



Update for the Virginia Joint Commission on Health Care

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President & CEO





The Virginia Center for Health Innovation

- Founded in 2012 as a 501(c)3
- Public-private partnership with annual funding from the Commonwealth of VA
- Mission: To accelerate the adoption of value-driven models of wellness and healthcare
- Governed by a diverse, multi-stakeholder board of directors
- Secured more than \$23M in grants for Virginia

The Board and Advisory Leadership Council:

- Advocate Health
- Aetna
- Anthem
- AON
- Augusta Health
- Ballad Health
- Boehringer-Ingelheim
- Bristol Chamber of Commerce
- Carilion
- Carmax
- Centra Health
- Cigna
- Commonwealth of Va
- GlaxoSmithKline
- HCA Virginia
- Inova Health System
- Johnson & Johnson
- LabCorp
- Lucas Law Firm
- MSV Foundation
- Merck
- Milliman MedInsight
- Newport Board Group
- Novo Nordisk
- Optima
- PATH Foundation
- Patient First
- Pfizer
- PhRMA
- Privia Health
- Riverside Health System
- Sanofi
- Sentara
- SQCN
- UnitedHealthcare
- UVA Health System
- VA Academy of Family Physicians
- VA Association of Health Plans
- Virginia Bio
- VA Business Council
- Virginia Care Partners
- VCU Health
- Virginia Health Care Foundation
- Virginia Health Catalyst
- VA Hospital & Healthcare Association
- VA Community Healthcare Association
- VA Council of Nurse Practitioners
- Virginia Premier
- Walgreens
- 3M



Our Work



Convene and educate stakeholders interested in accelerating the adoption of value-driven models of wellness and healthcare in an effort to improve patient outcomes and advance Virginia's well-being and economic competitiveness.



Oversee and facilitate demonstration research to test and evaluate models of value-driven wellness and health care.



Leverage data and analytical resources that inform and enable health care providers, public health professionals, government representatives, community organizations, employers and consumers to make better decisions.



Help prepare the health care delivery system and the public for a high quality, value-driven health care marketplace which features engaged and satisfied clinicians and patients.



Key Initiatives

- Virginia Health Innovation Network (2013-Current)
- State Innovation Model Design (2014-2016)
- Heart of Virginia Healthcare (2014-2017)
- Potomac Primary Care Collaborative (2017-2018)
- Healthy Minds, Healthy Children (2017-2018)
- Smarter Care Virginia (2019-Present)
- Virginia Vaccinates (2019-2021)
- Advancing Value in Virginia's Community Health Centers (2019-Present)
- AHRQ Alcohol Risk Assessment and Counseling Initiative (2020-Present)
- ABFM "Measures That Matter" Continuity Research (2020-Present)
- Governor's Task Force on Primary Care (2020-Present)





Purpose:

To prompt action for improving the value of health care services.

Measurement Approach:

To identify and report on the delivery of both low value and high value clinical services across Virginia and its regions.



The Virginia Health Value Dashboard

Aim I: Reducing Low Value Care

- A. Utilization and cost of potentially avoidable emergency room visits (3 measures)
- B. Low value services as captured by the MedInsight Health Waste Calculator (7 measures)
- C. Inappropriate preventable hospital stays (1 measure)

Aim II: Increasing High Value Care

- A. Virginians who are current with appropriate vaccination schedules (1 measure with multiple elements)
- B. Comprehensive diabetes care (2 measures)
- C. Clinically appropriate cancer screening rates (3 measures)
- D. Mental health care (2 measures)

Aim III: Improving the Infrastructure for Value-Based Care

- A. Commercial in-network payments that are value-based (1 measure)
- B. Claims in Virginia's All-Payer Claims Database (2 measures)



Now Available Online 2021 Dashboard

<http://www.vahealthinnovation.org/wp-content/uploads/2021/04/2019-VCHI-Health-Value-Dashboard.pdf>



WHO WE ARE Incorporated in January 2012 following a recommendation from Gov. Robert McDonnell's Virginia Health Reform Initiative, the Virginia Center for Health Innovation (VCHI) is a nonprofit, public-private partnership that seeks to facilitate innovation by convening key stakeholders and securing the resources to accelerate value-driven models of wellness and health care throughout Virginia. VCHI's work is focused on achieving three aims: reducing low-value health care, increasing high-value health care, and ensuring Virginia has the infrastructure in place to measure and reward value in health care.

