SIM-VHCIP State-Led Evaluation Summary and Process Update

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Kathryn O'Neill, MPH
State-Led Evaluation Director, Vermont Health Care Innovation Project
Payment Reform Program Evaluator, Green Mountain Care Board

What We Are Evaluating

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**.

Vermont received $45 million from CMMI over 2013-2017 to support a cross-State effort (AOA, AHS, GMCB, DVHA) to transform our state's health system through investments in:

→ payment model design and implementation,

→ practice transformation, and

→ health data infrastructure.

Visit Vermont Health Care Innovation Project website for more information.

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What We Are Evaluating

Federal evaluation

- Examination of state progress on project initiatives
- Quantitative impact analysis using claims data for Medicaid, Medicare and commercially insured populations within Vermont
- Cross-state studies of payment reform, data infrastructure, workforce development, and population health integration, including progress, challenges, and lessons learned

State-led qualitative evaluation

Studying SIM investment in Vermont within three topical areas:

- Care Integration and Coordination
- Use of Clinical and Economic Data to Promote Value-Based Care
- Payment Reform and Incentive Structures

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State-Led Evaluation

In 2016, the Green Mountain Care Board contracted with John Snow, Inc. (JSI) to conduct an independent State-led evaluation of the *Vermont Health Care Innovation Project* (VHCIP) payment and service delivery models under the SIM grant. The three major evaluation activities conducted by JSI are:

Implementation of a study that includes several components: an environmental scan to gain an understanding of Vermont's health reform landscape; implementation of site visits, stakeholder interviews, and focus groups; surveys targeting health care providers and care integration professionals; and evaluation findings from SIM-supported innovations.

Collection and synthesis of existing data including Shared Savings Program results, survey results, innovative pilot evaluation results, and results from the State-led evaluation study.

Design and implementation of a Learning Dissemination Plan to translate findings from the State-led evaluation into real world language, visuals and tools that will impact the practice and perception of health care in Vermont, and inform VHCIP sustainability planning.

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Objectives of the Qualitative Data Collection Tools

To understand respondents' *perception*, *experience*, and *readiness* in terms of:

Implementation of care coordination activities and perceived quality of care coordination.

Perspective and experience with SIM-supported payment and delivery reforms.

Facilitators and barriers to readiness for participating in alternative payment models.

Utilization of and perceived value of data and data infrastructure.

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State-led Qualitative Data Collection Activities

Site Visits and Interviews Conducted

Diverse scope of stakeholders based on geographic location, scope of project, partnerships, preliminary findings, including Community Collaboratives, Sub-grantees, ACOs, Consumers, Advocacy groups

Fall 2016

Focus Groups Conducted

Populations included persons with disabilities, Integrating Family Services (IFS), Support and Services at Home (SASH), older Vermonters, general care coordination population.

Counties: Addison, Caledonia, Chittenden, Rutland, Windsor

Winter and Spring 2017

Provider and Care Coordinator Surveys Fielded

Provider survey sent to MD, DO, NP, PA in primary care (family practice, general practice, internal medicine, OBGYN, Pediatrics).

– 34% response rate

Care Coordinator survey sent to care coordination professionals

– 31% response rate

Feb-April 2017

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Findings: Interviews and Focus Groups

Health Reform/SIM Generally

➡ Growing unity and cohesiveness supporting a common understanding of health care reform.

➡ Less understanding and consensus around operationalizing reform.

➡ Recognition that reform is complex.

➡ Overall vision of health care reform does not appear to be uniformly understood by front line providers or administrators.

➡ There is some "one more thing" resistance to engaging in new initiatives.

➡ Stakeholder interest in stronger statewide framework guiding primary prevention and prevention as a whole.

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Findings: Interviews and Focus Groups
Payment Reform

SIM funding to ACOs critical to infrastructure development for payment reform.

Scaling and sustaining efforts not possible without funding and scaling requires significant adaptation.

Bundled payments enable organizations to budget staffing and services more effectively because of the ability to think of staffing and future scaling based upon a global budget versus estimations of fee for service income.

Flexible funding linked to quality and population-based payments encourage longer-range strategic planning and infrastructure building to support health care reform.

Strong systems for communication, goals, and impact measurement, while including a highly flexible care model, is valued.

Provider fatigue and time limitations to adequately research and explore implications of shared savings were noted as why some practices do not participate in Shared Savings Programs.

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Findings: Interviews and Focus Groups

Care Coordination

VHCIP has served as a catalyst for care integration activities, building on existing programs to establish more formalized and efficient structures for integrated work, and supporting regional and state-wide collaborative structures.

VHCIP has led in discussions of how payment models can better support care coordination.

Formal agreements and procedures are hallmark of care coordination.

Referral to care coordinators by clinicians has become more routine and valued in care coordination activities for beneficiaries having difficulty managing their health or for whom social determinants of health create significant barriers to care or self-care.

Learning Collaboratives and Core Competency Trainings central to the success of care coordination activities.

Expansion to include supportive clinical providers and community based organizations would help advance care coordination activities, particularly as it relates to addressing social determinants of health.

Financial incentives exist to provide care coordination; however, incentives that enhance cooperation have not been leveraged.

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Findings: Interviews and Focus Groups

Data

Data and data infrastructure have been critical to improvements in care coordination in creating richer, more accurate data.

Divided thoughts as to whether it is a better strategy to build data infrastructure and analytic capacity locally or centrally.

