Relationships, Data, and Quality Improvement Infrastructure

Critical Factors when Accountable Care Organizations and Primary Care Practices Collaborate to Increase Colorectal Cancer Screening in Medicaid Members

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Background

• Health system stakeholders are increasingly aligning as Accountable Care Organizations (ACOs) to support improved quality, experience, and controlled costs.

• Context:

  – Oregon’s Coordinated Care Organizations (CCOs, Medicaid ACOs) are the single point of accountability for health care access, quality, and outcomes of Medicaid members.

  – Colorectal cancer screening is one of 18 CCO quality incentive metrics.

• **Research Questions:** How are clinics and ACOs/CCOs working together to improve care (colorectal cancer screening)? What interventions are they implementing?
Community Health Advocacy and Research Alliance (CHARA)

- Location: Columbia River Gorge (PacificSource CCO Region)
- Established with funding from the PCORI Pipeline to Proposal Award Series (2014 – 2017)
- **Goal**: Network of community members, local health leaders and researchers who can “identify, develop, and conduct health research to answer questions that matter here.”

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CHARA Process Overview
Controlling for age, beneficiaries had greater odds of receiving CRC testing if they were female (OR 1.04, 95% CI 1.01-1.08), commercially insured, or urban residents (OR 1.14, 95% CI 1.07-1.21).

Accessing primary care (OR 2.47, 95% CI 2.37-2.57), but not distance to endoscopy (OR 0.98, 95% CI 0.92-1.03), was associated with testing.
CRC Screening in Oregon’s CCOs

Thirteen CCOs achieved benchmark or improvement target for colorectal cancer screening between 2014 & 2015.

- Columbia Pacific
- AllCare Health Plan
- Primary/Health of Josephine County
- Yamhill CCO
- Willamette Valley Community Health
- FamilyCare
- Umpqua Health Alliance
- Jackson Care Connect
- Eastern Oregon
- PacificSource - Gorge
- Health Share of Oregon
- Intercommunity Health Network
- Western Oregon Advanced Health
- PacificSource - Central
- Trillium
- Cascade Health Alliance

Indicates CCO met benchmark or improvement target.
Point Prevalence of CRC Testing in Oregon CCO Medicaid Members

Results displayed where number of cases (denominator) > 10.
Methods

• Design & Setting: Observational cross case comparative study among Oregon’s 16 CCOs

• Data Collection & Participant Sample:
  – CRC technical assistance consults with CCOs between June – July 2016
  – Semi-structured interviews with key stakeholders between February – August 2016

• Analysis: Fieldnotes & interview transcripts transferred to Atlas.ti and analyzed using data-driven, emergent approach
Results - Participants

• Data gathered from 14 of 16 CCOs
  
  — 10 CCO consultations

  — 26 key informants: state innovator agents (n=4), CCO leadership (n=16) and primary care practice members (n=6)

• Over 30% of the informants (n=8) worked with more than 1 CCO.
Results

• CCOs developed their strategies and infrastructure to work with clinics over time

• CCOs often started very lean: “for over a year and a half, [the CCO] didn’t lease a physical office space... They held meetings in their partners’ offices.”  (P12)

• CCOs implemented multicomponent interventions to improve CRC screening

<table>
<thead>
<tr>
<th>CRC Intervention Strategy</th>
<th>Component</th>
<th>Evidence-based?*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase community demand</td>
<td>Client reminders</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Client incentives</td>
<td>Insufficient</td>
</tr>
<tr>
<td></td>
<td>Small media</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Mass media</td>
<td>Insufficient</td>
</tr>
<tr>
<td></td>
<td>One-on-one education</td>
<td>Yes</td>
</tr>
<tr>
<td>Interventions to increase community access</td>
<td>Reducing structural barriers</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Reducing client out-of-pocket costs</td>
<td>Insufficient</td>
</tr>
<tr>
<td>Interventions to increase provider delivery</td>
<td>Provider assessment &amp; feedback</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Provider reminder &amp; recall</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Provider incentives</td>
<td>Insufficient</td>
</tr>
</tbody>
</table>

* Based on the Guide to Community Preventive Services
CCO Case Examples

Regional efforts have focused on implementing incentive programs for members ($20 Walmart gift card for returning a fecal test) and providers ($50-$100 when a patient completes screening). The CCO has improvement staff who leverage relationships with practices to provide education on their alternative payment method (APM) strategies, help create pop-up reminders in clinic EHRs, and provide patient gap lists. Additionally, CCO receptionists make reminder calls to patients that are due for screening.

