MINNESOTA ACCOUNTABLE HEALTH MODEL CONTINUUM OF ACCOUNTABILITY ASSESSMENT: EVALUATION DATA SOURCE AND MORE

2016 Minnesota Health Services Research Conference

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Outline

- SHADAC overview
- Federal and state health reform context
- State Innovation Model (SIM) initiative
- Minnesota's Accountable Health Model
- Continuum of Accountability Assessment
- Examples of other assessments
- Preliminary findings
- Next steps

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SHADAC: Bridging the gap between research and policy

- Multidisciplinary health policy research center with a focus on state policy

- 2 faculty, 18 staff, 9 graduate students

- Recent projects include: State-led Evaluation of the State Innovation Model (SIM) in Minnesota, Impact of the ACA in Kentucky, Value-based Payment Reform in Medicaid

- Maintain the Data Center – state-level information on health insurance coverage, access and cost

- Funded by the Robert Wood Johnson Foundation, the State of Minnesota, and others

State and Federal health reform call for "testing" of alternate service delivery and payment models

Minnesota Reforms

- e-Health
- Health Care Homes
- Medicaid ACOs or IHPs
- Community Care Teams

Federal Reforms

- CMS' Innovation Center
- Payment demonstrations, e.g., episode based payment initiatives
- Care delivery Demonstrations, e.g., primary care transformation initiatives
- State Innovation Model

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State Innovation Model (SIM) Initiative

- Cooperative agreement between federal and state governments

- Two funding rounds; two types of awards (Design and Test)

- Purpose is to improve the quality of care and lower the costs of care for public programs including Medicare, Medicaid, and CHIP

- Emphasis on multi-payer involvement and improved health of state populations

- To date, 34 states, three territories and the District of Columbia have received SIM funding

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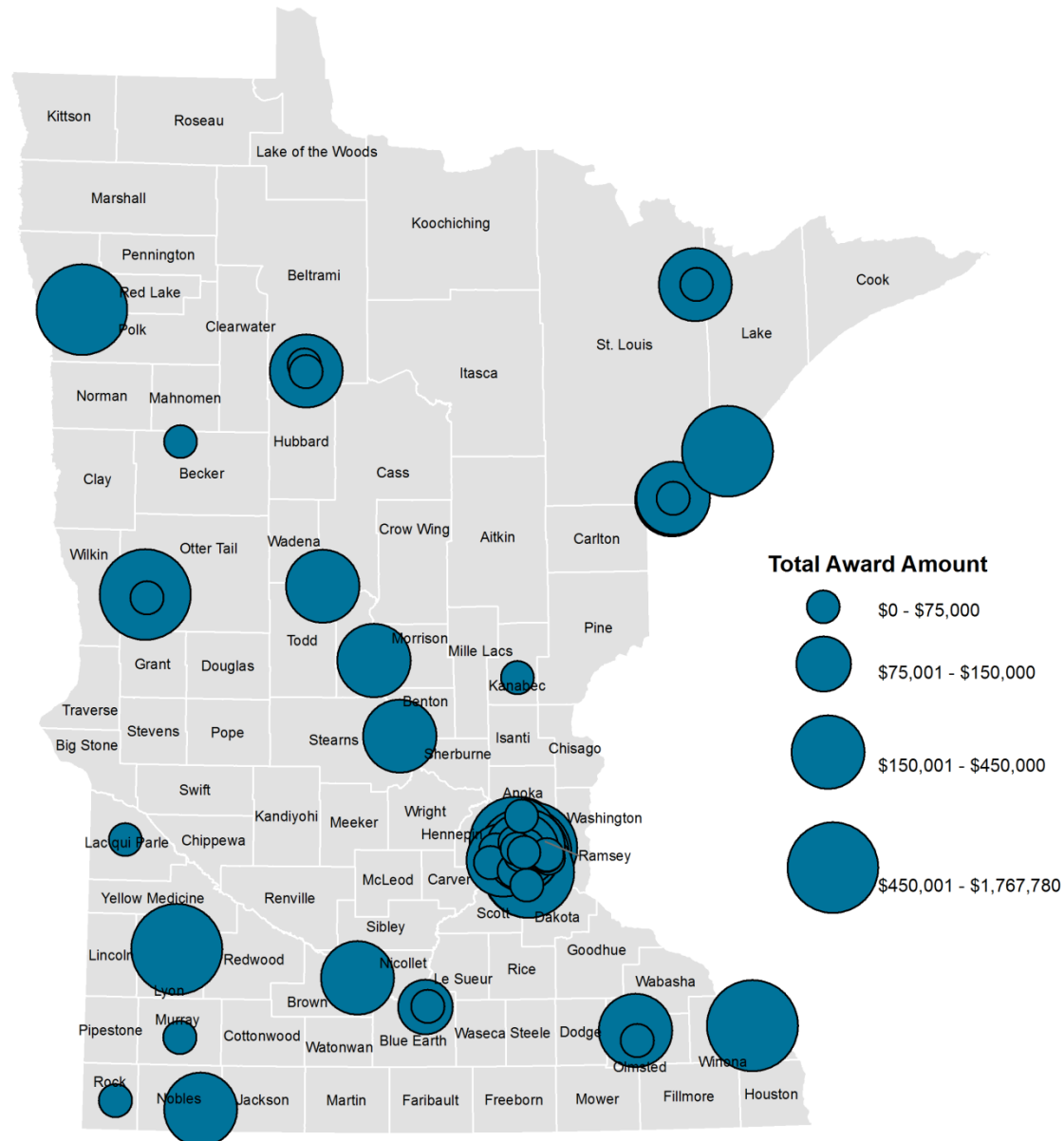STATE HEALTH ACCESS DATA ASSISTANCE CENTER

