Development of a Vermont ACO Pilot: A Community Health System To Achieve the Triple Aims

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Outline

- Context: Vermont Health Care Reform
- Building a Community Health System
  - Conceptual Framework
  - Enhanced Medical Home pilots
  - Development of an ACO pilot
- Key findings and conclusions
- Current status and next steps

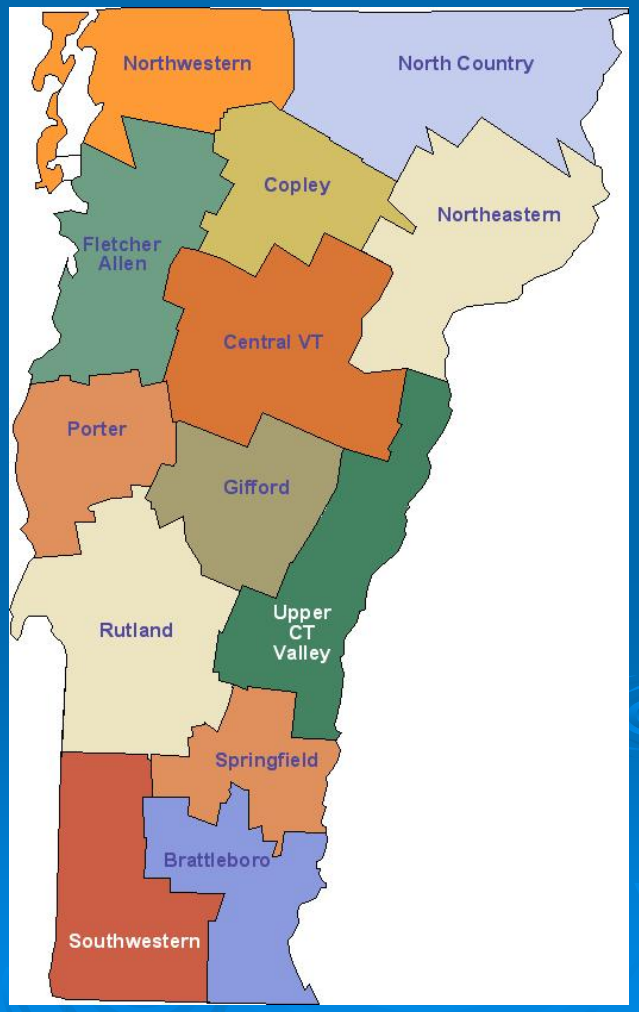
I. Context: VT Health Reform

600,000 total population

13 Hospital Service Areas define ‘community systems’

Payers: 3 major commercial + 2 public

History of collaboration: bipartisan and multi-stakeholder



Vermont's Reform Strategy

Act 191 (2006) created 'three legged stool' which balanced

1. Sustainable reduction in uninsured from 10% to 4% by 2010
2. Health IT as catalyst for improved performance
3. Bending the medical cost curve through delivery system reform
   - Blueprint for Health: Chronic illness prevention and care

Plus a variety of supporting projects (60+)

Building Blocks for Community Health System

- Chronic Care Model (2005-6):
  - VPQHC collaboratives on Wagner's Chronic Care Model
  - Blueprint for Health: Implement CCM in pilot communities
  - Add prevention component to CCM
- Enhanced Medical Homes (2007-10)
  - Expand beyond chronic illness
  - Begin building community based, population health focus
- Triple Aims (2007-10)
  - IHI Triple Aim participant (2007)
  - Legislation (2008)
- ACO Pilot (2008-10)
  - Feasibility study (2008)
  - Support for VT pilot site (2009)
  - Accelerated expansion of pilots (2010 in process)

II. Building a Community Health System

‘Every system is perfectly designed to obtain the results it achieves.’

Approach

- System redesign at multiple levels
  - Primary care practice level: Enhanced medical homes
  - Community health system: ACO or ‘neighborhood’ for medical home
  - State/regional infrastructure and support e.g. HIT, payment reform
  - National: Medicare participation
- Start in pilot communities

Payment Reform

- Necessary, but not sufficient element of reform
- One of most difficult, particularly integrating across payers
- Phase I: Blueprint enhanced medical home pilots links primary care incentives to medical home functions
- Phase II : ACO pilot broadens incentives to community providers
- What will enable the ACO pilot to be successful?