VCHI and its partners - health care providers, health systems, health plans, pharmaceutical manufacturers and laboratory companies, employers, consumers, and government – are committed to improving health value in Virginia. The Virginia Health Value Dashboard is our roadmap.

WHAT WE DO VCHI Improves value in health care through four core services. These are:



CONVENE AND EDUCATE STAKEHOLDERS

interested in accelerating the adoption of value-driven models of wellness and healthcare in an effort to improve patient outcomes and advance Virginia's well-being and economic competitiveness.



OVERSEE AND FACILITATE DEMONSTRATION RESEARCH

to test and evaluate models of value-driven wellness and health care.



LEVERAGE DATA AND ANALYTICAL RESOURCES

that inform and enable health care providers, public health professionals, government representatives, community organizations, employers and consumers to make better decisions.



for a high quality, value-driven health care marketplace which features engaged and satisfied clinicians and patients.

WHAT'S NEW IN THE 2021 VIRGINIA HEALTH VALUE DASHBOARD

Regional Performance

- In the Statewide analysis, there are two new columns highlighting the degree of regional variation ("Regional Variation") and the top performing region for each measure ("Top Region").

Health Equity

- In an effort to bring a health equity lens to our Dashboard measures, there is a new sheet that incorporates the Area Deprivation Index. "The Area Deprivation Index (ADI) is based on a measure created by the Health Resources & Services Administration (HRSA) over two decades ago for primarily county-level use, but refined, adapted, and validated to the Census block group/neighborhood level by Amy Kind, MD, PhD and her research team at the University of Wisconsin-Madison. It allows for rankings of neighborhoods by socioeconomic disadvantage in a region of interest (e.g. at the state or national level). It includes factors for the theoretical domains of income, education, employment, and housing quality. It can be used to inform health delivery and policy, especially for the most disadvantaged neighborhood groups." *Source: <https://www.neighborhoodatlas.medicine.wisc.edu/>*
- The column "Correlation to Area Deprivation Index" – uses a scale as follows:
If rate increases as Deprivation Score increases (higher score indicates higher level of deprivation) then positive, if rate decreases as Deprivation Score increases then negative. If the absolute value of the correlation coefficient is less than .3 then Low, if greater than .3 but less than .5 then Moderate, if greater than .5 then High.

STATE AND REGIONAL COMPARISON

2019

- = Better than statewide rate
- = Same as statewide rate
- = Worse than statewide rate

REDUCING LOW VALUE CARE

| | STATEWIDE | NORTHWEST | NORTHERN | SOUTHWEST | CENTRAL | EASTERN |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|-----------|----------|-----------|---------|---------|
| Utilization and Cost of Avoidable Emergency Room Visits | | | | | | |
| Potentially Avoidable ED Visits - As a Percentage of Total ED Visits | 12% | ■ | ■ | ■ | ■ | ■ |
| Potentially Avoidable ED Visits - Per 1,000 Member Months | 3.0 | ■ | ■ | ■ | ■ | ■ |
| Potentially Avoidable ED Visits - Per Member Per Year | 0.04 | ■ | ■ | ■ | ■ | ■ |
| Low Value Services as Captured by the MedInsight Health Waste Calculator | | | | | | |
| Don't obtain baseline laboratory studies in patients without significant systemic disease (ASA I or II) undergoing low-risk surgery – specifically complete blood count, basic or comprehensive metabolic panel, coagulation studies when blood loss (or fluid shifts) is/are expected to be minimal | 82% | ■ | ■ | ■ | ■ | ■ |
| Don't obtain EKG, chest X-rays or pulmonary function test in patients without significant systemic disease (ASA I or II) undergoing low-risk surgery | 6% | ■ | ■ | ■ | ■ | ■ |
| Don't obtain baseline diagnostic cardiac testing or cardiac stress testing in asymptomatic stable patients with known cardiac disease undergoing low or moderate risk non-cardiac surgery | 49% | ■ | ■ | ■ | ■ | ■ |
| Don't perform stress cardiac imaging or advanced non-invasive imaging in the initial evaluation of patients without cardiac symptoms unless high-risk markers are present | 9% | ■ | ■ | ■ | ■ | ■ |
| Don't order annual electrocardiograms (EKGs) or any other cardiac screening for low-risk patients without symptoms | 11% | ■ | ■ | ■ | ■ | ■ |
| Don't routinely order imaging tests for patients without symptoms or signs of significant eye disease | 16% | ■ | ■ | ■ | ■ | ■ |
| Don't place peripherally inserted central catheters (PICC) in stage III–V CKD patients without consulting nephrology | 86% | ■ | ■ | ■ | ■ | ■ |
| Inappropriate Preventable Hospital Stays | | | | | | |
| Prevention Quality Indicator #90: Prevention Quality Overall Composite Rate (per 100,000 population) | 1,196 | ■ | ■ | ■ | ■ | ■ |