Minnesota Accountable Health Model: Aims

- Four model aims, by 2017:

    - The majority of patients receive care that is patient-centered and coordinated across settings
    - The majority of providers are participating in ACO or similar models that hold them accountable for costs and quality of care
    - Financial incentives for providers are aligned across payers and promote the Triple Aim goals
    - Communities, providers, and payers have begun to implement new collaborative approaches to setting and achieving clinical and population health improvement goals

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Minnesota Accountable Health Model: Strategies

1. The expansion of e-Health

2. Improved data analytics across the State's Medicaid ACOs (i.e., Integrated Health Partnerships)

3. Practice transformation to achieve interdisciplinary, integrated care

4. Implementation of accountable communities for health (ACHs)

5. ACO alignment across payers related to performance measurement, competencies, and payment methods.

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SIM-Minnesota Investments

Total Award Amount

- $0 - $75,000
- $75,001 - $150,000
- $150,001 - $450,000
- $450,001 - $1,767,780

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Minnesota Accountable Health Model Continuum of Accountability Assessment

- Early in SIM implementation, DHS and MDH jointly developed, with stakeholder input, an assessment to:

  - Articulate the capabilities, relationships and functions needed to achieve Model aims

  - Request that participating organizations self-assess their status relative to desired factors

  - Identify what supports or technical assistance resources are needed

  - Track progress over time

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Overview of Continuum of Accountability Assessment Tool Items

- Self-assessment of organization status on 31 capabilities and functions within 7 categories:

  1. Model Spread and Multi-Payer Participation (1 item)
  2. Payment Transformation (1 item)
  3. Delivery and Community Integration and Partnership (14 items)
  4. Infrastructure to Support Shared Accountability Organizations (2 items)
  5. Health Information Technology (7 items)
  6. Health Information Exchange (4 items)
  7. Data Analytics (2 items)

Example Question from Tool

Delivery and Community Integration and Partnership Section

3. **Population Management: To what extent does your practice have a process to identify appropriate patients/clients for care coordination?** *Select the level that best represents your organization, and within that level choose the appropriate response by checking the box.*

Pre-Level	Level A	Level B	Level C	Level D
☐ None	We do not currently have a process in place but are planning or beginning to implement this.	We have an informal process where care team members and providers identify patients/clients for care coordination.	We routinely assess patients'/clients' needs for care coordination using methods such as pre-visit planning, use of registries and team / provider input.	We systematically assess the patient/client population for care coordination needs with use of data or screening tools, such as population based registry and community or payer data on a regular basis.
	☐ Beginning ☐ In progress ☐ Mostly done	☐ Beginning ☐ In progress ☐ Mostly done	☐ Beginning ☐ In progress ☐ Mostly done	☐ Beginning ☐ In progress ☐ Mostly done

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Other SIM States' Assessments

SIM State	Design or Test	Assessment Target	Assessment Categories
Round 1: Oregon	Model-Testing	Coordinated Care Organizations (CCOs)	Physical, Mental Health Service Integration; Patient-Centered Primary Care Homes; Outcome and Cost Control Payment Methods; Health Information Technology; Culturally-Competent Care
Rounds 1 and 2: Michigan	Model-Designing, then Testing	Organizations interested in becoming Accountable Systems of Care	Complex Care Management; Coordinated Care; Health Information Infrastructure; Financial Risk Management; Administration and Governance
Round 2: New Jersey	Model-Designing	Providers	Health Information Systems; Care Management, Access, and Health Promotion; Staffing and Practice Characteristics

