for continuous quality improvement though use of PDSA cycles; completion of chart abstraction and quality reporting; and operationally supporting all ACO requirements (i.e. beneficiary notification mailings and report submission including quality reporting).

CHAC has grown into an ACO that participates with all payer groups including Medicare, Medicaid, and Blue Cross Blue Shield of Vermont. The CHAC network has significantly increased in size. CHAC was founded by seven federally qualified health centers and Bi-State Primary Care Association in 2012 and began operating as an ACO in 2014. CHAC's network has significantly expanded since 2014 and now consists of ten (10) Federally Qualified Health Centers, four (4) Rural Health Clinics, seven (7) Hospitals including four (4) Critical Access Hospitals, fourteen (14) Designated Agencies, and nine (9) Certified Home Health Agencies. CHAC's current network serves approximately 57,000 patients, with about 15,000 attributed through CHAC's Medicare Shared Savings Program.

The structure of CHAC includes a dedicated Governing Board and four standing committees which are the clinical committee, finance committee, operations committee, and the consumer advisory panel. CHAC successfully recruited an inclusive Board of Directors to serve as the governing body in compliance with the regulations and guidelines set forth in agreements with the Medicare, Medicaid and Commercial payer groups. Board meetings have been and continue to be held on a monthly basis with many board members contributing time to sub-committees or external workgroups. The four standing committees were also successfully implemented and include representation from a wide variety of organizations in our network. All standing committees meet no less than quarterly, and updates on their activities are reported to the Board. It is important to note that the work of the governing board and the committees is done through in-kind hours of the committee members.

CHAC has been an active participant in the health payment reform initiative of the State and works collaboratively with the other two ACOs, OneCare Vermont and Vermont Collaborative Physicians. Alignment with the Blueprint for Health has allowed CHAC staff to support the Community Collaboratives and help influence locally based quality improvement projects. As the Vermont health care environment continues to evolve, CHAC will serve as a voice for primary care teams and will be the non-risk/ population management track as part of the Unified ACO Vermont Care Organization.

Discussion

Project Description

The goal of this project was to increase provider collaboration across the continuum of care in local communities. The objective was to grow and strengthen Community Health Accountable Care, LLC (CHAC), a Shared Savings Accountable Care Organization. The overall goal and objective have been well met. All initial activities described have either been completed or continue as ongoing ACO initiatives. Activities initially listed were to implement Medicare, Medicaid, and Commercial Shared Savings Programs; to complete recruitment of a comprehensive Board of Directors to govern CHAC; to develop a

representative structure of four CHAC committees; to continue active participation in payment reform conversations; and to continue to engage with the other two ACOs in Vermont.

CHAC entered into agreements with all three payer groups and began operating as a shared savings program for each product line in January 2014. Implementation of all programs included meeting standards of care management, quality and operational reporting, and measuring outcomes for three different population groups. CHAC has grown considerably since 2014, and now manages a network of ten Federally Qualified Health Centers, four Rural Health Clinics, seven Hospitals including four Critical Access Hospitals, fourteen Designated Agencies, and nine Certified Home Health Agencies. CHAC's current network serves approximately 57,000 patients.

CHAC Implementation and Main Activities

The structure of CHAC's Governing Board and four standing committees is an inclusive one meaning there is statewide representation from our members and community partners. The CHAC Board has eighteen members which include nine (9) delegates of CHAC's Member/Owners (eight (8) of whom are participating organizations), three (3) at large seats for participating organizations, one (1) hospital organization representative, one (1) representative of a behavioral health or substance abuse treatment facility, and one (1) representative of a post-care care facility participant. The remaining three (3) seats are held by beneficiaries with one (1) seat held by a Medicare beneficiary, one (1) seat held by a Medicaid beneficiary, and one (1) seat held by a commercially insured beneficiary. This board composition was successfully implemented and meets all requirements for the Medicaid, Medicare, and Commercial shared savings programs while promoting input from a statewide range of provider organizations. The meetings of the Board are generally held monthly allowing for oversight of CHAC operational activities and strategies.