INCREASING HIGH VALUE CARE

| | STATEWIDE | NORTHWEST | NORTHERN | SOUTHWEST | CENTRAL | EASTERN |
|------------------------------------------------------------------------------------------------|-----------|-----------|----------|-----------|---------|---------|
| Virginians Who Are Current with Appropriate Vaccination Schedules | | | | | | |
| Childhood Immunization Status: DTaP | 46% | ■ | ■ | ■ | ■ | ■ |
| Childhood Immunization Status: Influenza | 51% | ■ | ■ | ■ | ■ | ■ |
| Childhood Immunization Status: Hepatitis A | 75% | ■ | ■ | ■ | ■ | ■ |
| Childhood Immunization Status: Hepatitis B | 30% | ■ | ■ | ■ | ■ | ■ |
| Childhood Immunization Status: Hib | 61% | ■ | ■ | ■ | ■ | ■ |
| Childhood Immunization Status: IPV | 56% | ■ | ■ | ■ | ■ | ■ |
| Childhood Immunization Status: MMR | 76% | ■ | ■ | ■ | ■ | ■ |
| Childhood Immunization Status: Pneumococcal Conjugate | 47% | ■ | ■ | ■ | ■ | ■ |
| Childhood Immunization Status: Rotavirus | 49% | ■ | ■ | ■ | ■ | ■ |
| Childhood Immunization Status: VZV | 76% | ■ | ■ | ■ | ■ | ■ |
| Immunizations for Adolescents: HPV Vaccine* | 25% | ■ | ■ | ■ | ■ | ■ |
| Immunizations for Adolescents: Meningococcal Conjugate or Meningococcal Polysaccharide Vaccine | 55% | ■ | ■ | ■ | ■ | ■ |
| Immunizations for Adolescents: Tdap Vaccine | 66% | ■ | ■ | ■ | ■ | ■ |
| Comprehensive Diabetes Care | | | | | | |
| Hemoglobin A1c (HbA1c) Testing | 85% | ■ | ■ | ■ | ■ | ■ |
| Medical Attention for Nephropathy** | 87% | ■ | ■ | ■ | ■ | ■ |
| Clinically Appropriate Cancer Screening Rates | | | | | | |
| Breast Cancer Screening*** | 73% | ■ | ■ | ■ | ■ | ■ |
| Cervical Cancer Screening | 64% | ■ | ■ | ■ | ■ | ■ |
| Colorectal Cancer Screening | 51% | ■ | ■ | ■ | ■ | ■ |
| Mental Health Care | | | | | | |
| Follow-up after hospitalization for mental illness (7 days post-discharge) | 49% | ■ | ■ | ■ | ■ | ■ |
| Follow-up after hospitalization for mental illness (30 days post-discharge) | 74% | ■ | ■ | ■ | ■ | ■ |

*EBM version 7 rates were used for 2018 benchmark
 **2019 rates could not be generated for this measure due to the current unavailability of Medicare Part D prescription claims for the corresponding period
 ***Medicare FFS rates, which comprise the majority of the volume for this measure, were not available for 2018 due to the lookback period required by the methodology