Building ‘Systemness’

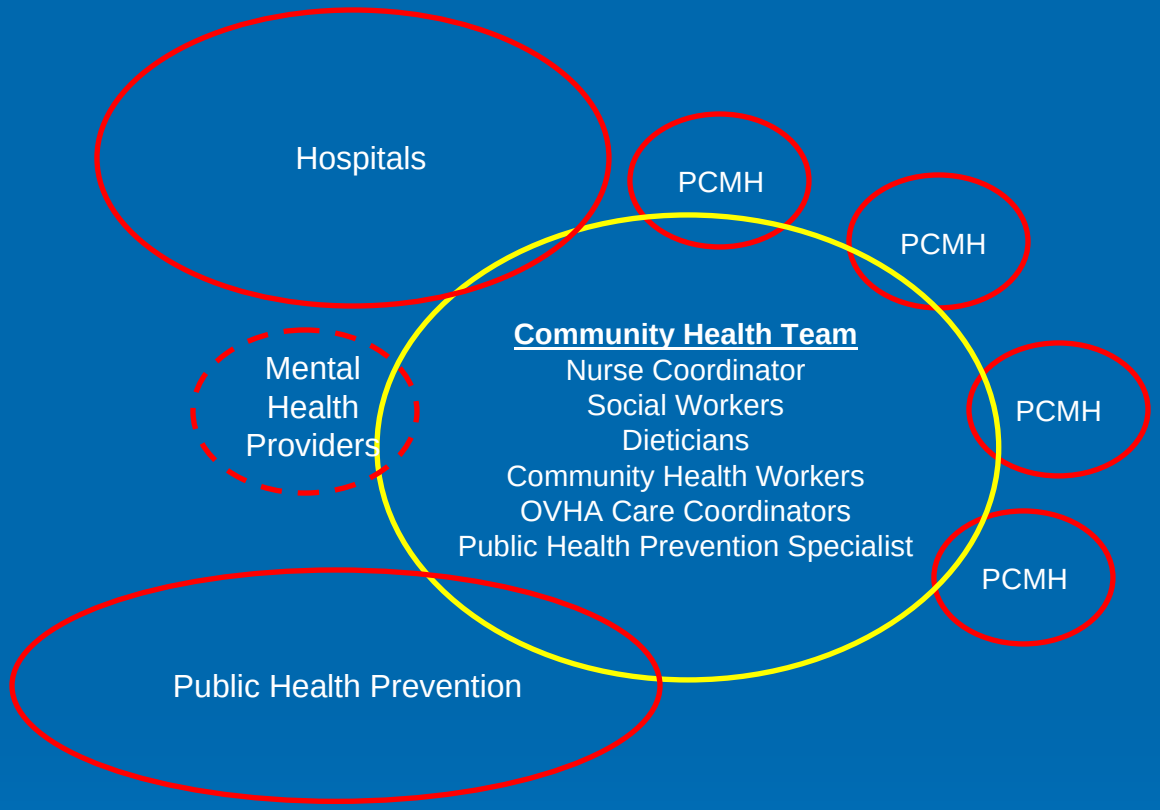
Key generic functions in a community health system

- **Service** integration across levels and settings of care
  - patient centered integrated care models
  - integration of health care, public health and supporting social services to support population health
- **Financial** integration
  - financial models across multiple payers
  - Local management of integrated budgets
- **Governance**: Provide leadership, and establish accountability
- **Information**: Deploy information tools to support care, management, process improvement and evaluation
- **Process improvement**: Design, implement and improve performance

Phase I: Community Based Enhanced Medical Home Pilots

- Payment reform for primary care
  - Patient Centered Medical Home (PCMH) model
  - Sliding care management fee linked to 10 NCQA PCMH criteria
- New community health team funded by payers
- All payer participation:
  - Mandated participation by 3 commercial payers and Medicaid
  - State paying for Medicare patients
- Community based prevention plan and evidence based interventions
- Strong IT support: DocSite clinical tracking tool, EMR interfaces, and health information exchange