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Sample of Completed Assessment Tools

Grant Program	Number of Tools (Received/Participating Organizations)
E-Health	82/160
IHP Data Analytics	9/11
Practice Transformation	45/54
Emerging Professions	13/69
ACH	72/170

Source: SHADAC (December 2015). "Assessment Tool Database: Continuum of Accountability Assessment Tools Submitted by Organizations Participating in the Minnesota State Innovation Model (SIM) Initiative."

Average Scores for All Organizations

% Pre-level

Category	Measure	Score	% Pre-level
Model Spread and Multi-payer Participation	Payment Arrangements		39.8
Payment Transformation	Alternatives to FFS		31.2
Delivery and Community Integration and Partnership	Knowledge of Community Resources		0.5
	Population Management		5.4
	Referral Process		0.5
	Patient and Family-Centered Care		7.2
	Culturally Appropriate Care Delivery		0
	Patient Input on Org. Improvement Activities		1.8
	Team-Based Work		2.7
	Transitions Communication		5.0
	Transitions Planning		4.5
	Self Management Support		3.6
	Communications Training		6.8
	Quality Improvement		7.2
	Emerging Workforce Roles		24.4
Infrastructure to Support Shared Accountability Organizations	Care Coordination		2.3
	Governing Body		8.1
	Governance Establishment		14.5
Health Information Technology Capabilities	EHR Implementation		10.9
	EHR for CPOE		20.8
	EHR for Immunization Monitoring		16.3
	EHR for Quality Improvement		5.9
	EHR Tracking of Consent to Release PHI		10.0
	EHR for Clinic Decision Support Tools		8.6
	EHR for Summary Care Records		11.3
Health Information Exchange	e-Prescriptions for Non-Controlled Substances		22.2
	e-Prescriptions for Controlled Substances		29.0
	e-Exchange of Clinical Information		8.6
	e-Exchange of Summary of Care Record		14.9
Data Analytics Capabilities	Data Analysis and Organization of Info.		4.5
	Use of Analysis		6.8

Axis: 2 — 2.5 — 3 — 3.5 — 4 — 4.5 — 5

(Level A) ⟶ (Level D)

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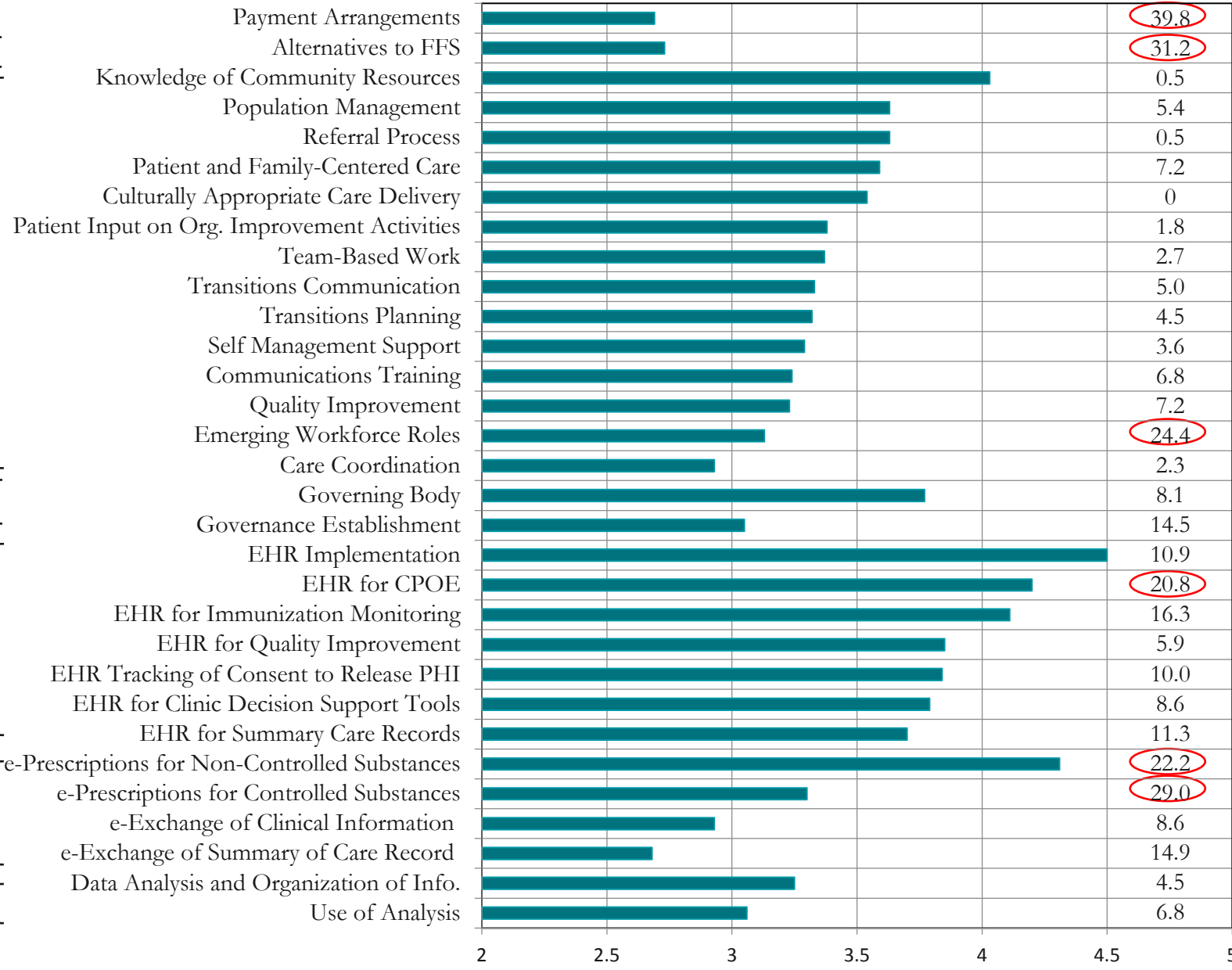
Preliminary Results for Item with Higher Average Scores - EHR Implementation