Development of new data systems need to consider compatibility with other systems, particularly the HIE, in order to assure future capability to exchange data and should apply across the spectrum of local, regional and statewide efforts.

Stakeholders understand the need for accountability, yet they are concerned that there is an imbalance in terms of the volume of measures versus the value of measurement.

Too many different ways to access data and too many portals that need to be used to gain access, resulting in poorer utilization of the data.

Alignment should continue to be a goal.

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Findings: Focus Groups (specifically)

- When patients/consumers are active participants of care team, care and experience is more positive, appropriate and timely.

- Social determinants are a predominant issue negatively impacting overall health and well being.

- Care coordinators, case managers and advocates increase consumers' access to and utilization of appropriate care and support services by working to:
  - increase provider awareness of social determinants via provider education.
  - arrange for provider home visits.
  - increase consumers' self-advocacy skills.
  - facilitate access to community supports and services to address social determinants.

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Findings: Care Coordinator Survey

While coordination has improved, there is room for continued improvement of cross-organization care coordination and with coordination and communication around care transitions.

How would you rate the difficulty that you have in doing the following activities to get patients/clients the services they need?
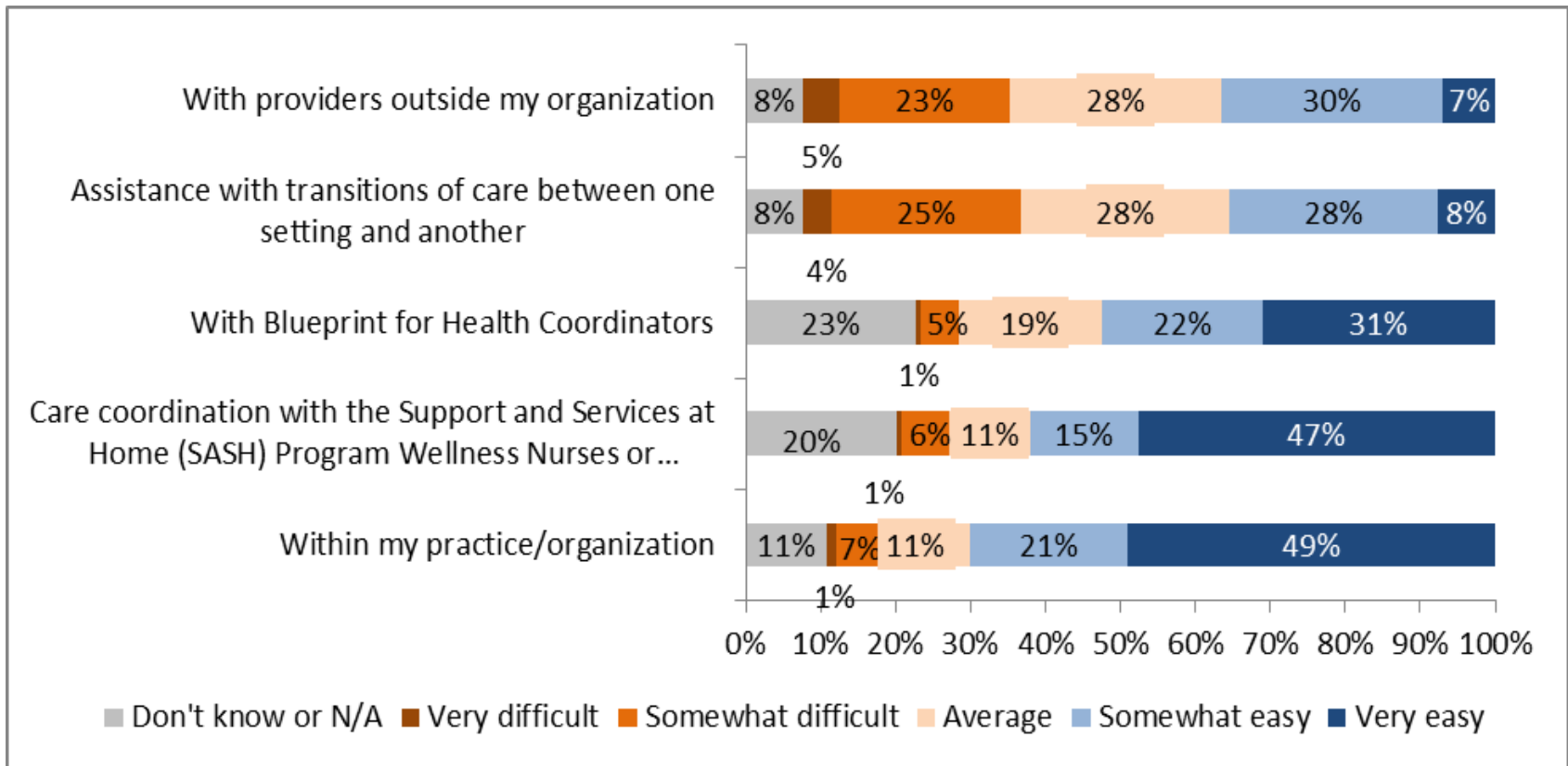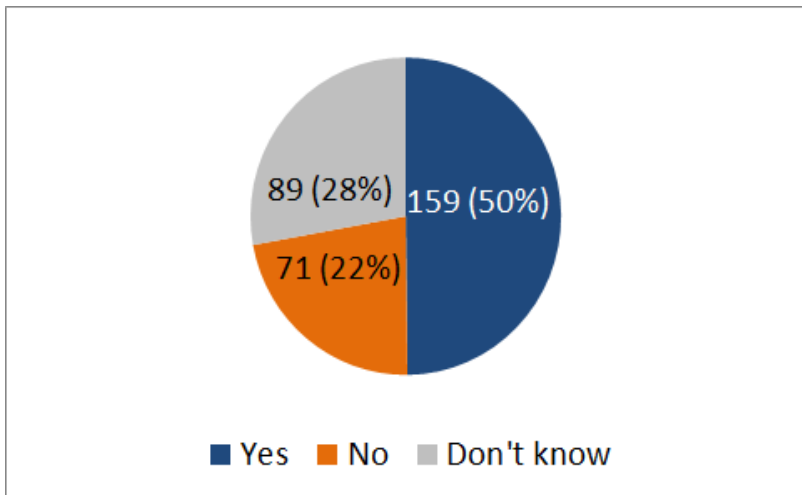
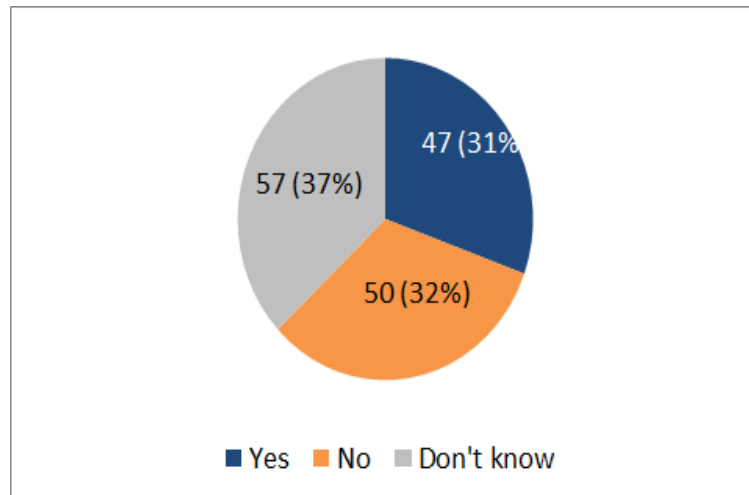# Findings: Provider and Care Coordinator Surveys