STATEWIDE

2019

| | 2019 | 2018 | Regional Variation | Top Region | Trend |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|-------|--------------------|------------|-------|
| REDUCING LOW VALUE CARE | | | | | |
| Utilization and Cost of Avoidable Emergency Room Visits | | | | | |
| Potentially Avoidable ED Visits - As a Percentage of Total ED Visits | 12% | 12% | Mod | N | ■ |
| Potentially Avoidable ED Visits - Per 1,000 Member Months | 3 | 3 | – | N | ■ |
| Potentially Avoidable ED Visits - Per Member Per Year | 0.04 | 0.04 | – | N | ■ |
| Low Value Services as Captured by the MedInsight Health Waste Calculator | | | | | |
| Don't obtain baseline laboratory studies in patients without significant systemic disease (ASA I or II) undergoing low-risk surgery – specifically complete blood count, basic or comprehensive metabolic panel, coagulation studies when blood loss (or fluid shifts) is/are expected to be minimal | 82% | 82% | Low | C | ■ |
| Don't obtain EKG, chest X-rays or pulmonary function test in patients without significant systemic disease (ASA I or II) undergoing low-risk surgery | 6% | 7% | High | SW | ■ |
| Don't obtain baseline diagnostic cardiac testing or cardiac stress testing in asymptomatic stable patients with known cardiac disease undergoing low or moderate risk non-cardiac surgery | 49% | 58% | Mod | SW | ■ |
| Don't perform stress cardiac imaging or advanced non-invasive imaging in the initial evaluation of patients without cardiac symptoms unless high-risk markers are present | 9% | 11% | High | SW | ■ |
| Don't order annual electrocardiograms (EKGs) or any other cardiac screening for low-risk patients without symptoms | 11% | 15% | High | SW | ■ |
| Don't routinely order imaging tests for patients without symptoms or signs of significant eye disease | 16% | 17% | Mod | N | ■ |
| Don't place peripherally inserted central catheters (PICC) in stage III–V CKD patients without consulting nephrology | 86% | 86% | Low | E | ■ |
| Inappropriate Preventable Hospital Stays | | | | | |
| Prevention Quality Indicator #90: Prevention Quality Overall Composite Rate (per 100,000 pop.) | 1,196 | 1,181 | High | N | ■ |
| INCREASING HIGH VALUE CARE | | | | | |
| Virginians Who Are Current with Appropriate Vaccination Schedules | | | | | |
| Childhood Immunization Status: DTaP | 46% | 50% | Mod | SW | ■ |
| Childhood Immunization Status: Influenza | 51% | 56% | Mod | N | ■ |
| Childhood Immunization Status: Hepatitis A | 75% | 81% | Low | N | ■ |
| Childhood Immunization Status: Hepatitis B | 30% | 35% | High | SW | ■ |
| Childhood Immunization Status: Hib | 61% | 66% | Low | SW | ■ |
| Childhood Immunization Status: IPV | 56% | 60% | Mod | SW | ■ |
| Childhood Immunization Status: MMR | 76% | 83% | Low | N | ■ |
| Childhood Immunization Status: Pneumococcal Conjugate | 47% | 51% | Mod | SW | ■ |
| Childhood Immunization Status: Rotavirus | 49% | 52% | Mod | SW | ■ |
| Childhood Immunization Status: VZV | 76% | 83% | Low | N | ■ |
| Immunizations for Adolescents: HPV Vaccine | 25% | 26% | Mod | N | ■ |
| Immunizations for Adolescents: Meningococcal Conjugate or Mening. Polysaccharide Vaccine | 55% | 58% | Mod | N | ■ |
| Immunizations for Adolescents: Tdap Vaccine | 66% | 70% | Low | SW | ■ |
| Comprehensive Diabetes Care | | | | | |
| Hemoglobin A1c (HbA1c) Testing | 85% | 88% | Low | N | ■ |
| Medical Attention for Nephropathy | 87% | 89% | Low | N | ■ |
| Clinically Appropriate Cancer Screening Rates | | | | | |
| Breast Cancer Screening | 73% | 75% | Low | N | ■ |
| Cervical Cancer Screening | 64% | 69% | Mod | N | ■ |
| Colorectal Cancer Screening | 51% | 50% | Mod | N | ■ |
| Mental Health Care | | | | | |
| Follow-up after hospitalization for mental illness (7 days post-discharge) | 49% | – | Mod | N | – |
| Follow-up after hospitalization for mental illness (30 days post-discharge) | 74% | – | Low | N | – |

| | 2019 | 2018 | Reg Var | Top Region | Trend |
|---------------------------------------------------------------------------------------------------|------|------|---------|------------|-------|
| IMPROVING THE INFRASTRUCTURE FOR VALUE BASED CARE | | | | | |
| Claims in Virginia's All Payer Claims Database | | | | | |
| Percent of VA Total Covered Lives with Claims Included in the VA All Payer Claims Database | 61% | 57% | – | – | ■ |
| Percent of VA Commercially Insured Lives with Claims included in the VA All Payer Claims Database | 50% | 40% | – | – | ■ |

*EBM version 7 rates were used for 2018 benchmark
 **2019 rates could not be generated for this measure due to the current unavailability of Medicare Part D prescription claims for the corresponding period
 ***Medicare FFS rates, which comprise the majority of the volume for this measure, were not available for 2018 due to the lookback period required by the methodology
 C = Central Virginia, E = Eastern Virginia, N = Northern Virginia, SW = Southwest Virginia, and Top Region = Top Performing Region.



