OneCare Program Evaluation Brief

Community Complex Care Coordination Program, Value-Based Incentive Fund, and Comprehensive Payment Reform Program

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EXECUTIVE SUMMARY

OneCare, an Accountable Care Organization (ACO) in the Vermont ACO All-Payer Model (VAPM), contracted with Cynosure Health and its subcontractor, Westat Insight, to conduct a mixed methods evaluation of the following OneCare programmatic initiatives:

1) Community Complex Care Coordination (CCCC) Program
2) Value-Based Incentive Fund (VBIF)
3) Comprehensive Payment Reform (CPR) Program for independent primary care

EVALUATION CONTEXT

To understand the context in which OneCare's programs were implemented, the evaluation team spoke with OneCare leaders, reviewed background documents, and interviewed participants in the OneCare network. We identified five key contextual factors related to OneCare's goals and approaches, as well as the overall state of health care reform and state-wide trends, that guided our interpretation of the findings and recommendations in this report.

First, we established that the OneCare programs we evaluated collectively incentivize progression toward advanced primary care. Second, consistent with its strategic plan, OneCare uses various approaches to payment reform as a lever throughout its programs to support practice transformation.

Although we observed alignment in the goals of the programs, complexity in the execution and incentives may hinder participants' progress. In general, OneCare's primary care practices were often in the early stages of transformation (as defined by the Health Care Payment Learning and Action Network) towards advanced primary care.

OneCare is one of multiple transformation agents in the state and challenges with alignment, or lack thereof, with other prominent programs may hinder progress. For example, OneCare's relationship with the Blueprint for Health is not well understood by primary care practices and collaborator organizations, even though their goals and approaches are closely related.

Finally, the COVID-19 pandemic and its impact on health care utilization patterns heavily influenced the findings. Without a comparison group for the evaluation, it was not possible to disentangle program impacts from pandemic impacts because they affect the same outcomes. Therefore, a lack of statistically significant findings may be a result of the COVID-19 PHE and not causal impacts of the program.

METHODS

Cynosure conducted quantitative and qualitative program evaluations between May and September 2023. As noted in the limitations section in the report (**table 5**), the data, program features, and the timing of the analyses (for example, overlap with the COVID-19 pandemic) precluded causal analysis. Therefore, Cynosure's analyses are correlational and cannot be interpreted as causal impacts of the OneCare programs.

Qualitative findings are based on a thematic analysis of semi-structured interviews with participating providers and collaborator organizations (such as Designated Agencies for Mental Health, Home Health and Hospice, and Area Agencies on Aging); interviews with OneCare's leaders; and a review and assessment of model-related documents.

Quantitative findings relied on descriptive and statistical analyses of claims data, quality measure data, and enrollment and participation assignment data. Additionally, descriptive trend analysis and summary statistics, combined with statistical modeling techniques, to provide as much pertinent information as possible about the three programs.

EVALUATION FINDINGS

Key findings for each of the programs, followed by cross-program themes, are highlighted below.

