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State Innovation Models (SIM) Initiative Evaluation

Provider survey methods and cross-state summary

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SIM Evaluation Provider Survey

Methods

In late summer and early fall, we used a Web-based platform to conduct a baseline provider survey. To maximize the number of responses, we based the survey on a census of providers offering at least some primary care to patients residing in the Test states. The source of provider contact information varied by state. We bought contact information from the boards of licensure in Maine, Massachusetts, and Oregon; received a combined list of providers participating in Arkansas Medicaid and licensed in Arkansas from the Arkansas Foundation for Medical Care; downloaded physician information from the Vermont Department of Health website; and received a list of primary care practice sites registered with the Minnesota Department of Health from Minnesota state SIM officials.

From each list, we selected physicians listed as having a primary or secondary specialty as one of the following (specific names of specialties varied by state): adolescent medicine, emergency medicine, family and preventive medicine, family medicine, family medicine/family practice, family practice, family practice/pediatrics, family practice/preventive medicine, general practice, internal medicine, internal medicine/gastroenterology, internal medicine/pediatrics, obstetrics and gynecology, and pediatrics. In Year 1, the total provider sample frames varied from 737 practices in Minnesota to 5,525 physicians licensed in Oregon. Screeners included in the survey instructions and instruments were used to confirm that respondents were currently providing at least some primary care to patients in the relevant Test state, defined as at least 20 hours of direct patient care.

The instrument used for the SIM provider survey focuses on a range of strategies that providers engaging in accountable care organizations (ACOs), patient-centered medical homes (PCMHs), or related models would likely apply to their practice. We adapted selected questions from the National Survey of Physician Organizations 3 and used standard Likert scale response categories (ranging from Always to Never on a five-point scale) for many of the questions. Because a low response rate for provider surveys is a well-known challenge, we limited the survey to take about 22 minutes to complete. RTI survey methodologists reviewed the instrument extensively. Following these reviews, four RTI physician researchers field-tested the instruments and provided comments on the wording and length. To allow cross-state analyses, we incorporated only minimal variation in the instrument for the different Test states.

In this baseline survey, we recruited potential provider respondents via an invitation letter mailed in a regular business-size envelope, and followed up with nonrespondents at least once, and in some states twice, using different methods to test for the best response/cost combination. The letter of invitation included a secure uniform resource locator (URL) and participant

identification code. A letter of support from CMS staff, or in some states a letter of support from a state official, was also enclosed. We offered no financial incentive for participation in the survey.

We mailed initial participation invitations to potential respondents on a state-by-state basis during the second and third weeks of July. We completed the Year 1 administration of the provider surveys on October 29, 2014.

Response rates

Survey results from this round of data collection must be interpreted with caution. While we used a census of providers to collect these data, as is often the case with provider surveys offering no financial incentive for participation, we achieved low response rates. As a result, these findings are not necessarily representative of providers or practices statewide. In all states, some respondents shared an address with usually one but no more than four other respondents, except in Minnesota where, as noted above, each respondent represented many providers. Thus, some clustering of responses by physical address existed for all states.

The absolute number of responses in each state ranged from 65 practices in Minnesota, to just under 100 physicians in the less populous states of Maine and Vermont, to 288 physicians in Oregon. Among the surveys sent, the percentage of respondents who screened out ranged from a low of less than 1 percent in Minnesota (six practices) to a high of 10 percent (112 physicians) in Vermont. The final response rate (computed using definition #2 of the American Association for Public Opinion Research [AAPOR]) ranged from a low of 4.7 percent in Massachusetts to a high of 9.6 percent in Vermont. ***Table 1*** summarizes the response results.

