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

PRESENTED BY: Melinda M. Davis, PhD, Director of Community Engaged Research, Associate Professor – Department of Family Medicine

DATE: August 14, 2017 LOCATION: CDC National Cancer Conference, Atlanta, MD

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.

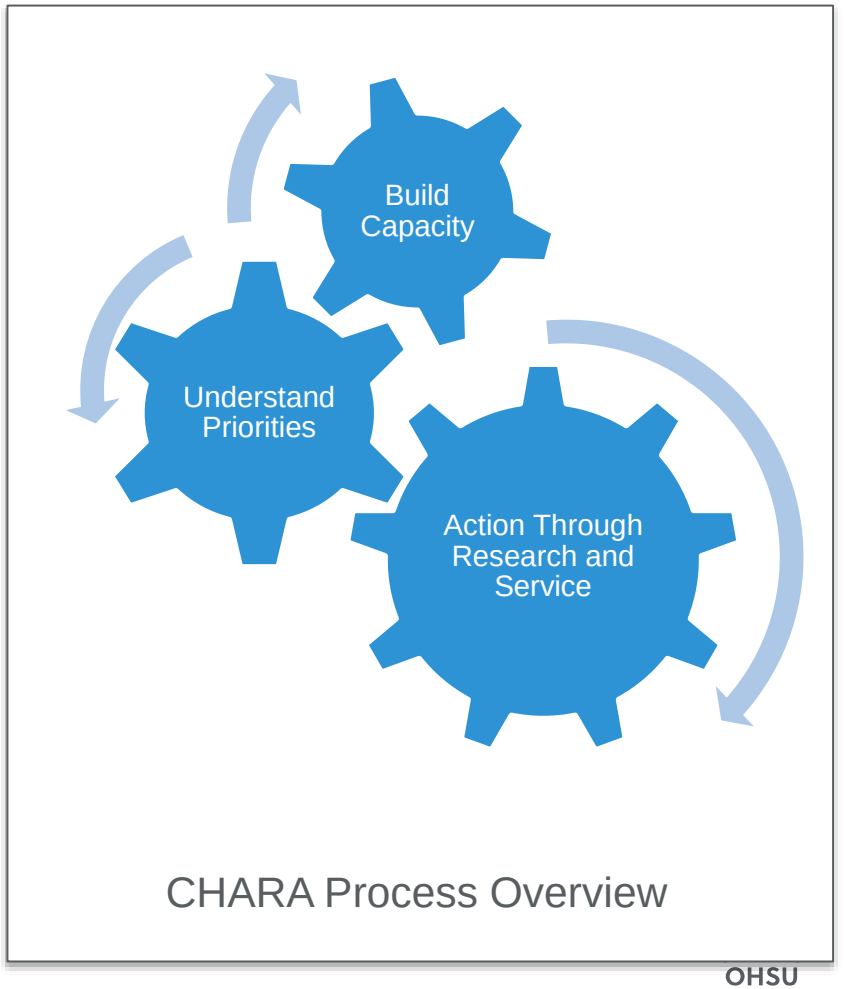
- **Research Questions:** How are clinics and ACOs/CCOs working together to improve care (colorectal cancer screening)? What interventions are they implementing?

OHSU


Coordinated Care Organization Service Areas
Health Share of Oregon
PacificSource Community Solutions Coordinated Care Organization, Columbia Gorge Region
Columbia Pacific Coordinated Care Organization
FamilyCare, Inc.
Yamhill Community Care Organization
Willamette Valley Community Health, LLC
Intercommunity Health Network Coordinated Care Organization
Trillium Community Health Plan
Western Oregon Advanced Health, LLC
AllCare Health Plan
PrimaryHealth of Josephine County, LLC
Jackson Care Connect
Cascade Health Alliance
Umpqua Health Alliance
PacificSource Community Solutions Coordinated Care Organization, Central Oregon Region
Eastern Oregon Coordinated Care Organization
CLATSOP
COLUMBIA
TILLAMOOK
WASHINGTON
CLACKAMAS
YAMHILL
POLK
MARION
LINCOLN
BENTON
LINN
LANE
DOUGLAS
COOS
CURRY
JOSEPHINE
JACKSON
KLAMATH
LAKE
DESCHUTES
JEFFERSON
CROOK
WASCO
HOOD RIVER
SHERMAN
GILLIAM
MORROW
WHEELER
GRANT
UMATILLA
UNION
WALLOWA
BAKER
HARNEY
MALHEUR
Overlapping coverage areas
Oregon Health Authority
OHSU

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."