CHAC successfully developed a committee structure and recruited representatives from our entire network to serve as committee members. For many of the committees we have representation from not only primary care organizations, but also from the mental health agencies, home health agencies, and hospital systems. The Finance Committee is responsible for all financial management considerations for CHAC, including advising the Governing Board regarding systems for claims processing, bookkeeping, and practitioner reimbursement as well as conducting audits. This committee has helped develop the CHAC budget and confirmed the shared savings distribution for achieved savings. The Operations Committee has developed policies and procedures for CHAC as well as standards for participation, a compliance plan, and an annual compliance training. This committee has also advised the Board on issues of compliance with external regulations. The Clinical Committee has established care management standards, an annual quality improvement plan, and clinical goals for the CHAC Network. This committee has produced many clinical recommendations and patient materials that have been implemented and used throughout CHAC's participating organizations for topics such as diabetes, falls risk, depression, congestive heart failure and chronic obstructive pulmonary disease. Joint meetings of Clinical and Operations Committees have been imperative to the implementation process as they have worked on PDSA cycles for quality improvement initiatives based on data. The Consumer Advisory Panel serves as a way for CHAC to receive feedback and insight from beneficiaries. Discussions with members of this committee have included topics such as access to care, communication with providers, and other

consumer led topics. Information from the consumers is reported back to the Board and the providers through reports and a network newsletter.

To allow for communication between organizations and the ACO, CHAC developed a website with a provider portal. The provider portal is only accessible to staff of our participant organizations and houses items such as the clinical recommendations, patient materials on various disease states, compliance training, learning collaborative webinars, and other network announcements and materials. CHAC has also developed a network newsletter that goes out once a month to all participating organizations. The Clinical Committee also utilizes a web-based project communications tool called Basecamp to post updates and ask questions. The FQHCs of CHAC's network have a strong peer–to-peer collaborative group that further enhances communication and the sharing of best practices.

CHAC has allowed for the FQHCs and other network participants to have a voice in Vermont's health care reform environment. CHAC has participated in all of the VHCIP workgroups and has successfully influenced statewide care management standards, quality reporting and data requirements, legislative policies, and population health projects. In collaboration with the Blueprint for Health and the other ACOs, CHAC has held a supportive role in the many community collaboratives across the state. The clinical recommendations that have been developed by the CHAC Clinical Committee have been shared statewide and even adopted by some of the community collaborative groups as focus areas.

As an ACO we strive to achieve the three parts of the Triple Aim. A success story of how CHAC's work has made an impact is one of practice improvement. One of our member organizations used CHAC's Falls Risk recommendation to increase their screening rate for patients over the age of 65 who have a history of falls from 26.9% to over 80% at their sites. This increase in screening has helped the providers identify patients for whom fall care plans are needed and will consequently reduce overall admissions. This exemplifies how CHAC initiatives are reducing costs while improving the quality of care for our patients.

Challenges

CHAC has experienced some internal challenges throughout the project. It has been an on-going challenge to participate fully in all external and collaborative meetings in addition to meeting operational deadlines and individual regulatory requirements. This is because CHAC is oriented to administrative efficiency, and has therefore maintained a lean administrative staff. This has been somewhat remedied through hiring permanent and temporary CHAC delegated staff members and through the ability to access Bi-State Primary Care Association's (Bi-State) staff and resources. Bi-State's management services agreement has tremendously impacted the success of CHAC as it enabled delegated staff to reach out to experienced employees to help with different parts of CHAC business. Implementation of the Governing Board was not without incident. It was a challenge to find adequate representation to meet the CMS requirement that 75% of the Governing Board be made up of organizations that attribute their Medicare lives to the ACO while maintaining Vermont's Medicaid and Commercial standards. CHAC worked with CMS to comply with this rule.

Alignment of measures and strategies has been an ongoing, overarching challenge throughout the initiative. The alignment of the different measure sets for each payers' shared savings program caused

provider team fatigue at member organizations due to the large number of quality performance measures expected to be reported on and reacted to. Bi-State staff members participated in the State/VHCIP committees to align measurements where possible. Another aspect that allowed for alignment throughout implementation was the willingness to collaborate with the other ACOs and State partners on data, quality, and care coordination efforts. Having a far-reaching and growing network led to complexities for communications and compliance tracking. To remedy this CHAC created a more accessible website, a network monthly newsletter, and hired a temporary staff member to help reduce administrative burden.