Table 1. SIM Initiative evaluation provider survey responses, Round 1 Test states

	Arkansas	Maine	Massachusetts	Minnesota	Oregon	Vermont
Sample size	3,595	1,638	4,941	737	5,525	1,112
Screened out						
Number	88	96	45	6	130	112
Percent	2.45%	5.86%	0.91%	0.81%	2.35%	10.07%
Completes						
Number	182	96	231	65	288	96
Percent	5.10%	5.90%	4.68%	8.82%	5.21%	8.63%
Dropped, insufficient responses						
Number	33	28	34	20	66	28
Percent	0.92%	1.71%	0.69%	2.71%	1.19%	2.52%
Returned mail						
Number	156	54	112	42	75	45
Percent	4.34%	3.30%	2.27%	5.70%	1.36%	4.05%
Average survey completion time (minutes)	24	22	19	28	21	19
AAPOR response rate #2	5.19%	6.23%	4.72%	8.89%	5.34%	9.60%

Notes: AAPOR = American Association for Public Opinion Research. Response rate #2 is calculated as follows: Numerator = Percent of respondents that completed the survey in full or met a threshold considered adequate for partial completion. Denominator = Sample size minus number of people who screened out.

Respondent characteristics

We included several practice characteristic questions in the survey instrument. ***Table 2*** summarizes the provider characteristic responses for specialty designation, practice size, and whether the provider or practice identifies a PCMH or is affiliated with an ACO. The most common primary care specialty reported in most states was family practice (between 34 and 43 percent), except in Massachusetts, where most respondents identified their specialty as internal medicine or pediatrics (35 and 33 percent, respectively). In all states, the most common number of practitioners in the respondent's practice was two to five (between 29 and 42 percent), except in Oregon. In Massachusetts, Oregon, and Vermont, a similar percentage of respondents had practice sizes of two to five or six to 10, just under one-third of respondents.

We collected information on respondents identified as part of a PCMH or ACO because Test states are focusing, in part, on expansions of these or similar model variants. The percentage of respondents who identified as belonging to a practice that is a PCMH ranged from 12 percent in Arkansas to 35 percent in Vermont and 36 percent in Oregon. The percentage of respondents who reported participating in any currently active ACO (with contracts with commercial insurers, Medicare, or Medicaid) ranged from 13 percent in Arkansas to 51 percent in Vermont and 52 percent in Massachusetts.

Table 1. Base year provider survey respondent characteristics, SIM Initiative federal evaluation, Round 1 Test states

	Arkansas	Maine	Massachusetts	Minnesota	Oregon	Vermont
Number of eligible respondents	182	96	231	65	288	96
Practice specialty						
Family medicine	42%	43%	21%	n/a	43%	34%
Internal medicine	14%	26%	35%	n/a	31%	29%
Obstetrics/gynecology	15%	17%	8%	n/a	10%	15%
Pediatrics	20%	14%	33%	n/a	14%	18%
Emergency medicine	4%	—	—	n/a	—	—
Other primary care	3%	1%	4%	n/a	2%	4%
Practice size						
1	21%	14%	16%	2%	10%	15%
2–5	33%	42%	29%	34%	27%	32%
6–10	21%	30%	26%	26%	28%	30%
11–30	12%	10%	17%	23%	23%	20%
31–100	6%	2%	8%	11%	6%	2%
Over 100	3%	1%	2%	2%	6%	1%
No response	4%	1%	3%	3%	1%	0%
Patient-centered medical home and accountable care organization status						
PCMH	12%	25%	12%	22%	36%	35%
Any type of ACO (e.g., commercial, Medicare, or Medicaid)	13%	39%	52%	34%	30%	51%

Notes: PCMH = patient-centered medical home; ACO = accountable care organization
Practice size is measured by the number of physicians, physician assistants, and nurse practitioners providing care either full-time or part-time in the practice. Practices counted as a PCMH if they responded yes to one or more state-specific categories, as follows: Arkansas—PCMH; Massachusetts—PCMH; Maine—PCMH, MaineCare Health Homes for individuals with chronic conditions, or MaineCare Behavioral Health Homes for individuals with severe mental illness; Minnesota—Health care homes; Oregon—Patient-centered primary care homes or PCMH recognized by the National Committee for Quality Assurance (NCQA) or another entity; Vermont—PCMH.