CHARA Process Overview

For more information: davismel@ohsu.edu
http://www.communityresearchalliance.org/

CRC Testing in Oregon: Multilevel Factors

Preventive Medicine

Available online 13 May 2017

In Press, Accepted Manuscript — Note to users

Geographic and population-level disparities in colorectal cancer testing: A multilevel analysis of Medicaid and commercial claims data

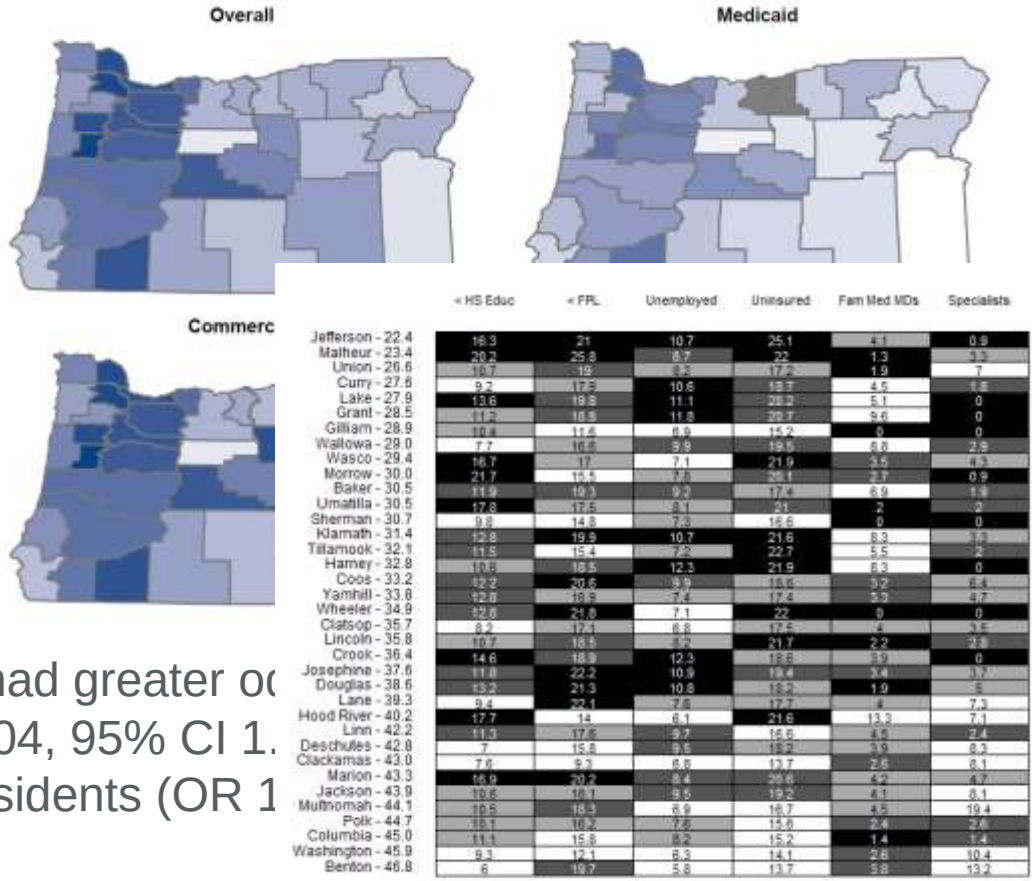
Melinda M. Davis[a, b], Stephanie Renfro[c], Robyn Pham[a], Kristen Hassmiller Lich[d], Jacklen Shannon[a], Gloria D. Coronado[c], Stephanie B. Wheeler[a, e]