Grant Program	Mean	Location	Mean
E-Health (n=56)	4.45	Urban (n=104)	4.82
IHP Data Analytics (n=9)	5.00	Rural (n=56)	4.45
Practice Transformation (n=42)	4.93		
Emerging Professions (n=8)	5.00		
ACH (n=46)	4.65		

Note: The same organization could have submitted more than one completed tool due to participation in more than one grant program; sample sizes vary by question due to missing data and number of "prelevel" responses.

Question 19:

2 (Level A) = We do not use an EHR but are in the planning and/or implementation process.

3 (Level B) = We have an EHR in use for 1%-50% of staff and providers at our practice.

4 (Level C) = We have an EHR in use for 51%-80% of staff and providers at our practice.

5 (Level D) = We have an EHR in use for more than 80% of staff and providers at our practice.

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Preliminary Results for Item with Lower Average Scores – Alternatives to FFS

Grant Program	Mean	Location	Mean
E-Health (n=43)	2.65	Urban (n=83)	2.77
IHP Data Analytics (n=8)	3.25	Rural (n=42)	2.62
Practice Transformation (n=34)	2.26		
Emerging Professions (n=5)	3.00		
ACH (n=36)	3.11		

Question 2:

2 (Level A) =We have little or no readiness to manage global costs, but may be willing to assume fixed payment for some ancillary services.

3 (Level B) =We are ready to manage global costs with upside risk. We participate in shared savings or similar arrangement with both cost and quality performance with some payers; may have some financial risk.

4 (Level C) =We are ready to manage global cost with upside and downside risk. We participate in shared savings and some arrangements moving toward risk sharing through Total Cost of Care or partial to full capitation for certain activities; may include savings reinvestments and/or payments to community partners not directly employed by the contracting organization

5 (Level D) =We are ready to accept global capitation payments. Community partners are sharing in accountability for cost, quality and population health are included in the financial model in some form.

Delivery and Community Integration and Partnership Items for Health Care Homes (HCHs)

Question	HCH Average Score	Non-HCH Average Score
Population Management	4.21	3.59
Care Coordination	2.89	2.74
Team-Based Work	3.69	3.47
Referral Processes	4.02	3.67
Transitions Planning	3.49	3.34
Quality Improvement	3.89	3.62
Knowledge of Community Resources	4.04	3.78
Culturally Appropriate Care Delivery	3.91	3.40
Patient and Family Centered Care	4.15	3.35
Self Management Support	3.55	3.03

Note: Average score and % prelevel pre-grant for clinics and health systems by Health Care Home certification status, across all SIM grant programs (HCH n=51, non-HCH n=38).