Baseline findings

In this section, we report the results of selected key questions and discuss only the percentages of physicians choosing the highest level response category or categories—that is, the highest engagement and/or use of the specific strategy. Our hypothesis is that the proportion of responses in these high categories will increase as the innovation models are spread and will

mature during the course of the project. Unless otherwise noted, the denominators for the presented percentages are the total number of completes reported in Table 2-1. We will field the provider survey in two additional rounds to test this hypothesis. A separate document includes the full responses, by state.

Overall, we see reporting of many strategies associated with reform models (including PCMHs, health homes, and ACOs). This level of strategies being reported suggests that the clinical concepts behind these models may have already gained some traction in the Test states prior to the SIM Initiative. However, some strategies show low or inconsistent use by respondents, suggesting room for growth. Some of these strategies (e.g., regular practice team meetings prior to patient encounters and active participation in practice patients' inpatient care) reflect relatively aggressive engagement in care coordination and management that may not be realistic for all practices. We do not necessarily expect all practices to engage in these strategies, but rather to observe over time at least an increase in these activities as the SIM interventions progress and mature.

Patient-centered access to care

One domain of the provider survey is provider availability to patients during and after office hours. Access to primary care is one mechanism by which coordination of care could increase and unnecessary emergency room (ER) use could decrease. Most providers in the Round 1 Test states reported having same-day appointments available and using secure email to communicate with patients, although few offered after-hours access to office visits. ***Table 3*** provides a summary of these results. Between 52 percent (in Vermont) and 77 percent (in Minnesota) of providers reported using advanced or open-access scheduling for patients.

- When asked about how the practice usually responds to patient requests during business hours, most providers reported that "We respond through phone, secure email messaging, or face-to-face communications on the same day, with same-day appointments usually available if needed," instead of other choices: responding the same day with limited appointments available, responding to urgent requests only, or having difficulty responding the same day. An exact concordance did not exist between practices that had open-access scheduling and those that felt they usually had same-day appointments available.

- Between 46 percent (in Arkansas) and 70 percent (in Massachusetts) of providers reported using secure email to communicate with patients.

- Respondents generally did not report availability to offer after-hours access to office visits, ranging from 11 percent in Vermont to 21 percent in Minnesota.

Table 1. SIM Initiative base year provider survey: Patient-centered access to care

Survey instrument question	Response category	Arkansas	Maine	Massachusetts	Minnesota	Oregon	Vermont
Does your practice use "advanced-access" or "open-access" scheduling that encourages your office staff to offer same-day appointments to virtually all patients who want to be seen?	Yes	67%	58%	64%	77%	61%	52%
Which statement best describes how your practice most often responds to requests during regular business hours?	Respond same day, appointments usually available	58%	73%	83%	74%	63%	64%
Does your practice ever use secure email messaging to communicate between clinicians/practice teams and the patient?	Yes	46%	54%	70%	68%	66%	58%
Which statement best describes your practice's after-hours access (i.e., evenings and weekends)? Check all that apply.	For routine care, available for office visits	13%	14%	18%	21%	15%	11%

Care coordination and care management

One domain within the provider survey asked respondents to describe care coordination and management strategies commonly used in fully implemented PCMHs, health homes, and ACOs. In some areas, practices are proactive in managing the care of patients, through getting notifications of ER use or hospital inpatient stays; identifying patients who would benefit from care management services; using office systems like registries to identify patients who have not used recommended preventive services; and assigning patients to care teams. However, fewer providers reported that their practices are taking the next step in developing care plans; using phone, mail, or secure email to remind patients to schedule those preventive services; or working in care teams. ***Table 4*** (and other remaining tables) summarizes the highest or most engaged category responses.