Payment activities to incentivize improved quality may not be reaching, or may not be well-understood by the front line professionals working on quality improvements.

Are any portion of payments to the practice where you spend the majority of your time based on performance of quality of care, costs, efficiency, or any other performance metrics for any insurer?

PROVIDER RESPONSE

89 (28%) 159 (50%)
71 (22%)

■ Yes ■ No ■ Don't know

CARE COORDINATOR RESPONSE

47 (31%)
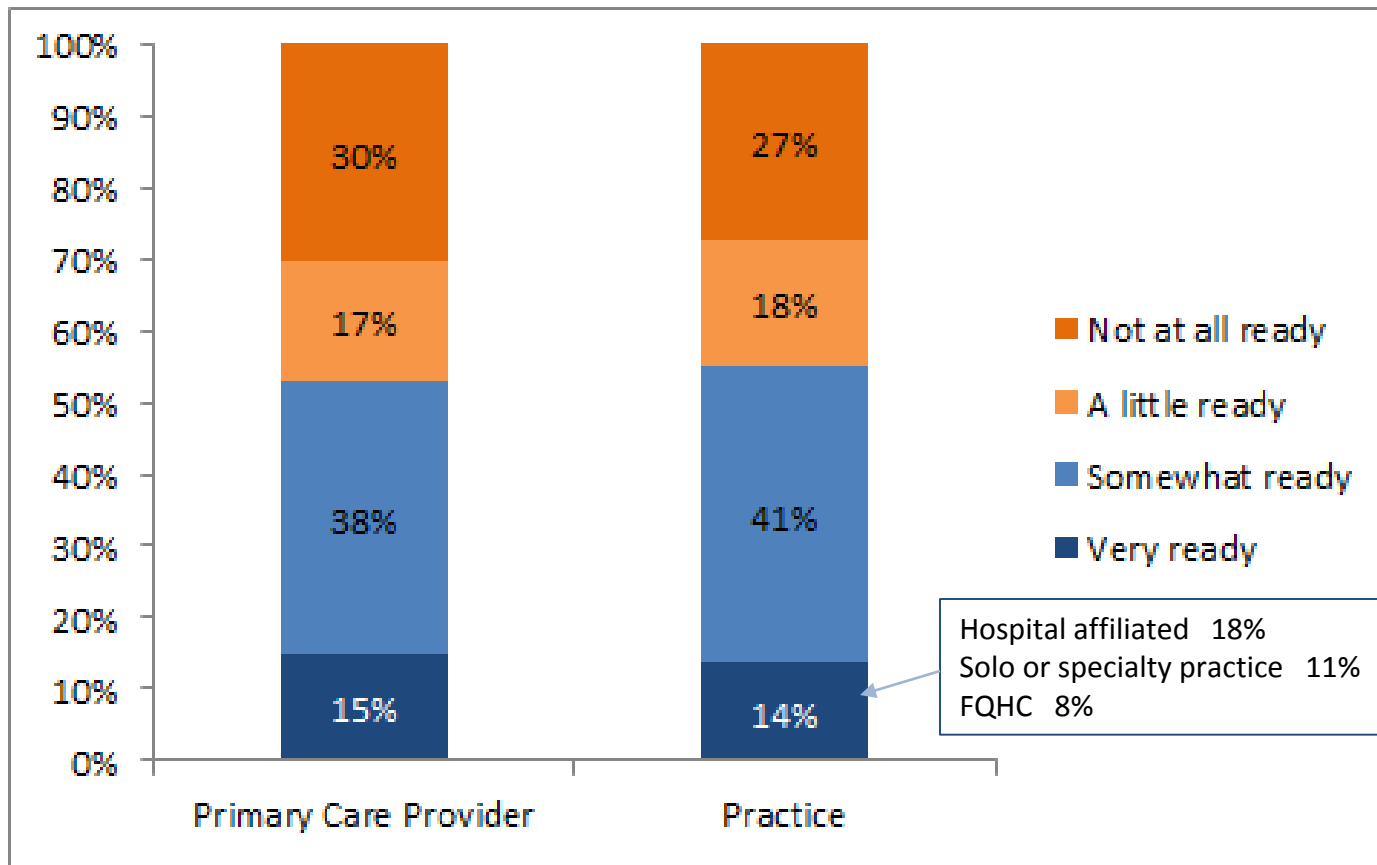57 (37%)
50 (32%)