COMMUNITY COMPLEX CARE COORDINATION PROGRAM

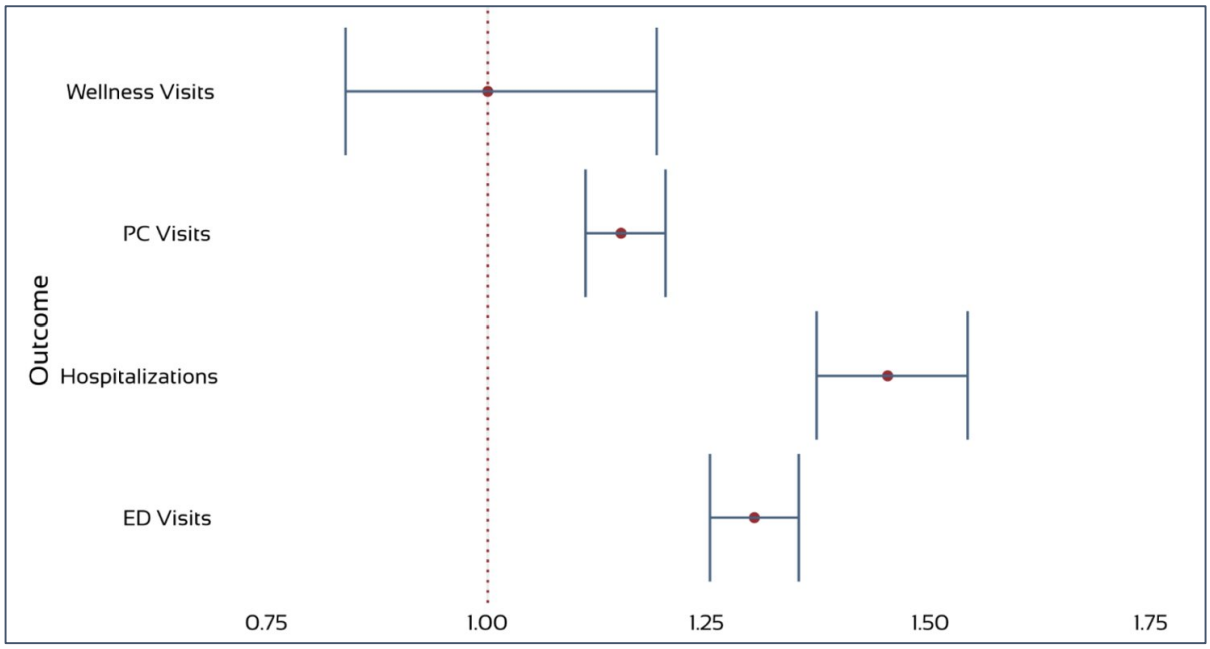
The Community Complex Care Coordination program is OneCare's longest standing and largest investment in population health. The payment structure, specific program requirements, and available technology (for example, Care Navigator) evolved over time, yet the core program goals remained consistent: to increase community-based, cross-organizational care coordination, especially for high-risk beneficiaries, in order to advance OneCare's population health goals to increase access to primary care and improve health outcomes.

We explored who is receiving care management services and observed the findings to be consistent with the goals of the program, that is: to target care management services for patients with greater levels of risk, chronic conditions, or high utilization. We observed that members who are at higher risk and have chronic conditions have a greater likelihood of being care managed. Related, we found that members with chronic conditions and a younger age have a greater likelihood of receiving the expected frequency of encounters. These observations may warrant further investigation to understand the barriers that older adults face in achieving the expected frequency of encounters.

We also observed that continuously care managed members (for at least 6 months) had substantially higher primary care and acute care utilization than non-care managed members (**figure 1**). We cannot and should not conclude that being continuously care-managed caused members to be higher health care utilizers. It is more likely they were chosen to be care-managed because they were already high utilizers of health care. Future analyses with more years of data and

more information on the true eligible population for a more effective control group may be better able to evaluate CCCC program impacts.

Figure 1. *Coefficient Plot of Associations Between Outcomes and Whether Patients Were Ever Care Managed*



In interviews with primary care practices and collaborator organizations, respondents universally reported that their care coordination processes are well-established, payor-agnostic, and exist independent of OneCare's CCCC program, which they view primarily as a reporting requirement. Respondents described many care coordination processes that are well-established in their organizations and communities (for example, community care coordination meetings and systems to identify and prioritize patients for services), but implementation of these practices varies widely across organizations and health service areas (HSAs).