Blueprint Enhanced Medical Home Pilots



Health IT Framework

Global Information Framework

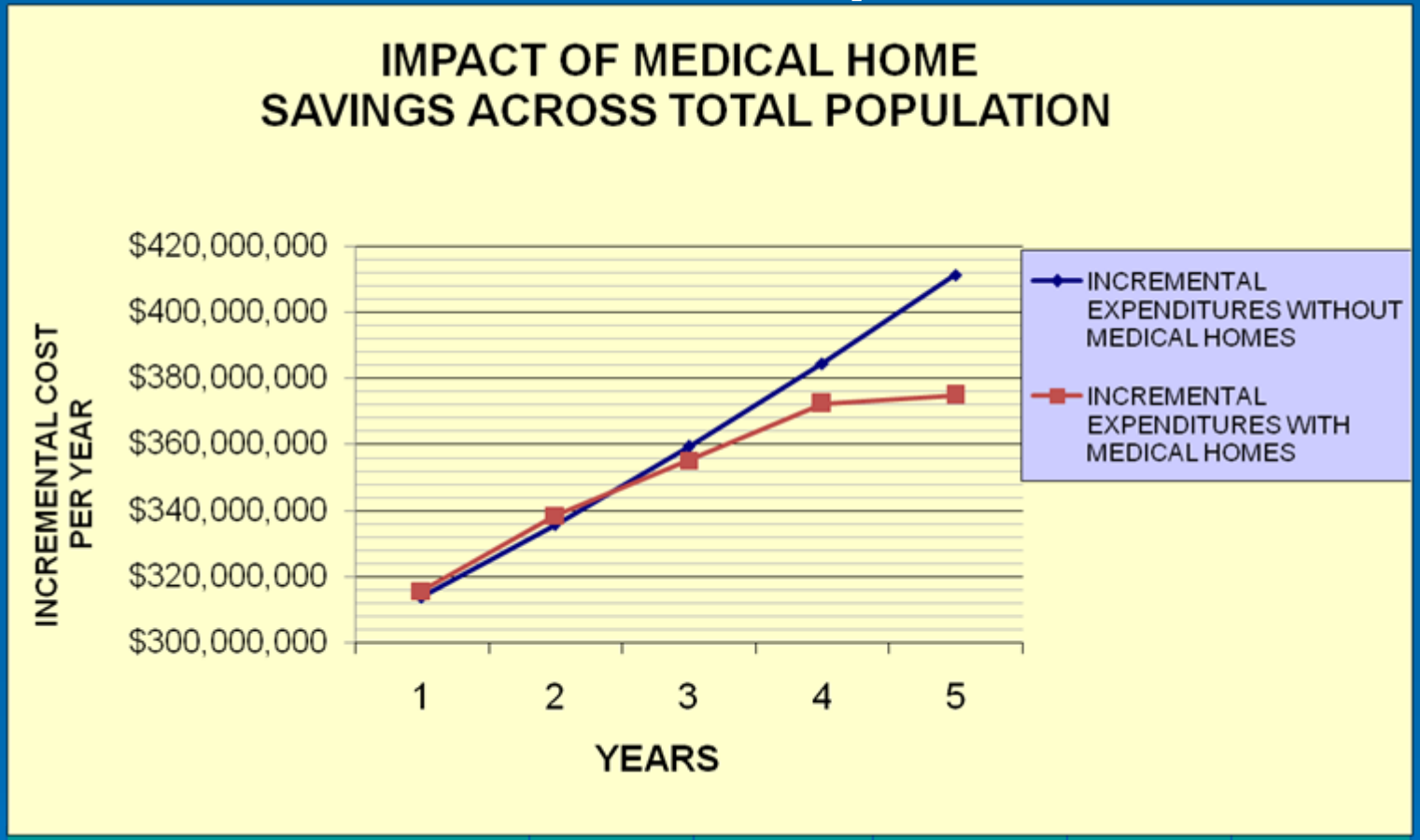
Evaluation Framework

Operations

Status: Enhanced Medical Homes

- Pilot communities (20,000 patients in each)
  - started 8/08, 1/09, 1/10
  - cover 10% of total population
  - well received by patients, physicians and staff
- Currently laying foundations for state wide expansion by 2013
- Medicare participation: HHS has announced state based, multi-payer pilots in advanced primary care models based on Vermont's design