■ Yes ■ No ■ Don't know

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Findings: Provider Survey

Readiness for payment reform is similar at provider and practice levels, though level of readiness varies by practice type.

How ready do you feel to have some amount of your compensation tied to performance?

Hospital affiliated   18%
Solo or specialty practice   11%
FQHC   8%

Findings: Provider Survey

Perception of program impact on quality of services.

To what extent has participation with (the program) affected your ability to improve the quality of services at the practice?
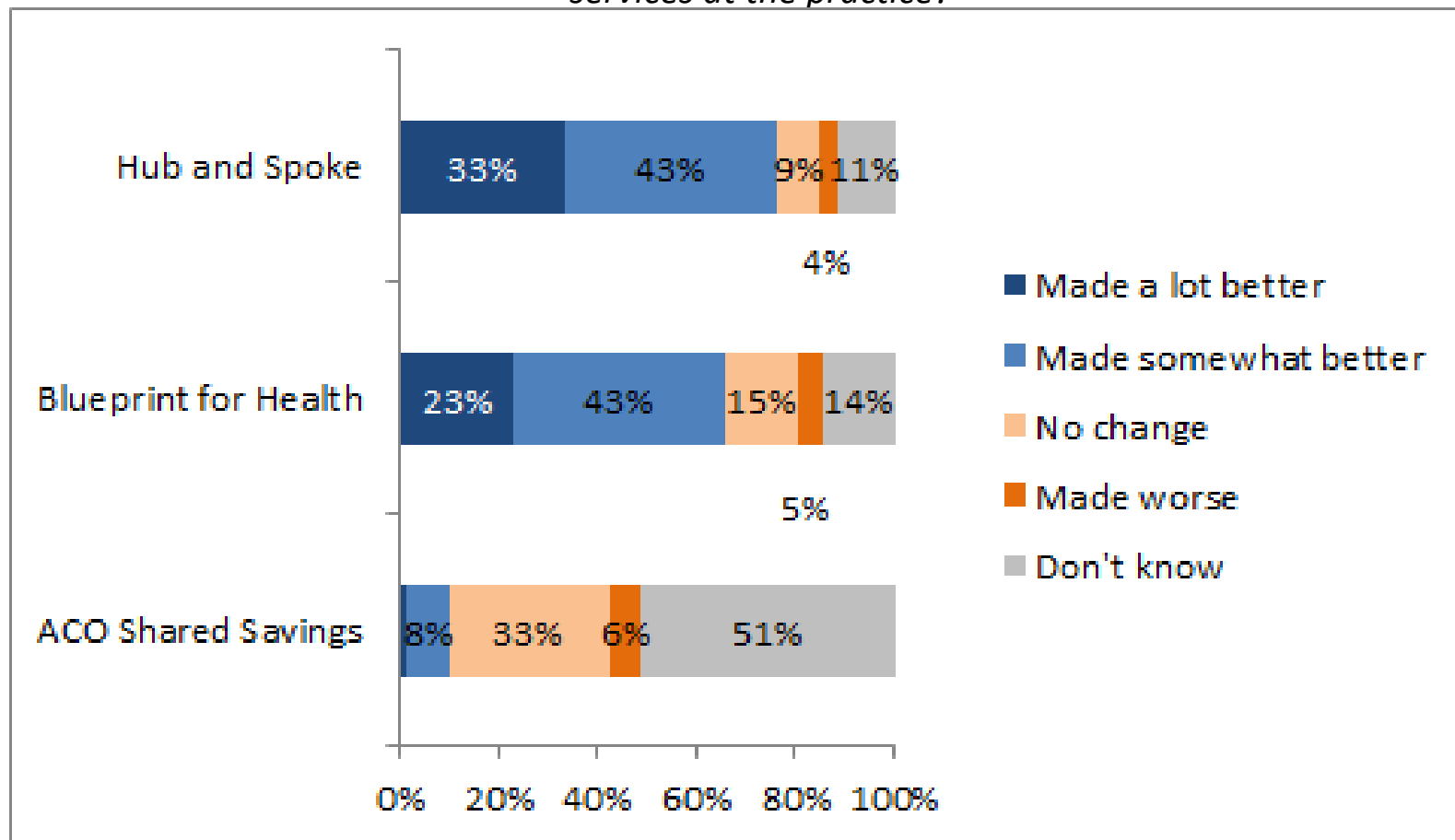
Findings: Provider Survey

Perception of program impact on patient outcomes.