Lessons Learned

We would not change many aspects of this initiative because we have very efficiently used our resources. One lesson learned was that it would have been best to have locked in on call contractors beforehand to aid with network management, implementation, data, etc. when needed. Some of this work is cyclical in nature requiring short bursts if high activity, which our lean administrative structure struggled to support. This was not done as it takes time to seek out and develop contracts with those resources. Secondly, adoption and implementation of new processes can be challenging to disseminate across a statewide network of individual organizations and requires a champion at each location to advocate for the changes. Our clinical committee members, who are deeply invested in the clinical recommendations they developed and agreed to adopt, have taken on the role of champions in an effort to unite our provider network and establish the expectation for ongoing quality improvements. The CHAC committees, especially the Clinical Committee, are working committees that have fully embraced the challenging work needed to succeed as an ACO. It is important for the clinical and operations to be integrated, and we have facilitated this communication through joint meetings of the Clinical and Operations committees.

Project Evaluation:

The target population for this initiative includes CHAC's designated contract employees, Governing Board, Standing Committees, participating organizations, providers, contractors, and 57,000 attributed beneficiaries. There are about 340 providers attributing to CHAC and are consequently directly impacted by the VHCIP Sub-grant program.

Table 1. CHAC Network Growth by Attributed Lives

Payer Groups	**2015**	**2016**
Medicaid	20,000	33,000
Medicare	6,400	14,700
Commercial	8,900	10,500
Total	35,300	57,000

The evaluation methodology used for the "Furthering Community Health Accountable Care" project was to compare the project status to the project work plan. CHAC has been further evaluated by whether it achieved savings in any of its three product lines, whether those savings surpassed the minimum savings rates (MSR), and whether the ACO has improved quality of care by utilizing ACO quality measures and through successful implementation of CHAC Clinical Recommendations.

CHAC used data from payer claims, the annual Shared Savings quality reporting, and the provider rosters to evaluate the outcomes. The data was collected through manual chart abstraction and member-self reporting. To analyze the data CHAC relied on the state contractors (the Lewin Group) for analysis of the Medicaid and Commercial data while CMS has their own methods for analyzing and reporting Medicare results to the ACO. Limitations of our data include that the sampling was spread out across eleven participant organizations and is not easily broken down into actionable data for the individual provider organizations. Due to the differences in patient population sizes for the different health centers, the sampling was minimal for some sites and therefore skewed towards those that had more charts pulled from their patient population. Also, due to the configuration of CHAC, as it is mostly made up of FQHCs, the denominators for some of the quality reporting measures for Medicaid were too small to be valuable.

2014 Medicaid Percentile Benchmarking Results

Description	30th	40th	50th	60th	70th	80th	90th	Score	Goal
Colorectal Cancer Screen ^	19.81	33.93	**48.49**	63.29	78.13	94.93	100.00	51.99%	HP - 70.5
Depression Screening ^	5.31	10.26	16.84	23.08	**31.43**	39.97	51.81	38.71%	HP - 2.4
BMI with follow up ^	40.79	**44.73**	49.93	66.35	91.34	99.09	100.00	47.58%	UDS - 53.3
DTaP (4 doses)	30.00	40.00	50.00	60.00	70.00	**80.00**	90.00	84.04%	HP - 90
IPV (3 doses)	30.00	40.00	50.00	60.00	70.00	80.00	**90.00**	93.81%	HP - 90
MMR (1 dose)	30.00	40.00	50.00	60.00	70.00	80.00	**90.00**	91.21%	HP - 90
HIB (3 doses)	30.00	40.00	50.00	60.00	70.00	80.00	**90.00**	90.88%	HP - 90
Hep B (3 doses)	30.00	40.00	50.00	60.00	70.00	80.00	**90.00**	90.23%	HP - 90
VZV (1 dose)	30.00	40.00	50.00	60.00	70.00	80.00	**90.00**	91.53%	HP - 90
PCV (4 doses)	30.00	40.00	50.00	60.00	70.00	**80.00**	90.00	86.64%	HP - 90
Hep A (1 dose)	30.00	40.00	50.00	60.00	70.00	**80.00**	90.00	80.13%	HP - 85
RV (2 or 3 doses)	30.00	40.00	50.00	60.00	70.00	**80.00**	90.00	83.39%	HP - 80
Flu (2 doses)	30.00	40.00	50.00	**60.00**	70.00	80.00	90.00	67.10%	HP - 70
Kid's Immunizations - Combo 10	30.00	**40.00**	50.00	60.00	70.00	80.00	90.00	46.58%	*
Kid's BMI and Follow Up (Ages 3 to 17)	**30.00**	40.00	50.00	60.00	70.00	80.00	90.00	32.35%	UDS 51.8
DM - Poor Control ^	70.00	60.00	50.00	40.00	**30.00**	20.00	10.00	23.81%	HP - 16.1
DM - Comp ^	17.39	21.20	23.48	25.78	28.17	31.37	36.50	12.50%	HP - 28

Table 2. 2014 CHAC Overall Medicaid Percentile Benchmarking Results. Highlights percentiles show how CHAC scored on these quality measures in 2014.