Show more

https://doi.org/10.1016/j.ypmed.2017.05.001 Get rights and content

Highlights

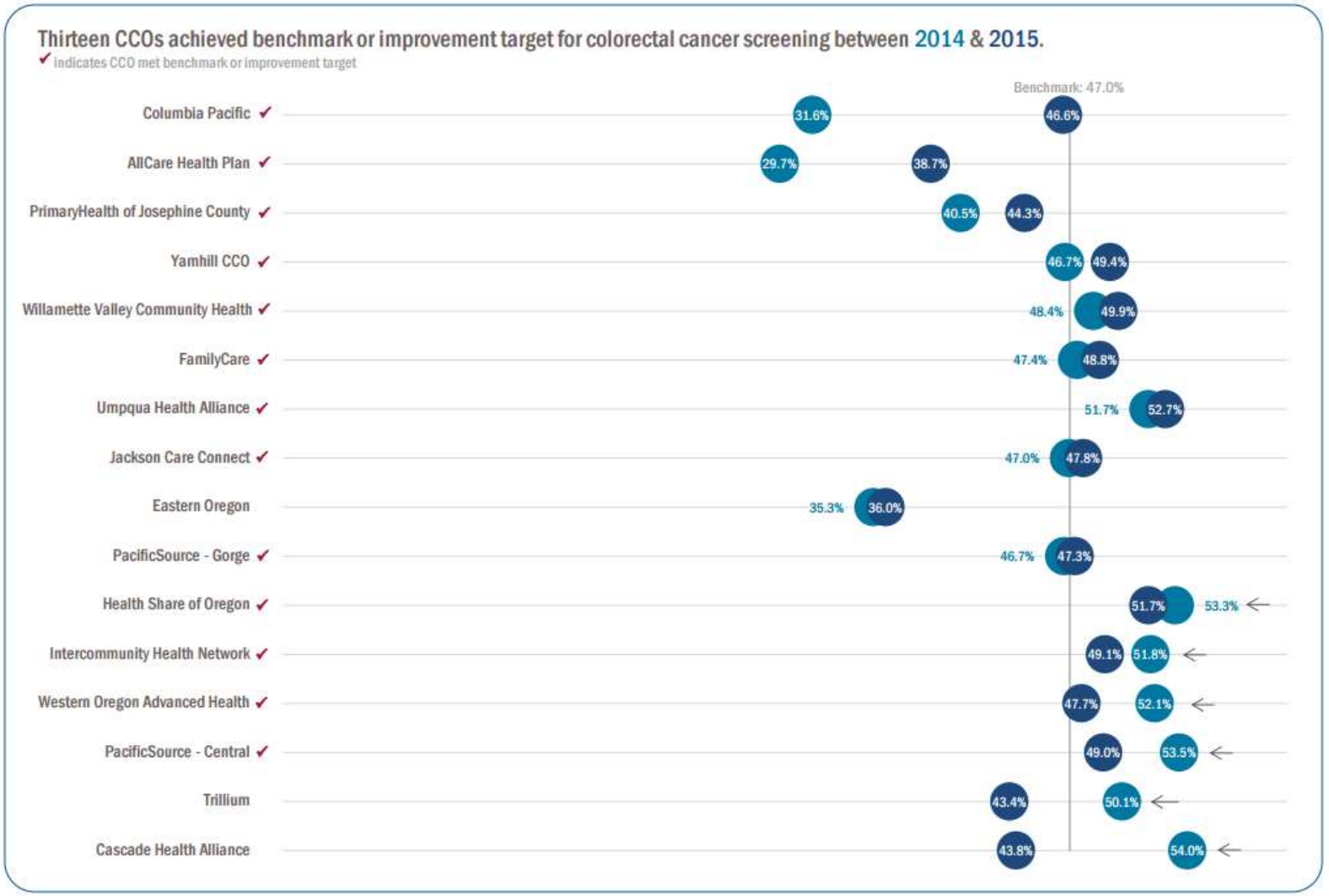
- Despite insurance, 58% had not received colorectal cancer (CRC) testing.
- CRC testing varied from 22.4% to 46.8% across Oregon's 36 counties.
- Individual, community, and health system-level factors impacted CRC testing.
- Counties with higher socioeconomic deprivation displayed lower CRC testing.
- Work to increase CRC testing in targeted counties and populations is needed.



- Controlling for age, beneficiaries had greater od testing if they were female (OR 1.04, 95% CI 1. commercially insured, or urban residents (OR 1 1.21).
- Accessing primary care (OR 2.47, 95% CI 2.37 [illegible]), but not distance to endoscopy (OR 0.98, 95% CI 0.92-1.03) was associated with testing.