- Almost half of providers in all Round 1 Test states, except Arkansas, reported working in care teams, defined as a group of physicians and other staff who meet with each other regularly to discuss the care of a defined group of patients and who share responsibility for their care. Only one-third of providers in Arkansas reported working in care teams.

Table 2. SIM Initiative base year provider survey: Care coordination and care management

Survey instrument question	Response category	Arkansas	Maine	Massachusetts	Minnesota	Oregon	Vermont
Do clinicians in your practice work in teams? By team, we mean a group of physicians and other staff who meet with each other regularly to discuss the care of a defined group of patients and who share responsibility for their care.	Yes	35%	43%	47%	50%	47%	48%
Are patients in your practice assigned a specific clinician or care team from which they are encouraged to seek care?	Yes	67%	84%	84%	82%	85%	84%
Before a patient office visit, how often, if at all, does a "team huddle" or similar planning process take place to prepare the clinician/practice team to meet the patient's chronic care or prevention needs?	Always or usually	14%	31%	37%	35%	31%	40%
From how many hospitals does your practice receive timely information about patients' emergency department visits?	All or most	55%	73%	76%	75%	75%	70%
[Of those who get any notification] How often does your practice follow up with patients who were seen in an emergency department? (Number of eligible respondents)	*Always or usually*	*78% (166)*	*83% (89)*	*86% (222)*	*77% (60)*	*82% (268)*	*78% (90)*
From how many hospitals does your practice receive timely information about patients' inpatient admission?	All or most	65%	83%	82%	77%	79%	82%
[Of those who get any notification] Which of the following best describes your practice's involvement in your patients' care during hospital inpatient or postacute care facility stays? (Number of eligible respondents)	*Part of the inpatient care team, and follows up after discharge*	*30% (164)*	*27% (89)*	*15% (222)*	*26% (61)*	*19% (271)*	*25% (91)*
Does your practice routinely identify patients for whom clinical care management services would be beneficial? These services could include coordination with other providers, help with transitions between care settings, provision of educational resources, or coordination with community-based organizations.	Yes	60%	67%	75%	71%	64%	80%

(continued)

Table 4. SIM Initiative base year provider survey: Care coordination and care management (continued)

Survey instrument question	Response category	Arkansas	Maine	Massachusetts	Minnesota	Oregon	Vermont
Does your practice routinely develop patient care plans?	Yes	55%	34%	44%	65%	42%	44%
Do your clinicians/practice teams use office systems (e.g., registries and clinical decision support reminders) to identify patients who have not yet received recommended preventive services (e.g., cancer screenings and immunizations)?	Yes	59%	83%	85%	88%	73%	76%
Which of the following best describes how consistent your practice is in using phone calls, mail, or secure email messaging to remind patients to schedule needed preventive services? (Number of eligible respondents)	*Always remind*	*33% (102)*	*20% (76)*	*49% (195)*	*20% (57)*	*29% (207)*	*23% (72)*

- In all Round 1 Test states, except Arkansas, more than 80 percent of providers reported that patients are assigned specific clinicians or care teams. In Arkansas, two-thirds of providers reported assignment of patients to specific clinicians or care teams.
- Relatively few providers reported that practice teams "always or usually" met or huddled to prepare for or discuss patient needs. The percentage of providers reporting always huddling to discuss patient needs before visits ranged from a low of 14 percent in Arkansas to a high of 40 percent in Vermont.
- Knowledge of and follow-up from ER visits can be an important strategy in care coordination and management. Most providers reported getting ER visit information from all or most hospitals. Responses ranged from 55 percent (in Arkansas) to 76 percent (in Massachusetts). When providers received this information, most reported that they always or usually follow up, with responses ranging from 77 to 86 percent.
- Similarly, a majority of responding providers and practices in Test states reported that they get notifications from all or most hospitals regarding practice patients who have inpatient admissions. Responses ranged from 65 percent (in Arkansas) to 83 percent (in Massachusetts) of providers. However, provider involvement resulting from access to this information varied. For example, among practices that received notifications of inpatient stays, few reported that they were both involved in their patient's inpatient stay and followed up with the patient after the discharge—from 15 to 30 percent.