Blueprint Integrated Pilots
Financial Impact



	2009	2010	2011	2012	2013
Percentage of Vermont population participating	6.7%	9.8%	13.0%	20.0%	40.0%
Participating population	42,179	61,880	82,332	127,045	254,852
# Community Care Teams	2	3	4	6	13

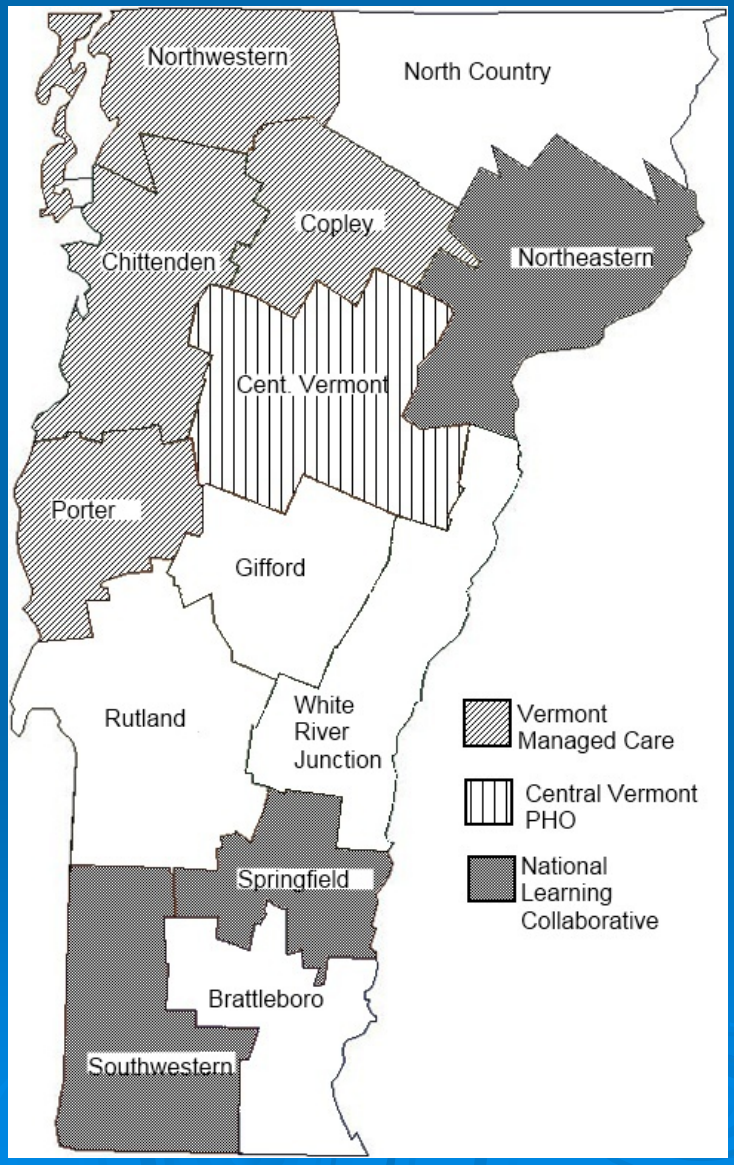
Phase II: ACO Pilot

- Focus on community health system level
- Translate potential system wide savings into actual savings
- Capture part of shared saving to reinvest in local community health system
  - Transition funding for adjusting to reallocation
  - Investments in population health, primary care, etc.