To what extent has participation with (the program) affected your ability to improve health outcomes for your patients at the practice?

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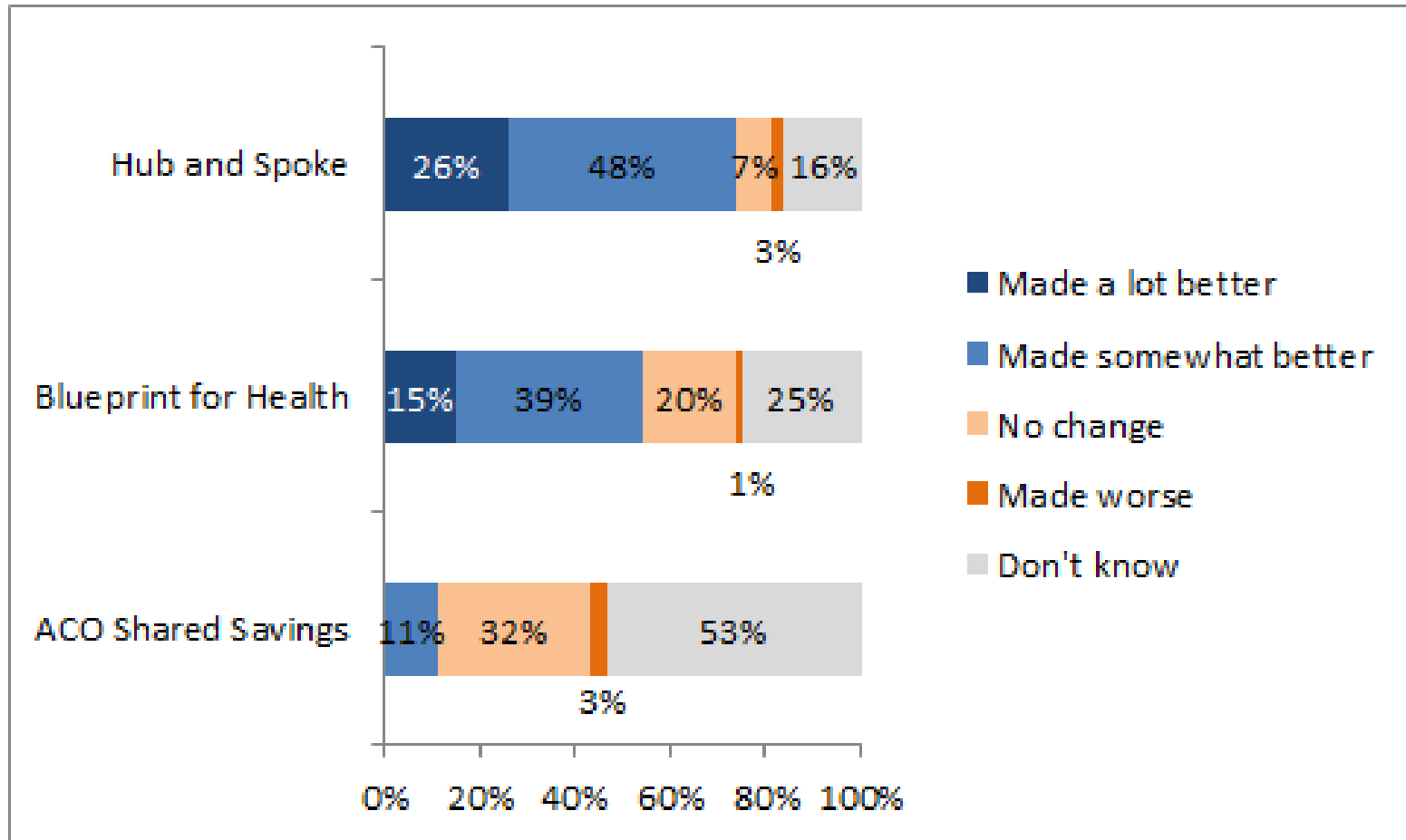# Findings: Provider Survey

Perception of program impact on cost.