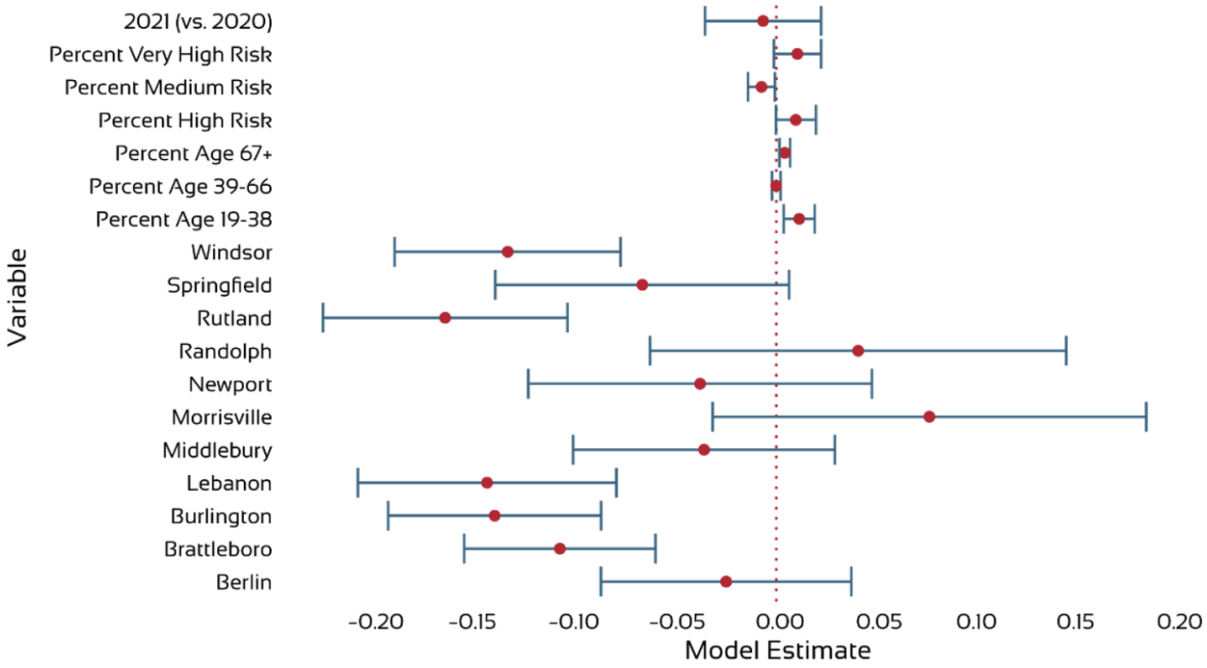
Respondents reported that cross-organization communication remains a barrier to collaboration. Multiple organizations identified the need for an interoperable technology solution to support further integration across care teams.

VALUE BASED INCENTIVE FUND

In 2021, the focus of the VBIF program was refined to address four quality metrics: blood pressure (BP) control, hemoglobin A1c, depression screening and follow-up among children aged 12 and older, and developmental screening for children aged 0–3. The mean rates for three of the four measures improved during the evaluation period of 2021 through 2022. This may, in part, reflect a return to the status quo after the COVID-19 pandemic or could be related to the VBIF program.

We observed variation in the annual rates for the VBIF measure, primarily by HSA. For example, **figure 2** shows annual regression model estimates for the annual rate of BP control with significant variation by HSA. Variation may be due to specific approaches or programs that the provider organizations have in place, or it may be due to differences in the underlying patient population, which we could not account for in these models.

Figure 2. *Adjusted Regression Model Estimates – Annual Rate of BP Control*



Changes in median quality metric performance from 2021 to 2022 varied by measure:

- Median change in **A1c control** was an increase of 1.9 percent, with about 60 percent of providers improving. Most of these improvements were between 0 and 5 percentage point increases.
- Median change in **BP control** rates was a decrease of 0.6 percent, though several outlier providers significantly increased their control rate by over 20 percent.
- Median change in **developmental screening rates** was an increase of 0.9 percent, with one outlier improving its rate by 25 percent.
- Median change in **depression screening rates** was 0 percent (no change), though several outliers also increased their screening rates greatly over this period.

Table 1 shows the positive outliers (providers with the greatest increases in measure rates), including their baseline (Q1 2021) rates, absolute improvement, percent improvement, and number of eligible members.