Goals of The ACO Pilot

- Improve performance in IHI ‘triple aims’
  - Bend the medical cost curve – significant savings over projected trend line of costs (2-5%/yr)
  - Improve the health of the community population and the patient experience
- Test the ACO concept in a small number of ‘early adaptor’ community provider networks that already have key functional capabilities.
- Have at least one Vermont site in the national ACO Learning Collaborative and Learning Network

Potential Vermont ACO Sites



ACO Pilot Support

Commission's Approach:

- Create working design and assess critical issues and tasks in
  - Scale and scope of pilot: e.g. minimum population, covered services
  - Responsibilities and criteria for ACO site
  - Financial model, including incentive structure
  - Funding of new functions and pilot administration
- Educate broad based workgroup of stakeholders in the ACO concept
- Support provider development of pilot application for national ACO collaborative. (VT could not fund its own ACO program.)

III. Findings

	Service integration	Financial integration	Governance & leadership	IT tools and reporting	Process improvement
Primary care practice					
Community health system					
Regional/ state					
National/ federal					

Service Integration by Level

- Practice level
  - Chronic Care Model
  - Enhanced Medical Home
- Community level
  - Clinical care coordination and integration
  - Medical home support: Community Health Team
  - Prevention: Community Health Assessment and Activation
- State level
  - VPQHC learning collaboratives for Chronic Care Model
  - Blueprint for Health: Start up funding, training, technical support, evaluation
- National level
  - ACO learning collaboratives: training, technical support
  - CMS Advanced Primary Care Model pilot: CHT's

Financial Integration by Level

- Practice level
  - PCP payment reform: pmpm care coordination fee
- Community level
  - ACO financial incentive: savings sharing
  - Management of integrated medical budget
- State level
  - All payer payment reform model (medical home, ACO)
  - Medicaid & Medicare participation in pilots
  - Patient attribution model
  - ACO financial impact model
- National
  - Medicare & Medicaid participation in pilots
  - ACO learning collaboratives: technical support
  - Foundation support (CMWF) for financial model

IT Tools & Reporting by Level

- Practice level
  - Patient clinical tracking: registry, flow sheet, population based reports
  - EMR interface
- Community level
  - Health information exchange for clinical coordination
  - Financial reporting: actual vs. target, drill down
  - Population based reports
- State level
  - Health information exchange
  - Development of web based tools for practices (DocSite)
  - All payer claims data base
  - Population based reports, public health reporting

Conclusions

- Community health system level is the focal point of delivery system reform
  - Integration/coordination of service network that provides bulk of care to a population
  - Integration of community based health assessment and intervention plan
  - Development of local resources to support healthy behaviors

Conclusions

- ACO is a promising financial reform at community level which should be tested in pilots.
- ACO's will require participation of public payers, particularly Medicare, to realize their potential
- Likelihood of success of ACO pilots is enhanced by key pre-requisites
  - Implementation of medical home model, including primary care payment reform
  - All payer participation in a common financial framework, including Medicare, Medicaid and commercial
  - Strong IT support for operations, reporting and evaluation
- These pre-requisites require significant effort and time.

  Vermont is 6-12 months away from completing foundation work for ACO

Conclusions

- Some large integrated care systems have the scale and resources to work concurrently at practice, community and regional/state levels to support ACO's.
- However, most small and medium sized communities and care systems will depend upon state/national support for
  - Defining a common financial framework for all payers
  - IT support for clinical tools, process improvement, information exchange, reporting and evaluation
  - Technical support and training
  - Start up funding

IV. Current Status and Next Steps

- Three qualified and interested ACO pilot sites identified & participating in National Learning Network
- Creating all payer model
  - Three major commercial payers participating and consolidated shared savings pool accepted
  - Plan for Medicaid participation and waiver filing due 7/10
  - Planning for Medicare participation: reform bills or Medicare pilot
- Financial impact model for ACO developed for two sites
- Draft legislation to accelerate expansion to 50% of hospitals by 2013
- Coordinate/integrate development of local infrastructure with Blueprint medical home statewide expansion
  - Core staffing: project management, practice facilitator
  - IT support and health information exchange

- “You can count on Americans to do the right thing … after they have tried everything else” (Winston Churchill)

Resources

- Vermont Health Reform
  - Health reform : http://hcr.vermont.gov/
  - Information technology: http://www.vitl.net/
  - Health Care Reform Commission: http://www.leg.state.vt.us/CommissiononHealthCareReform/default2.cfm

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