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Practice Transformation Grant Program: Change Over Time
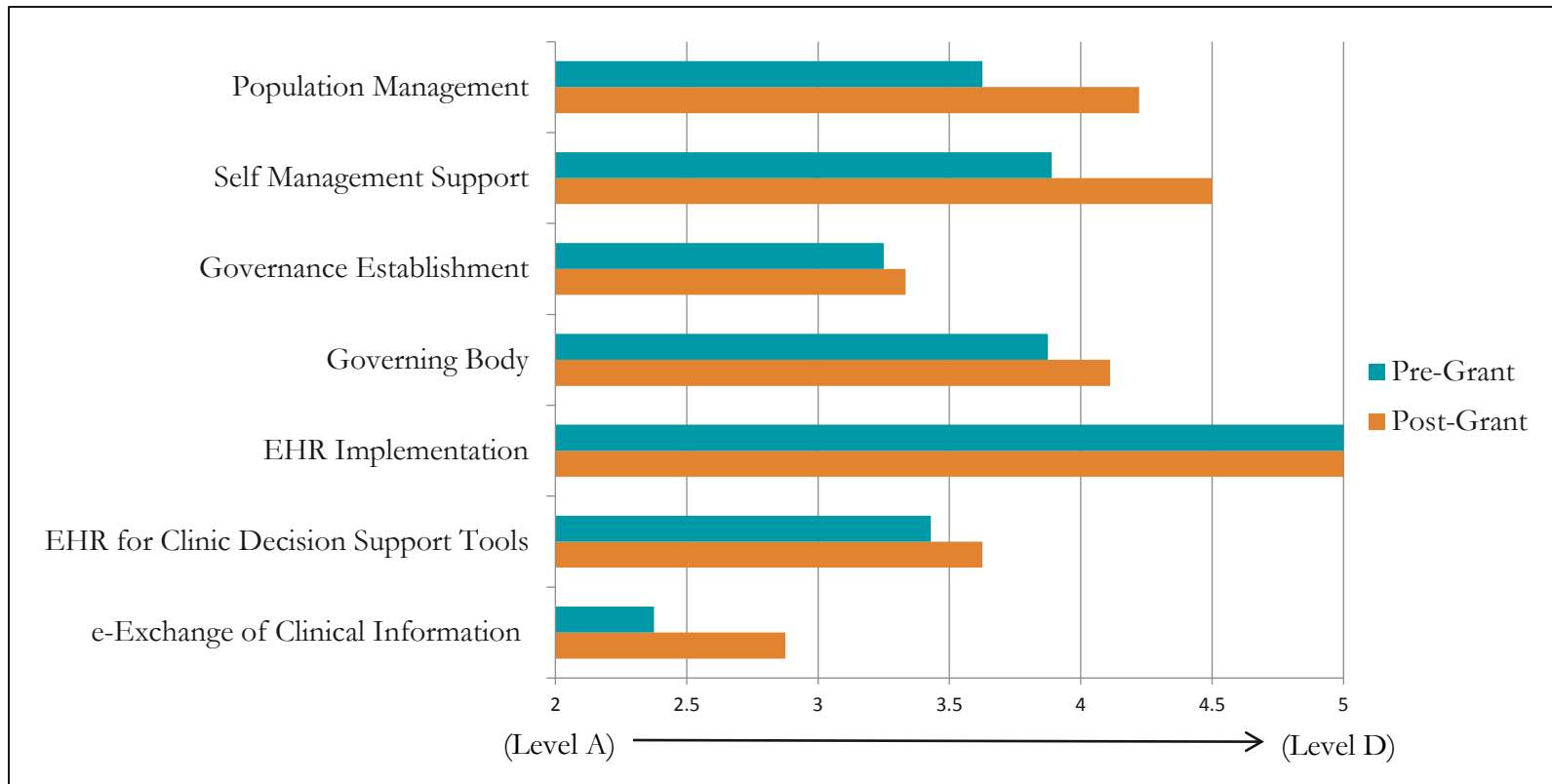
Note: Average score pre- and post-grant for organizations that received Round 1 Practice Transformation funding (n=10).

Next Steps

- With additional post-award data, the SHADAC evaluation team will be tracking movement along the Continuum of Accountability in year two of the state evaluation.

- The State has also asked SHADAC to provide feedback on the tool for future use.
  - Strengths
  - Limitations
  - Stakeholder and grantee perspectives on tool design, administration, and results

Thank you!

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