Table 1. Top Improvers Across All VBIF Metrics

	BASELINE RATE (Q1 2021)	CHANGE IN RATE	PERCENT CHANGE	NUMBER OF ELIGIBLE MEMBERS
Hemoglobin A1c Control				
St. Albans Health Center	81%	9%	11%	267
Gene Moore MD, PLLC	91%	6%	7%	44
CVMC Pediatrics Primary Care	88%	7%	8%	423
Gifford Health Care	78%	6%	7%	91
Blood Pressure Control				
Champlain Center for Natural Medicine	62%	14%	22%	29
Natural Family Health, P.C.	60%	18%	30%	10
Developmental Screening				
North Country Pediatrics and Adolescent Medicine	62%	25%	40%	234
Green Mountain Pediatrics	91%	7%	8%	33
CHCRR Pediatrics	64%	7%	11%	506
CVMC Pediatrics Primary Care-Berlin	79%	6%	8%	360
Upper Valley Pediatrics	70%	9%	13%	70
Depression Screening and Follow-Up				
Pediatric Medicine, PLC	71%	8%	11%	211
Green Mountain Pediatrics	92%	6%	7%	111
Lamoille Health Pediatrics	52%	7%	13%	94
Essex Pediatrics	65%	8%	13%	198
Upper Valley Pediatrics	53%	33%	62%	120
Lakeside Pediatrics	56%	16%	28%	185
Richmond Pediatric and Adolescent Medicine	51%	20%	39%	157

In interviews, respondents appreciated the narrowed focus on the four measures, but said that the VBIF program did not drive new or additional quality improvement efforts within their organization. Respondents were largely supportive of the VBIF focus areas, noting that these aligned with work they were already doing.

Practices found the program complex and difficult to understand, which led to frustration and may have limited engagement. For example, practices described instances where the measures did not align with other standardized metrics for the focus area, which created significant burdens in collecting the relevant data. Related to the incentives, multiple organizations said they did not understand the financial calculations or that they were supportive of the improvement work, but that the financial incentive specifically did not drive changes in their behavior.

COMPREHENSIVE PAYMENT REFORM PROGRAM

CPR impact evaluation models were the most rigorous and the most direct attempt possible of any of the three program evaluations to assess true program impacts. We performed a range of

statistical tests to rigorously assess how outcomes changed after providers first joined the CPR program, which provided relatively consistent findings.

However, cohorts of CPR participants differ greatly, such as in the percentage of low-risk versus very high-risk patients attributed, the percent of pediatric patients attributed, and payer mix. This fundamental difference in the patient population by cohorts demonstrates the incomparability of the cohorts, which precludes comparison to uncover true program effects. **Figures 3** and **4** describe the cohort differences in both health care utilization and underlying patient characteristics.

Figure 3. *Unadjusted Average Emergency Department Visits by Cohort and Year, 2019-2022*

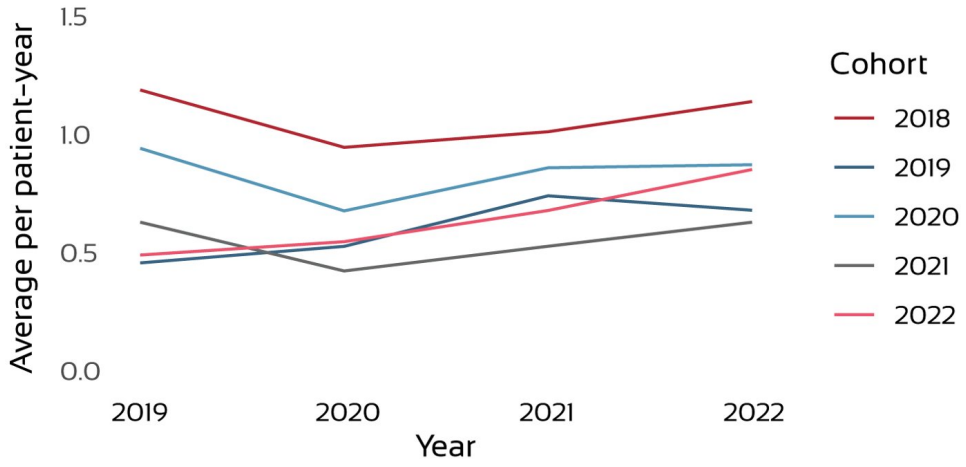
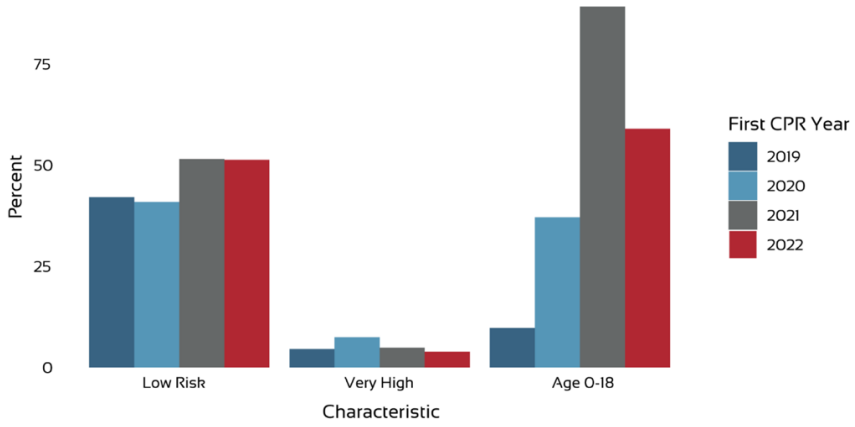