To what extent has participation with (the program) affected your ability to reduce health care costs at the practice?
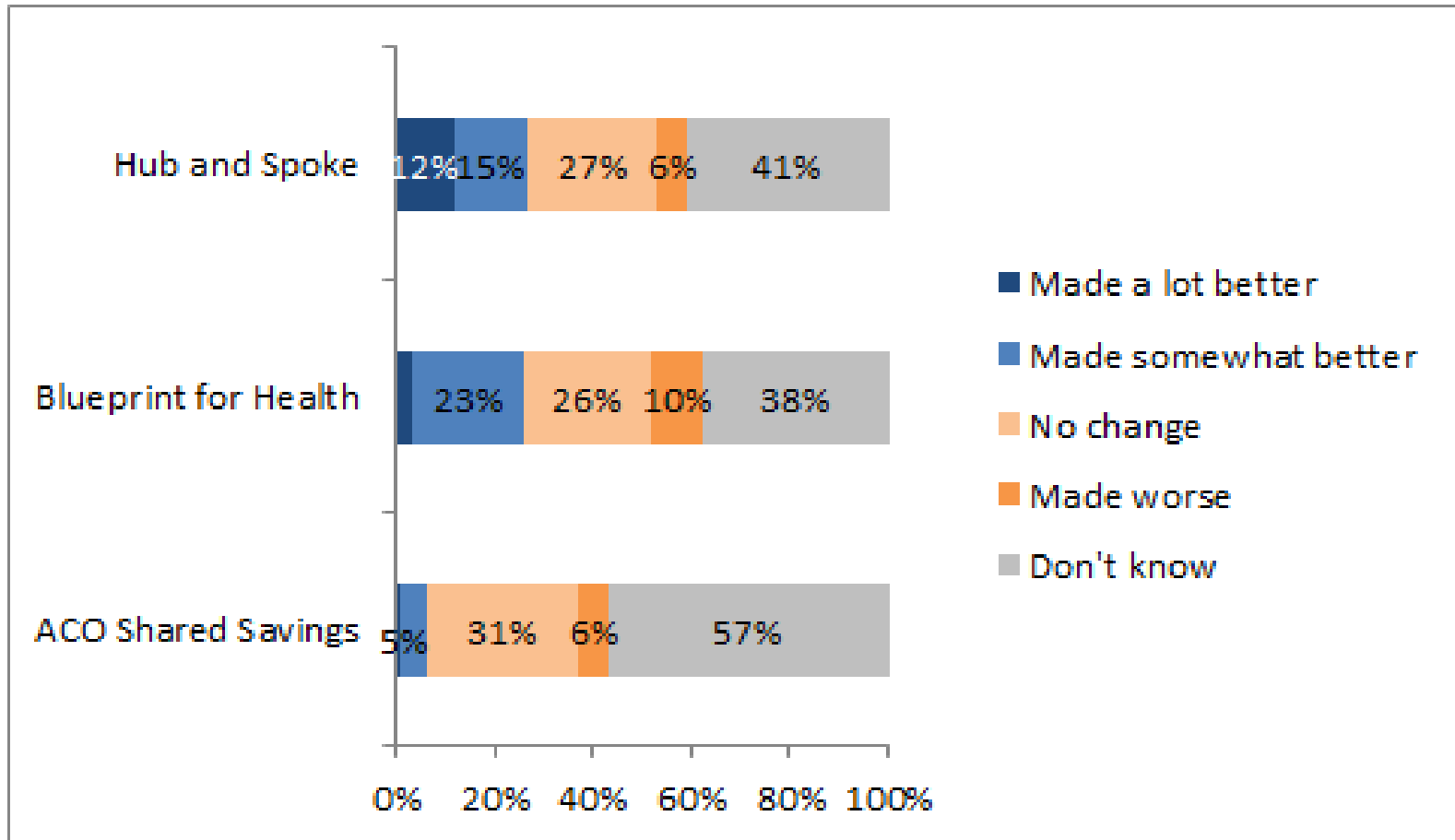
Findings: Provider Survey

The most commonly requested support to improve readiness for alternative payment models were standardized quality measures and better analytics, which is consistent with findings nationally.

Which of the following would make you and/or the practice where you spend the majority of your time more ready to participate in alternative payment models, such as global payment, shared savings with downside risk, or other non-fee-for-service payment models?
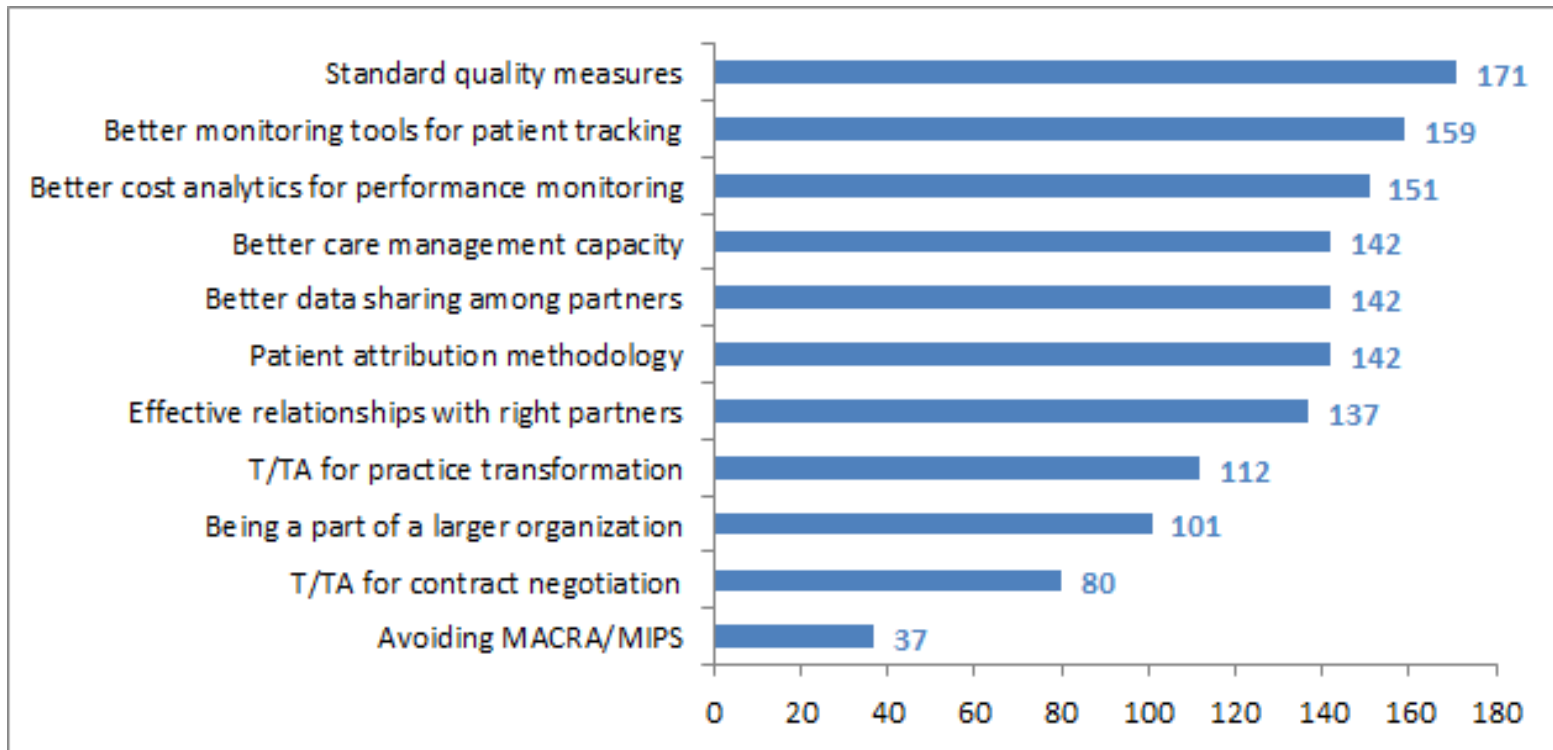
Findings: Provider and Care Coordinator Surveys