New: Area Deprivation Index Analysis

| REDUCING LOW VALUE CARE | 2019 Rate | Correlation to Area Deprivation Index |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|---------------------------------------|
| Utilization and Cost of Avoidable Emergency Room Visits | | |
| Potentially Avoidable ED Visits - As a Percentage of Total ED Visits | 12% | + |
| Potentially Avoidable ED Visits - Per 1,000 Member Months | 3 | - |
| Potentially Avoidable ED Visits - Per Member Per Year | 0.04 | - |
| Low Value Services as Captured by the MedInsight Health Waste Calculator | | |
| Don't obtain baseline laboratory studies in patients without significant systemic disease (ASA I or II) undergoing low-risk surgery – specifically complete blood count, basic or comprehensive metabolic panel, coagulation studies when blood loss (or fluid shifts) is/are expected to be minimal. | 82% | - |
| Don't obtain EKG, chest X-rays or pulmonary function test in patients without significant systemic disease (ASA I or II) undergoing low-risk surgery. | 6% | - |
| Don't obtain baseline diagnostic cardiac testing or cardiac stress testing in asymptomatic stable patients with known cardiac disease undergoing low or moderate risk non-cardiac surgery. | 49% | - |
| Don't perform stress cardiac imaging or advanced non-invasive imaging in the initial evaluation of patients without cardiac symptoms unless high-risk markers are present. | 9% | - |
| Don't order annual electrocardiograms (EKGs) or any other cardiac screening for low-risk patients without symptoms. | 11% | - |
| Don't routinely order imaging tests for patients without symptoms or signs of significant eye disease. | 16% | + |
| Don't place peripherally inserted central catheters (PICC) in stage III–V CKD patients without consulting nephrology. | 86% | + |
| Inappropriate Preventable Hospital Stays | | |
| Prevention Quality Indicator #90: Prevention Quality Overall Composite Rate (per 100,000 population) | 1,196 | + |

| INCREASING HIGH VALUE CARE | 2019 Rate | Correlation to Area Deprivation Index |
|------------------------------------------------------------------------------------------------|-----------|---------------------------------------|
| Virginians Who Are Current with Appropriate Vaccination Schedules | | |
| Childhood Immunization Status: DTaP | 46% | + |
| Childhood Immunization Status: Influenza | 51% | - |
| Childhood Immunization Status: Hepatitis A | 75% | - |
| Childhood Immunization Status: Hepatitis B | 30% | + |
| Childhood Immunization Status: HiB | 61% | + |
| Childhood Immunization Status: IPV | 56% | + |
| Childhood Immunization Status: MMR | 76% | - |
| Childhood Immunization Status: Pneumococcal Conjugate | 47% | + |
| Childhood Immunization Status: Rotavirus | 49% | - |
| Childhood Immunization Status: VZV | 76% | - |
| Immunizations for Adolescents: HPV Vaccine* | 25% | - |
| Immunizations for Adolescents: Meningococcal Conjugate or Meningococcal Polysaccharide Vaccine | 55% | - |
| Immunizations for Adolescents: Tdap Vaccine | 66% | + |
| Comprehensive Diabetes Care | | |
| Hemoglobin A1c (HbA1c) Testing | 85% | - |
| Medical Attention for Nephropathy** | 87% | - |
| Clinically Appropriate Cancer Screening Rates | | |
| Breast Cancer Screening*** | 73% | - |
| Cervical Cancer Screening | 64% | - |
| Colorectal Cancer Screening | 51% | - |

- = Low Negative, + = Low Positive, - = Moderate Negative, + = Moderate Positive, - = High Negative, and + = High Positive.

The Area Deprivation Index (ADI) is based on a measure created by the Health Resources & Services Administration (HRSA) over two decades ago for primarily county-level use, but refined, adapted, and validated to the Census block group/neighborhood level by Amy Kind, MD, PhD and her research team at the University of Wisconsin- Madison. It allows for rankings of neighborhoods by socioeconomic disadvantage in a region of interest (e.g. at the state or national level). It includes factors for the theoretical domains of income, education, employment, and housing quality. It can be used to inform health delivery and policy, especially for the most disadvantaged neighborhood groups.

*Correlation to Area Deprivation Index" was calculated as follows—if rate increases as Deprivation Score increases (higher score indicates higher level of deprivation) then positive, if rate decreases as Deprivation Score increases then negative. If the absolute value of the correlation coefficient is less than .3 then Low, if greater than .3 but less than .5 then Moderate, if greater than .5 then High.