- Providers generally reported routinely identifying patients who should receive care management services, including for transitions of care or coordination with community-based organizations, ranging from 60 percent in Arkansas to 80 percent in Vermont. However, we noted a greater range of responses in the proportion of Test state providers reporting routine development of care plans for patients. Responses varied from 34 percent of providers in Maine to 65 percent of practices in Minnesota.
- Although most providers reported that they use office systems to identify patients who have not received preventive services, in most states a clear minority of respondents—one-fifth to one-third of responding providers—reported that they consistently remind patients of needed preventive services. The exception was Massachusetts, where 49 percent of respondents reported that they always remind patients of needed preventive services.

Communication with patients and other health care providers

Communication of medical information to patients and with other health care providers is key for successful care management and coordination. ***Table 5*** provides a summary of responses relating to communication with patients and other health care providers.

- Most providers reported that their practice tracks and follows up with patients' clinical referrals. Of the survey respondents, 53 percent in Maine and 68 percent in Vermont reported always or usually tracking and following up with patients' clinical referrals.
- Almost all providers reported that they systematically communicate laboratory results directly to patients, and almost all responding providers in Round 1 Test states reported that they transmit referral information, such as the reason for the referral, to specialists, hospitals, and other medical providers.
- However, with some exceptions, fewer referrals include clinical information and other patient information relevant to the referral.

Link to behavioral health care

One particular focus within care coordination generally is the extent to which strategies to integrate primary care and behavioral health care are being implemented. The provider survey asked about respondents' most frequent action when a patient has behavioral health needs: whether to give a list of behavioral provider names for the patient to contact on his/her own; refer the patient to a behavioral health care provider with whom the practice has an established relationship; refer the patient to behavioral health providers on site at the practice; or none of the above. As shown in ***Table 6***, the patterns of responses varied across states, with Oregon having the highest percentage of respondents reporting having behavioral health providers on site at the practice (35 percent) and Arkansas having the highest percentage of respondents reporting established relationships with behavioral health care providers (54 percent). The percentage of respondents reporting using either one of those strategies ranged from 46 percent in Massachusetts to 71 percent in Minnesota.

Table 3. SIM Initiative base year provider survey: Communication with patients and other health care providers

Survey instrument question	Response category	Arkansas	Maine	Massachusetts	Minnesota	Oregon	Vermont
How often does your practice track and follow up with patients after clinical referrals (e.g., to specialists or other health care providers) either by phone and/or a follow-up visit?	Always or usually	63%	53%	60%	66%	62%	68%
How often are laboratory test results ordered by this practice communicated to patients in a systematic, routine manner (e.g., by phone, secure email messaging, mail, or patient portal)?	Always or usually	95%	96%	93%	99%	92%	95%
Who routinely transmits patient referral information from your practice to specialists, hospitals, and other medical care providers?	The practice	99%	99%	93%	98%	94%	98%
How often do the referrals your practice provides contain the reason for referral?	Always or usually	99%	100%	97%	100%	99%	100%
How often do the referrals your practice provides contain clinical information relevant to the referral (e.g., test results or medical history)?	Always or usually	91%	98%	87%	95%	96%	97%
How often do referrals your practice provides contain other patient information (e.g., medications the patient is taking or patient allergies)?	Always or usually	81%	93%	71%	87%	87%	87%

Table 4. SIM Initiative base year provider survey: Link to behavioral health care