...the CCO elected to implement a direct mail program modeled after Kaiser. CCO leadership worked with 4-5 clinics to pilot test the intervention and work out the kinks in the first year; this included learning to have clinics review member lists in advance. The program has expanded over time and recently transitioned from implementation by CCO staff to a contract with a vendor who supports material prep and distribution. The CCO also distributes money from the quality metric pool back to clinics that meet their CRC performance targets.
Results

CCOs addressed three key dimensions as they sought to improve CRC screening with regional clinics:

1) Establishing and building relationships

2) Producing and sharing data

3) Developing a process and infrastructure to support quality improvement (QI)
1) Establishing Relationships

Relationships and physical proximity were critical in building trust, buy-in, and shared decision making for improvement activities by CCO and clinic partners.

“…[CCO A] did not exist as an entity on the ground before…for us in [rural] Oregon, Portland can sometimes be a million miles away…Versus [CCO B] that has a physician led organization and the community…you knew the players from that one [from the start].” (P15)
“I think that's the way we've been able to achieve anything [is by building and leveraging relationships]. It has to be a partnership with the clinic, because we really are a guest in their clinics, so you can't just go in there and tell them what to do.”

- CCO Staff, P9
2) Producing and Sharing Data

Multiple CCOs focused on generating and producing actionable data to inform improvement efforts
• Some CCOs routinely, and strategically, shared data with member clinics
• Others were refining their approach

Clinics varied in their interest and ability to respond to performance data
“We have really good reporting… We have gap lists that we can produce by clinic, by provider, by measure. We know who's got the most members and clients…so that we know where to target.”

—CCO Staff, P10

“…the reports that we had gotten from the CCO were not very helpful … we would get reams of paper and about the fourth or fifth page in when three-quarters…weren't assigned to us we sort of saw them as unuseful and put them aside….

- Clinic Member, P8
3) Developing a Process and Infrastructure to Support QI

Some CCOs led regional learning collaboratives and supported improvement staff
• Clinic-based panel managers and QI leads
• CCO-level improvement staff

“The CCO improvement staff] actually come [out here to] the clinic and say, “What do you guys need as a clinic? What can we do to help you?”…they do a lot of support for [clinic] management …for implementation of metrics… They are really there to help operationalize [what] we need to do to show that we’re giving good care….They help with data collection…They're fabulous. I couldn't ask for anything more.” (P11)
Conclusions

• CCOs used multicomponent strategies to increase CRC screening

• Not all interventions had sufficient evidence, according to the Community Guide

• CCOs needed to address relationships, data, and QI infrastructure when working with clinics to increase CRC screening

→ similar steps for other quality metrics?
Implications & Recommendations

• Health system and policy leaders must consider relationships, data, and QI infrastructure when implementing population health initiatives across diverse settings
  – Understand/assess/respond to local context
  – Allow prior history and experience to inform partnership goals
  – Set realistic improvement targets based on local capacity

• Use and equity-based participatory implementation science approach

• Monitor for unintended consequence: increasing disparities because of focus on “larger” clinics/systems

See also, Wheeler & Davis (In Press). “Taking the Bull by the Horns”: Four Principals to Align Public Health, Primary Care, and Community Efforts to Improve Rural Cancer Control. *Journal of Rural Health.*
Acknowledgements

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Thank You

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Community Health Advocacy and Research Alliance (CHARA) Timeline

2011: ACO rules released by DHS & Oregon HB 3650 authorized CCOs

2012: Oregon CCOs launched, including Pacific Source Columbia Gorge CCO

2013: Drs. Davis and Dillon brainstorm at NAPCRG


2015: PCORI P2P Tier II awarded. CHARA named.

2016: PCORI P2P Tier III awarded. PCORI and NIH proposals submitted

2017: Sustainability Transition

Davis K12 Awarded

Finding the Right FIT Awarded

Accountable Communities of Health Awarded; MARC evaluation

Gorge employees Collective Impact Health Specialist

Columbia Gorge CCO region receives RWJF Culture of Health Prize.
CRC Screening in Oregon’s CCOs

Percentage of adult members who had appropriate screening for colorectal cancer in 2015 and 2016, by CCO.

- Indicates CCO met benchmark or improvement target. Grey dots represent 2014.