Partnership with Altarum



DATA BRIEF NO. 42 | JULY 2019

Virginians Struggle to Afford High Healthcare Costs; Support a Range of Government Solutions Across Party Lines

Nationally, consumer worry about healthcare affordability is well documented but now—for the first time—a new survey reveals how affordability concerns and ideas for action play out in Virginia.

KEY FINDINGS

A survey of more than 1,100 Virginia adults, conducted from March 12 to April 2, 2019, found that:

- More than half (55%) experienced healthcare affordability burdens in the past year;
- More than three-quarters (78%) were worried about affording healthcare in the future; and
- Across party lines, they expressed strong support for government-led solutions.

A RANGE OF HEALTHCARE AFFORDABILITY BURDENS

Like many Americans, Virginians currently experience hardship due to high healthcare costs. All told, 55% of Virginia adults experienced one or more of the following healthcare affordability burdens in the prior 12 months:

1.) BEING UNINSURED DUE TO HIGH PREMIUM COSTS

- 64% of uninsured adults cited “too expensive” as the major reason for not having coverage, far exceeding other reasons like “don’t need it” and “don’t know how to get it.”

2.) DELAYING OR FORGOING HEALTHCARE DUE TO COST

Nearly half (46%) of Virginia adults encountered one or more cost related barriers to getting health care during the prior 12 months, including:

- 33%—Delayed going to the doctor or having a procedure done
- 29%—Avoided going to the doctor or having a procedure done altogether
- 25%—Skipped a recommended medical test or treatment
- 20%—Did not fill a prescription
- 18%—Cut pills in half or skipped doses of medicine
- 15%—Had problems accessing mental healthcare

Moreover, cost was by far the most frequently cited reason for not getting needed medical care, exceeding a host of other barriers like transportation, difficulty getting an appointment, lack of childcare and other reasons.

Of the various types of medical bills, the ones most frequently associated with an affordability barrier included doctor visits, dental, and prescriptions, likely reflecting the frequency with which Virginia adults seek these services—or, in the case of dental, lower rates of coverage for these services.