Survey instrument question	Response category	Arkansas	Maine	Massachusetts	Minnesota	Oregon	Vermont
Patients sometimes need behavioral health services. When your practice has a patient needing these services, which of the following is done most often?	The practice refers the patient to partners with whom the practice has established relationships.	54%	26%	21%	40%	22%	27%
	Behavioral health providers are on site at the practice.	7%	31%	25%	31%	35%	29%
[Of respondents who provide any referral to behavioral health care] How often are behavioral health services available to patients in a timely and convenient manner? (Number of eligible respondents)	*Always or usually*	*57% (159)*	*61% (85)*	*40% (220)*	*37% (61)*	*48% (267)*	*49% (88)*

Electronic health records and health information technology

Round 1 Test states are using SIM resources to fund a range of health information technology (health IT) strategies, including expanding the adoption of electronic health records (EHRs) and using EHRs as tools to support and enable improved care coordination, management, and patient engagement. ***Table 7*** summarizes selected findings from the provider survey that touch on this domain.

- High proportions of practices in all Round 1 Test states reported using EHRs. Vermont had the lowest rate of use (84 percent), and Minnesota had the highest (97 percent).
- Most practices in all Test states reported using EHR or other health IT to document medical care and progress notes. Most practices also reported that they use EHRs or other health IT to send prescriptions to pharmacies electronically.
- Providers varied in their use of an EHR or other health IT systems to view electronic information from patients' health care providers outside the practice (e.g., through health information exchanges [HIEs]). Responses ranged from 27 percent (in Arkansas) to 54 percent (in Maine).
- Providers also varied in their use of patient portals, with responses ranging from 50 percent (in Arkansas) to 79 percent (in Minnesota).

Monitoring quality and expenditure data

Another aspect of care coordination and management is performance monitoring, which identifies opportunities for improvement at both the patient and practice level. Monitoring the quality of care patients receive, as well as their total cost of care and utilization patterns, is common in practices fully engaged in care coordination and management. In some cases, information may be available from within a practice's EHR; however, the SIM Initiatives in some states—and some payers—may provide external reports regarding quality, cost, and utilization information for a provider's or practice's patients.

The provider survey asked respondents about whether they monitor quality and expenditure data for particular patient groups or at the practice level. The survey defined patient groups to mean patients within the practice grouped by source of insurance (e.g., all Medicare patients), chronic conditions (e.g., all patients with diabetes), or other categories; practice-level data monitoring referred to all patients in the practice regardless of source of insurance, chronic conditions, or other category. The survey defined expenditures as those incurred at the practice alone, or across multiple health care providers.

Table 5. SIM Initiative base year provider survey: Electronic health records and health information technology

Survey instrument question	Response category	Arkansas	Maine	Massachusetts	Minnesota	Oregon	Vermont
Does your practice use EHRs?	Yes	86%	94%	95%	97%	90%	84%
How long has your practice used your current EHR system?	3 or more years	59%	70%	78%	60%	61%	54%
Does your practice use an EHR or other health IT system to document medical and/or progress notes?	Yes	87%	92%	93%	95%	90%	84%
Does your practice use an EHR or other health IT system to prescribe electronically?	Yes	85%	94%	98%	94%	89%	89
Does your practice use an EHR or other health IT system to view electronic information from patients' health care providers outside the practice (e.g., through a health information exchange)?	Yes	27%	54%	47%	52%	41%*	40%
Does your practice use an EHR or other health IT system to share electronic clinical data with patients (e.g., lab results through a patient portal)?	Yes	50%	60%	67%	79%	67%	60%

Notes: EHR = electronic health record; health IT = health information technology
*This is the percentage of respondents who use either the Oregon Health Authority's Care Accord system or the Emergency Department Information Exchange to view electronic information from patients' health care providers outside the practice.

Overall, it is more common for providers to review quality information than expenditure information for their patients. We asked questions about monitoring quality data in two different ways. First, we asked whether respondents used EHRs or other health IT tools to *generate* quality measures, and then asked whether they *reviewed* quality measures at the patient group or practice level. A higher percentage of respondents reported that they *generated* quality measures than reported that they *reviewed* quality measures.