2014 Commercial Percentile Benchmarking Results

Measure	30th	40th	50th	60th	70th	80th	90th	Score	Goal
Colorectal Cancer Screen ^	19.81	33.93	48.49	**63.29**	78.13	94.93	100	71.11%	HP 70.5
Depression Screening ^	5.31	10.26	**16.84**	23.08	31.43	39.97	51.81	18.13%	HP - 2.4
BMI with follow up ^	40.79	44.73	**49.93**	66.35	91.34	99.09	100	51.30%	UDS - 53.3
DTaP (4 doses)	30	40	50	60	70	80	90	-	HP - 90
IPV (3 doses)	30	40	50	60	70	80	90	-	HP - 90
MMR (1 dose)	30	40	50	60	70	80	90	-	HP - 90
HIB (3 doses)	30	40	50	60	70	80	90	-	HP - 90
Hep B (3 doses)	30	40	50	60	70	80	90	-	HP - 90
VZV (1 dose)	30	40	50	60	70	80	90	-	HP - 90
PCV (4 doses)	30	40	50	60	70	80	90	-	HP - 90
Hep A (1 dose)	30	40	50	60	70	80	90	-	HP - 85
RV (2 or 3 doses)	30	40	50	60	70	80	90	-	HP - 80
Flu (2 doses)	30	40	50	60	70	80	90	-	HP - 70
Kid's Immunizations - Combo 10	30	40	50	60	70	80	90	-	*
Kid's BMI and Follow Up (Ages 3 to 17)	30	40	**50**	60	70	80	90	55.67%	UDS - 51.8
DM - Poor Control ^	70	60	50	40	30	**20**	10	13.22%	HP - 16.1
DM - Comp ^	17.39	21.2	23.48	25.78	28.17	31.37	36.5	12.11%	HP - 28

Table 3. 2014 CHAC Overall Commercial Percentile Benchmarking Results. Highlighted percentiles show how CHAC scored on these quality measures in 2014.

Medicare Measure Summary Data

Measure Description	Total Eligible	Denominator Exceptions	Denominator	Measure NOT met	Measure Met	Measure Rate	Complete	Total Complete	Total Incomplete
Medication Reconciliation	213	0	213	4	209	98.12%	236	236	0
Falls Risk	473	3	470	429	41	8.72%	411	492	124
CAD - Lipid Tes	115	0	115	35	80	69.57%	115	124	0
CAD - ACE/ARB Rx	64	11	53	13	40	75.47%	115	124	0
CAD - Composite	115	0	115	46	69	60.00%	115	124	0
DM - Poor Control	128	0	128	93	35	27.34%	128	132	0
DM - Blood Pressure Control	128	0	128	36	92	71.88%	128	132	0
DM - Lipid Test and Level	128	0	128	70	58	45.31%	128	132	0
DM - A1C under 8	128	0	128	54	74	57.81%	128	132	0
DM - IVD Dx and Aspirin	48	0	48	6	42	87.50%	128	132	0
DM - Tobacco Non-Use	128	0	128	47	81	63.28%	128	132	0
DM Composite	128	0	128	108	20	15.63%	128	132	0
HF Dx with Beta Blocker Rx	18	1	17	0	17	100.00%	43	59	0
HTN Control	233	0	233	62	171	73.39%	233	280	0
IVD - Dx and Lipid Test	109	0	109	53	56	51.38%	109	141	0
IVD - Dx and Aspirin	109	0	109	15	94	86.24%	109	141	0
Mammogram	420	0	420	144	276	65.71%	411	488	128
Colorectal Cancer Screen	459	0	459	162	297	64.71%	411	499	117
Flu Shot	474	18	456	146	310	67.98%	411	554	62
Pneumonia Shot	474	0	474	76	398	83.97%	411	490	126
BMI with follow up	482	3	479	175	304	63.47%	411	515	101
Tobacco Screen with follow up	462	0	462	107	355	76.84%	411	493	123
BP Screen with follow up	290	0	290	180	110	37.93%	290	616	0
Depression Screening	437	2	435	211	224	51.49%	411	616	0

Table 4. 2014 CHAC Overall Medicare Measure Rates. The measure rate is the quality score for that clinical measure.