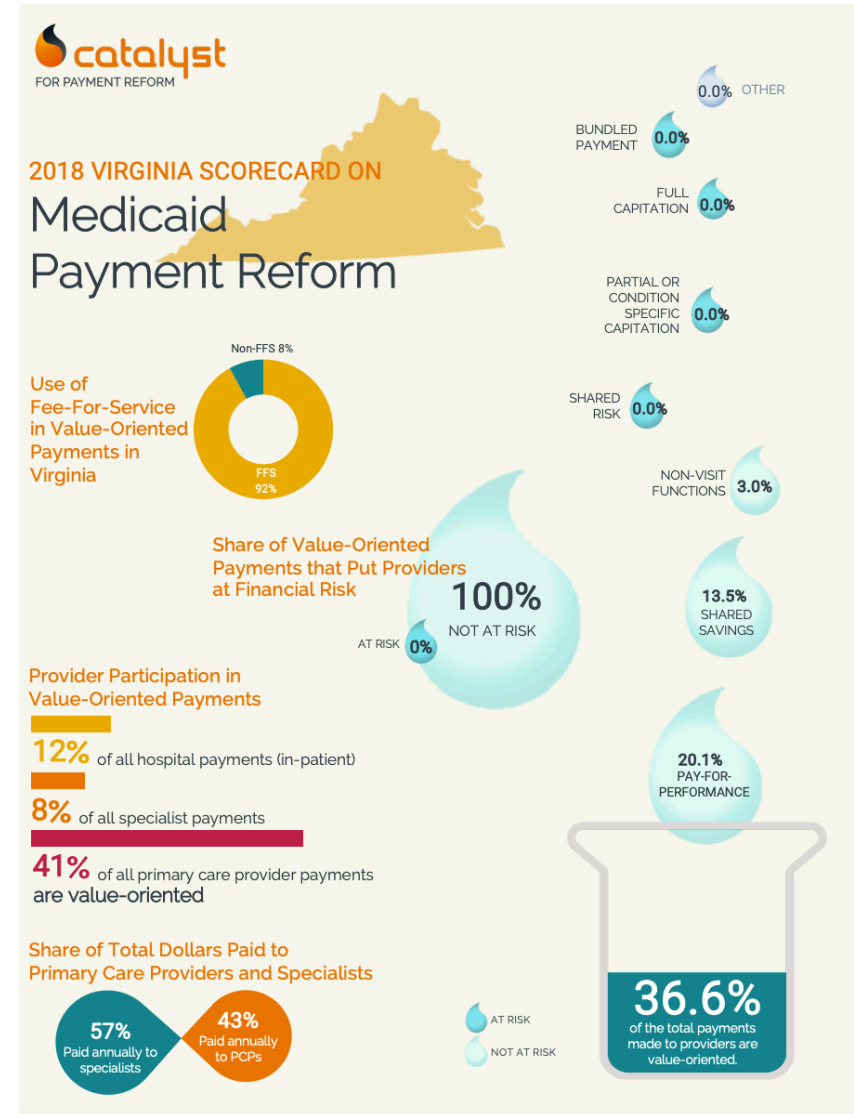
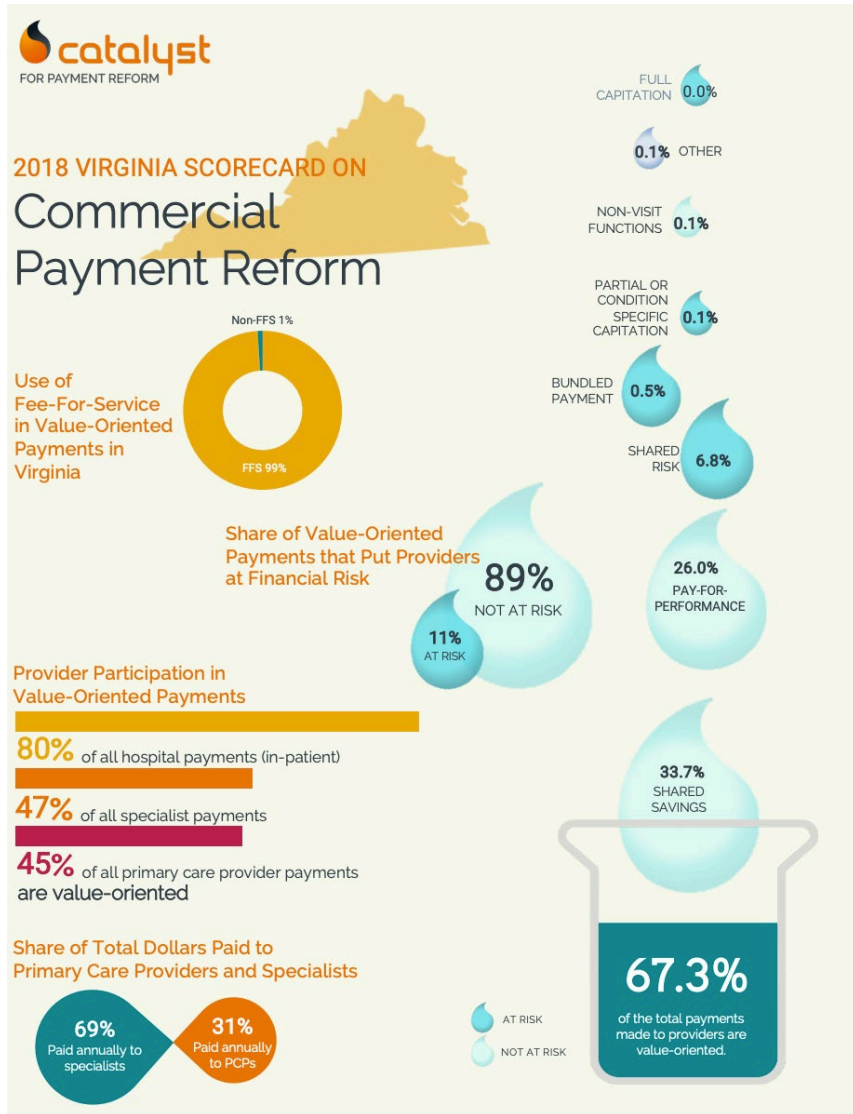
Results from Altarum’s Consumer Healthcare Experience State Survey

Altarum’s Consumer Healthcare Experience State Survey (CHESS):

- designed to elicit respondents’ unbiased views on a wide range of health system issues
- uses a web panel from *SSI Research Now* of ~1,100 Virginians 18 and older
- fielded March 12 - April 2, 2019
- English language only

More methodology and demographics available at:
HealthcareValueHub.org/Virginia-2019-Healthcare-Survey