Table 8 summarizes selected results related to this survey domain.

- A relatively high proportion of respondents reported reviewing health care quality performance at both the patient group and practice level, either through an EHR or from other sources. Between 62 percent (in Vermont) and 92 percent (in Minnesota) reported using their EHR to *generate* quality measure data. Between 78 percent (in Minnesota) and 46 percent (in Arkansas) of respondents reported *reviewing* quality performance information at the patient group level. Similarly, between 87 percent (in Minnesota) and 50 percent (in Arkansas) reported quality monitoring at the practice level.

Table 6. SIM Initiative base year provider survey: Patient and practice performance monitoring and payment

Survey instrument question	Response category	Arkansas	Maine	Massachusetts	Minnesota	Oregon	Vermont
Does your practice use an EHR or other health IT system to look up cost information (e.g., for medications or lab tests)?	Yes	27%	31%	22%	32%	23%	24%
Does your practice use an EHR or other health IT system to monitor patient expenditures and utilization for services rendered by the practice?	Yes	15%	16%	20%	34%	16%	15%
Does your practice regularly review health care expenditures at the patient group level? Health care expenditures could be those incurred at your practice alone, or across multiple health care providers.	Yes	24%	15%	21%	33%	12%	7%
Does your practice regularly review health care expenditures at the practice level? Health care expenditures could be those incurred at your practice alone, or across multiple health care providers.	Yes	33%	19%	30%	38%	18%	22%
Does your practice use an EHR or other health IT system to generate quality measure data?	Yes	64%	80%	81%	92%	70%	62%
Does your practice regularly review health care quality performance at the patient group level?	Yes	46%	60%	69%	78%	57%	49%
Does your practice regularly review health care quality performance at the practice level?	Yes	50%	66%	76%	87%	60%	58%
Are any portion of payments to your practice based on performance for quality of care, costs, efficiency, or any other performance metrics for any insurer (e.g., Medicare, Medicaid, or commercial insurance group)?	Yes	52%	62%	84%	60%	55%	33%

Notes: EHR = electronic health record; health IT = health information technology

- Few providers reported monitoring expenditures (costs of care) at the patient group or practice level, using an EHR, other health IT tool, or other source of information. Monitoring cost of care can be a key strategy among primary care providers to help themselves and their patients consider costs in making health care choices. Respondents from Minnesota (at 33 percent) reported the highest rates of using this strategy. Somewhat higher proportions of providers reported reviewing expenditures at the practice level, with Minnesota practices (at 38 percent) again reporting the highest positive responses.
- Monitoring of performance is incentivized by payment system reforms that reimburse providers in part based on quality, cost, utilization, or other specific metrics. Performance systems of these types are commonly applied as part of ACOs, PCMHs,

or health homes and are described as value-based purchasing or pay-for-performance. In some Test states, significant proportions (including Massachusetts at 84 percent) reported some performance-based payment. In contrast, only 33 percent of provider respondents from Vermont reported some payment based on performance. In the remaining four states, between 52 and 62 percent of providers reported performance-based payments.

Summary

The SIM Initiatives in the Round 1 Test states are focused on promoting delivery system and payment reforms intended to increase care coordination and care management—and invest in health IT, a data analytic infrastructure, and facilitation of primary care practice transformation. At baseline, in fall 2014, results from the provider survey suggest that engagement in selected care coordination and management–related strategies is already quite high in Test states. For example, large proportions of practices reported assigning patients to specific providers or teams, transmitting referral information to specialists and other providers, using EHR and other health IT systems to document medical/progress notes and prescribe medications, and monitoring quality-of-care performance at the patient group and practice level. However, findings from the baseline survey suggest that considerable room for improvement exists in attaining the highest levels of provider engagement in other strategies, including reminding patients to schedule needed preventive services, following up with patients after referrals, creating links with behavioral health care providers, and monitoring costs and utilization.