CHAC Comparative Measure Rates

CHAC	2014	2015	Improved?
Adult BMI	55.9%	73.7%	Y
Child BMI	42.3%	53.5%	Y
Diabetes Poor Control	20.8%	18.8%	Y
Depression Screening	37.2%	49.8%	Y
Tobacco Screening	69.8%	88.4%	Y
Colorectal Cx Screen	62.8%	65.2%	Y

Table 5. This combines Medicare, Medicaid, and Commercial samples, where possible. Diabetes Poor Control is an inverse measure.

The results from the claims data and annual quality reporting were used to help determine clinical goals and focus areas. The results were disseminated widely starting with the CHAC Board and committees. The Clinical committee reviewed the results and proposed areas of focus for each program year as shown in Table 6 below.

Table 6. Clinical Focus Areas		
Year 1	**Year 2**	**Year 3**
Creation of recommendations for: • Chronic Obstructive Pulmonary Disease • Congestive Heart Failure • Falls Risk • Diabetes • Depression	Implementation of recommendations and encouragement of PDSA cycles on: • Adolescent Well-Child Visits • Developmental Screening • Chlamydia Screening	Continued implementation and quality improvement efforts for: • Chronic Obstructive Pulmonary Disease • Congestive Heart Failure • Diabetes • Adolescent Well-Child Visits • Developmental Screening

Bi-State staff members were able to use the information gathered during manual chart abstraction along with the quality results to provide individual feedback to the FQHCs. This process was called the Data Roadshow because staff went out in person to present site specific results to a select group of executive staff, providers, and quality improvement staff at each organization. The ACO annual results of Medicare quality reporting are posted on our website, and we are willing to share all results with the public as requested by the State and at all field team meetings. The GMCB holds an annual

transformation meeting during which the results of the three ACOs are analyzed, compared, and discussed.

As an ACO, CHAC achieved 2014 savings, surpassing the MSR, under the Vermont Medicaid Shared Savings Program. CHAC's quality score entitled it to 85% of the shared savings and highlights several successes and several areas for future focus and improvement. CHAC achieved 2014 savings under the Medicare Shared Savings Program, but did not surpass the Medicare MSR. 2014 savings under the Commercial Shared Savings Program were not achieved.

Project Sustainability:

CHAC is part of the ongoing statewide health care reform work. Currently, CHAC is transitioning to the non-risk role as part of unified ACO Vermont Care Organization. This transition will impact our operations and scope as CHAC expands to include new participants and aligns our work more closely with that of OneCare Vermont. CHAC will continue to collaborate with community partners, OneCare Vermont, the State, and other organizations. We hope to maintain the peer to peer opportunities for sharing of best practices and for identifying areas for quality improvement efforts. We will not receive the results of our year three quality reporting until the summer of 2017. Due to this lag, we will continue to use the 2014 and 2015 results to conduct quality improvement projects network wide.

Conclusion

Overall, the "Furthering Community Health Accountable Care" initiative has been successful in fulfilling stated goals and objectives and has had many impacts. There has been widely positive support for CHAC's grass roots clinical work which is a model that is important as the state continues with quality improvement efforts. CHAC has become a respected voice at the table on many healthcare reform issues and a major player in the overall development of the All Payer Model. CHAC provides a state level voice for primary care. CHAC supports sharing across the network of our evidence based best practice recommendations and QI processes. Through our committees the need for peer to peer support on a regular basis has become clear for the provider organizations. CHAC has provided a vehicle for collaboration and idea sharing across the FQHCs and our other network participants through meetings and online communication platforms. Our very talented staff have become more involved in public meetings such as the VHCIP workgroups, which has made our organization and the good work of our participants more external. Through the work with the VHCIP work groups, CHAC has informed selection and roll out of statewide reporting measures and care management standards which have been used across health service areas agnostic of ACO work. CHAC has demonstrated the importance of a non-risk option for healthcare reform and has solidified a place in health care for 2017 as the non-risk track of the Unified ACO under the All Payer Model.