Partnership with Catalyst for Payment Reform





GOVERNOR'S TASK FORCE
ON PRIMARY CARE

Overview

- Call to action to address the urgent needs of primary care and to consider new models of resource allocation and accountability
- Emphasis on ensuring primary care maintains its ability to achieve its proven salutary effects - higher quality care at lower costs with greater equity across populations – despite challenges exacerbated by the COVID-19 pandemic
- Launched July 2020
- Staffed by VCHI, funding support from Arnold Ventures for Year 1
- Commonwealth of Virginia recently announced funding support for Year 2



Task Force Aims

- Build a stakeholder coalition to direct primary care support and advance the use of data/communication systems for action;
- Define payment models to better support primary care and support practice viability through systems that allow for predictability in financial support;
- Describe the infrastructure needed to support primary care;
- Identify markers of high value care in the COVID and post COVID era to function as quality metrics; and
- Promote innovations in telehealth, population health management, and outreach to adapt to the changing COVID environment.



Emerging Recommendations by Subgroup

| Infrastructure | Payment Reform | Performance Measurement |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Develop and prepare a Virginia Primary Care Spend Report. This will require building consensus on patient attribution and risk adjustment methodologies. Report should break out spending by type of insurance and by population (adult versus pediatric).</p> | <p>Work with DMAS to prepare budget amendment support documentation to secure the increased funds needed to ensure Medicaid primary care services (adult and pediatric) are paid at least at parity with Medicare – while developing a pathway to move these payments from a FFS to PMPM mechanism that includes increased accountability for inappropriate ER utilization and improved health and cost outcomes.</p> | <p>Continue and expand existing workgroup, finalize measure recommendations, and secure participation agreements from relevant entities. New measures should move beyond clinical quality measures, to include social determinants of health measures, patient-reported outcome measures, and population performance measures.</p> |
| <p>Develop and prepare a Virginia Overall Healthcare Spend Report. Phase one would be the preparation of a statewide report. Phase two (to be funded through new APCD federal funding and completed in 2023) would be the development of individual clinician and practice level Total Cost of Care reports.</p> | <p>Explore the feasibility of developing and implementing a dashboard to track primary care participation in VBP contracts.</p> | |
| <p>Develop and prepare a Virginia Plan to Enhance Communication between Public Health and Primary Care.</p> | | |
| <p>Develop a detailed plan to provide Virginia primary care clinicians with the tools and resources they need to engage in VBP contracts. Supports to be researched and considered include: 1) care delivery transformation strategies and workflow optimization, 2) data and analytic support, 3) incorporating social determinants of health information into care delivery, 4) centralized care coordination and health coaching, 5) telehealth support, 6) policy expertise, and 7) contracting support.</p> | | |



Where We are Headed is in Alignment with Other State Experiences

- CHCS: Advancing Primary Care Innovation Through Medicaid Managed Care (Profiles Other State Activities)
- Primary Care Collaborative: Primary Care Investment Report

Example: Colorado

- **Multi-payer alignment.** Multi-payer alignment is crucial to the success of alternative payment models (APMs), and Colorado should build upon the prior and ongoing work of payers and providers to advance high quality, value-based care. Practices need common goals and expectations across payers in order to transform care delivery and shift from fee-for-service (FFS) to value-based payment at the practice-level. Alignment across payers improves efficiency, increases the potential for change, and reduces administrative burden for practices.
 - **Measuring primary care capacity and performance.** Measures used to evaluate primary care APMs should be aligned across public and private payers and reflect a holistic evaluation of practice capacity and performance.
 - **Measuring system-level success.** Measures to determine whether increased investment in primary care and increased use of APMs are achieving positive effects on the health care system should examine various aspects of care and value.
 - **Incorporating equity in the governance of health reform initiatives.** The governance of initiatives to support and enhance primary care services should reflect the diversity of the population of Colorado.
 - **Data collection to address health equity.** Data collection at the plan, health system, and practice-level should allow analysis of racial and ethnic disparities.
-



Proposed Year 2 Deliverables

- Virginia Primary Care Spend Report
- Virginia Overall Health Care Spend Report
- Virginia Value-Based Contracting Dashboard
- Virginia Primary Care Core Measures Set with Defined Pathways for New Measure Adoption
- Virginia Plan to Enhance Communication between Public Health and Primary Care
- Virginia Medicaid Primary Care Payment Reform Model
- Virginia Plan to Enhance Primary Care Infrastructure Support