Figure 4. *Histogram of Risk Level and Patient Mix in the First Year of Participation by Cohort*



CROSS-PROGRAM ANALYSES

Our interviews also yielded themes that apply across and beyond the specific programs included in the evaluation:

1. **Vision and messaging.** Across organization types and geography, we found that individuals and organizations could not clearly articulate OneCare's role in the broader context of reform, the unique value it provides in driving transformation, or their own need to move along the transformation pathway.
2. **Connecting data to action.** Respondents offered mixed comments on the utility of OneCare's data and reports, with specific opportunities to better align program requirements or metrics and to offer additional guidance on how to change their approach based on the data.
3. **Support for improvement.** Primary care practices and collaborator organizations alike expressed interest in more support with the "how-to" of improvement, such as through state-wide collaboratives, peer-to-peer connections, or more direction on how to approach practice changes.

RECOMMENDATIONS

We conclude with recommendations both for future evaluations and to guide future design and implementation of programs to accelerate transformation toward advanced primary care.

FUTURE EVALUATIONS

1. **Establish suitable control groups.** For several OneCare programs we could not identify a comparison group. For example, all practices participated in the CCCC program between 2020 and 2021 or participants differed from non-participants (e.g., CPR program, care managed versus non-care managed individuals), precluding the identification of program impacts. Future comparisons will be possible if suitable comparison groups can be identified (e.g., non-participants that are otherwise similar to participants with regard to demographic and clinical factors). Alternatively, OneCare might consider using data from other states to conduct high-level comparisons of statewide outcomes before and after program implementation.
2. **Document a clear record of program changes.** Keep a log of when program changes occurred and who (patients, providers, provider groups) was affected. Documentation ideally should include quantitative indicators of program changes.
3. **Re-evaluate impacts when more data are available.** Additional data is needed to establish trends prior to and after program implementation.
4. **Determine the true eligible population for programs** in which individuals self-select into participation. For example, for the CCCC program, establish a way to quantitatively distinguish between those who were offered services and declined versus those who were never offered services.

STRATEGIC CONSIDERATIONS

1. **Develop a multi-modal communications strategy that continually emphasizes goals, approaches, and progress.** To increase buy-in, demonstrate how programs align with or

complement others in the state, especially the Blueprint for Health. For example, consider simple fact sheets or FAQ documents that outline how CCCC and PCMH requirements are complementary. Demonstrate value for providers and generate enthusiasm by circulating easy-to-comprehend results at an organizational-, HSA-, and state-wide level. Consider case studies or stories to describe how specific actions are leading to progress.

2. **Bolster relationships with statewide stakeholders (such as the Blueprint and Department of Mental Health) and explore new ways to influence state-wide policy and planning.** For example, consider how insights from OneCare data could supplement the Blueprint team's understanding of their work. Collaborate to develop materials that share progress toward common goals and coordinated messaging campaigns. Convene diverse stakeholders across the network to address state-wide challenges, such as availability of mental health providers.
3. **Develop explicit transformation targets and hold practices accountable.** Draw on resources from HCP-LAN and the Merit-based Incentive Program to identify specific infrastructure and process metrics ,in addition to outcome metrics, that demonstrate how clinical practices are transforming the way they deliver care. Hold practices accountable through data and reporting, sharing out updates at practice-, HSA-, and the state-level. Provide technical assistance and coaching for practices that are struck or who have plateaued in their performance and consider the use of jointly created corrective action plans for practices that consistently do not progress towards targets.