The majority of providers and care coordinators report their behavior is at least somewhat data driven, though this reflects the need for improved health data infrastructure.

Please state the extent to which you agree/disagree with the following statement(s):

Legend:
- ■ Strongly agree
- ■ Somewhat agree
- ■ Somewhat disagree
- ■ Strongly disagree
- ■ Don't know

PROVIDER RESPONSE

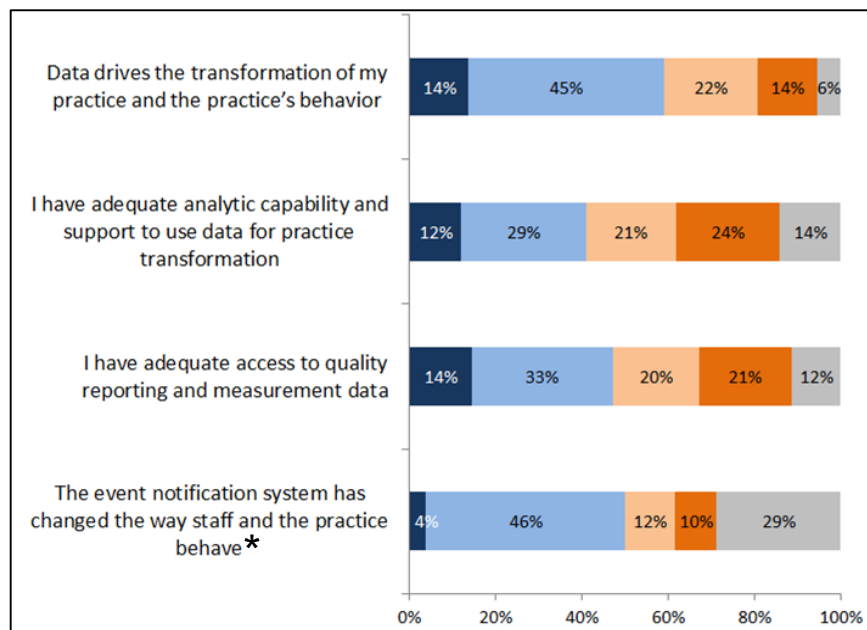| Statement	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree	Don't know
Data drives the transformation of my practice and the practice's behavior	14%	45%	22%	14%	6%
I have adequate analytic capability and support to use data for practice transformation	12%	29%	21%	24%	14%
I have adequate access to quality reporting and measurement data	14%	33%	20%	21%	12%
The event notification system has changed the way staff and the practice behave *	4%	46%	12%	10%	29%

76% of PROVIDER respondents did not use any event notification system and therefore did not answer this question

CARE COORDINATOR RESPONSE

Statement	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree	Don't know
Data drives the transformation of my practice and the practice's behavior	24%	52%	13%	5%	7%
I have adequate analytic capability and support to use data for practice transformation	13%	41%	18%	16%	12%
I have adequate access to quality reporting and measurement data	12%	45%	18%	13%	12%
The event notification system has changed the way staff and the practice behave *	22%	45%	8%	5%	19%

49% of CARE COORDINATOR respondents did not use any event notification system and therefore did not answer this question

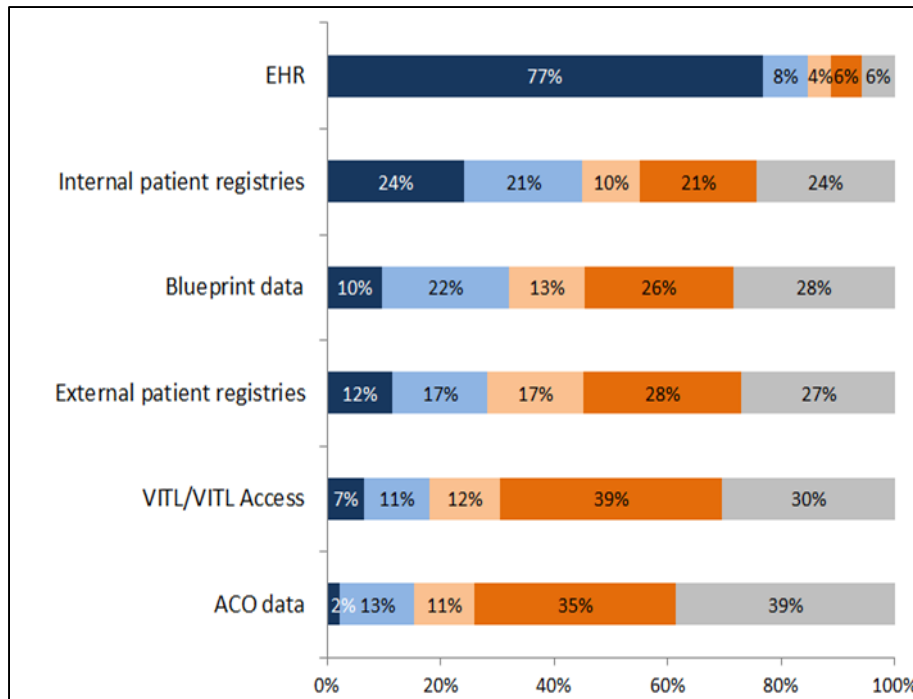VERMONT
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Findings: Provider and Care Coordinator Surveys

Providers are using data systems to facilitate and improve care, and may be most likely to use existing systems, like EHRs rather than newer data sources.
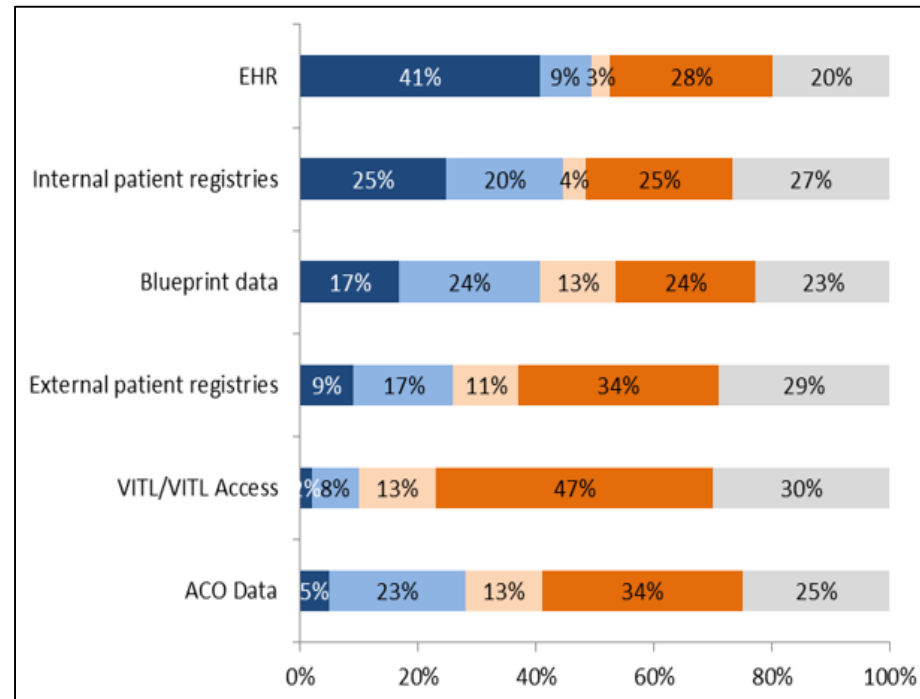
How often do you use the following data systems in support of patient care or quality improvement?

Legend:
- Often (dark blue)
- Sometimes (light blue)
- Rarely (tan)
- Never (orange)
- Don't know or N/A (gray)

PROVIDER RESPONSE

Data System	Often	Sometimes	Rarely	Never	Don't know or N/A
EHR	77%	8%	4%	6%	6%
Internal patient registries	24%	21%	10%	21%	24%
Blueprint data	10%	22%	13%	26%	28%
External patient registries	12%	17%	17%	28%	27%
VITL/VITL Access	7%	11%	12%	39%	30%
ACO data	2%	13%	11%	35%	39%

CARE COORDINATOR RESPONSE

Data System	Often	Sometimes	Rarely	Never	Don't know or N/A
EHR	41%	9%	3%	28%	20%
Internal patient registries	25%	20%	4%	25%	27%
Blueprint data	17%	24%	13%	24%	23%
External patient registries	9%	17%	11%	34%	29%
VITL/VITL Access	2%	8%	13%	47%	30%
ACO Data	5%	23%	13%	34%	25%

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Secondary Analyses included in Final Evaluation Summary Report

✓   SSP and Blueprint Measure Results

✓   Patient Experience Survey Results

✓   Sub-Grant Self-Evaluation Results

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Upcoming Contract Deliverables

The *Provider and Care Coordinator Survey Results Report* will be submitted by contractor (JSI) at the end of June 2017.

The final full *State-led Evaluation Study Report* will be available in 3rd quarter 2017. This report will provide an overall summary of findings and recommendations.

NOTE: Contract amendment to build data visualization tools will not be conducted due to truncated contract timeline.

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