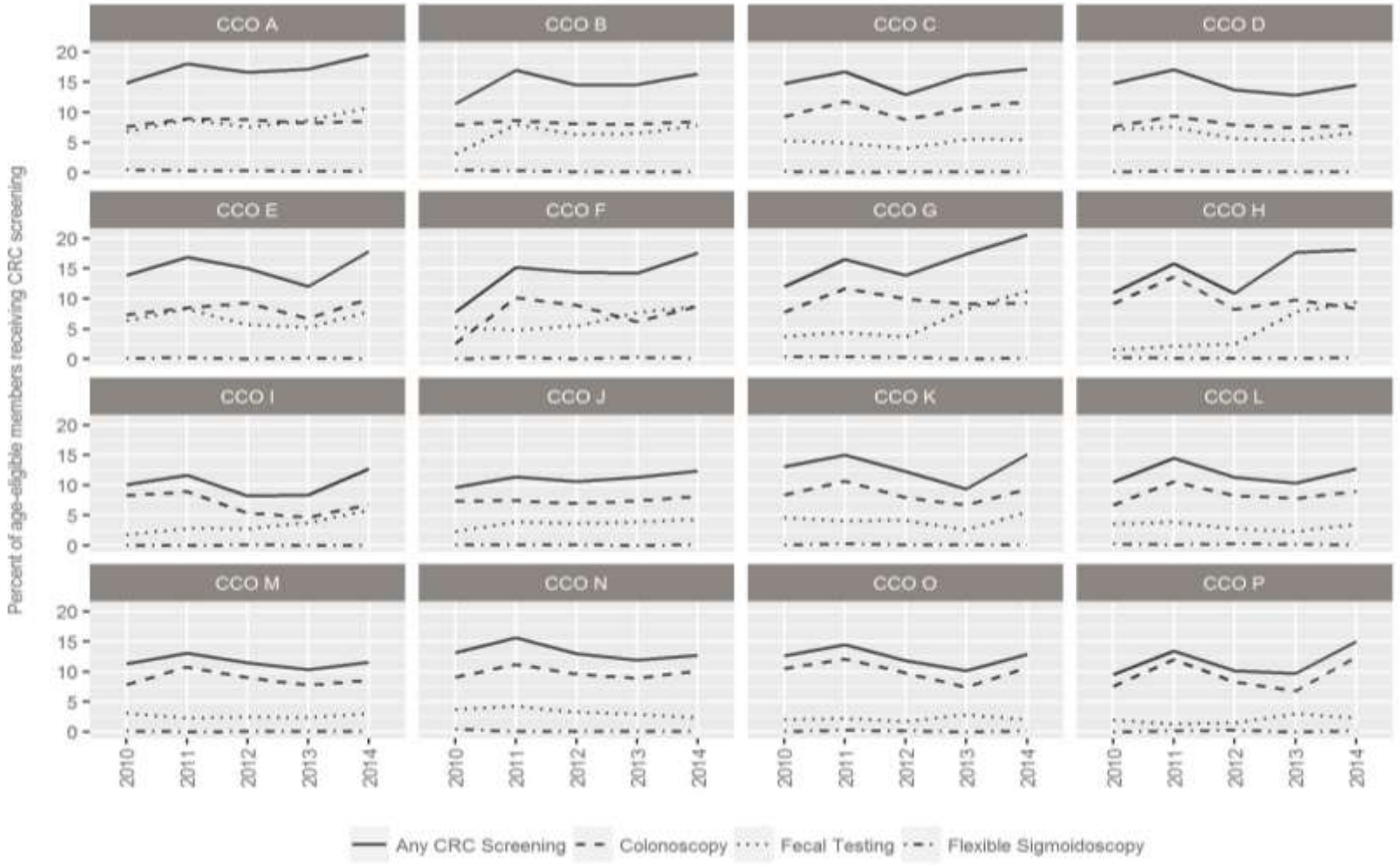
OHSU

CRC Screening in Oregon's CCOs



OHSU

Point Prevalence of CRC Testing in Oregon CCO Medicaid Members



Results displayed where number of cases (denominator) ≥ 10.

OHSU

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

OHSU

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.

OHSU

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

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

* Based on the Guide to Community Preventive Services

OHSU

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)

OHSU

“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)

OHSU

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?

OHSU

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

- **Co-Authors:** Rose Gunn, MA; Robyn Pham, BA; Amy Wiser, MD; Kristen Hassmiller-Lich, PhD; & Stephanie B. Wheeler, PhD
- **Facilitative Partners:** Adrienne Mullock & Patricia Schoonmaker, MPH

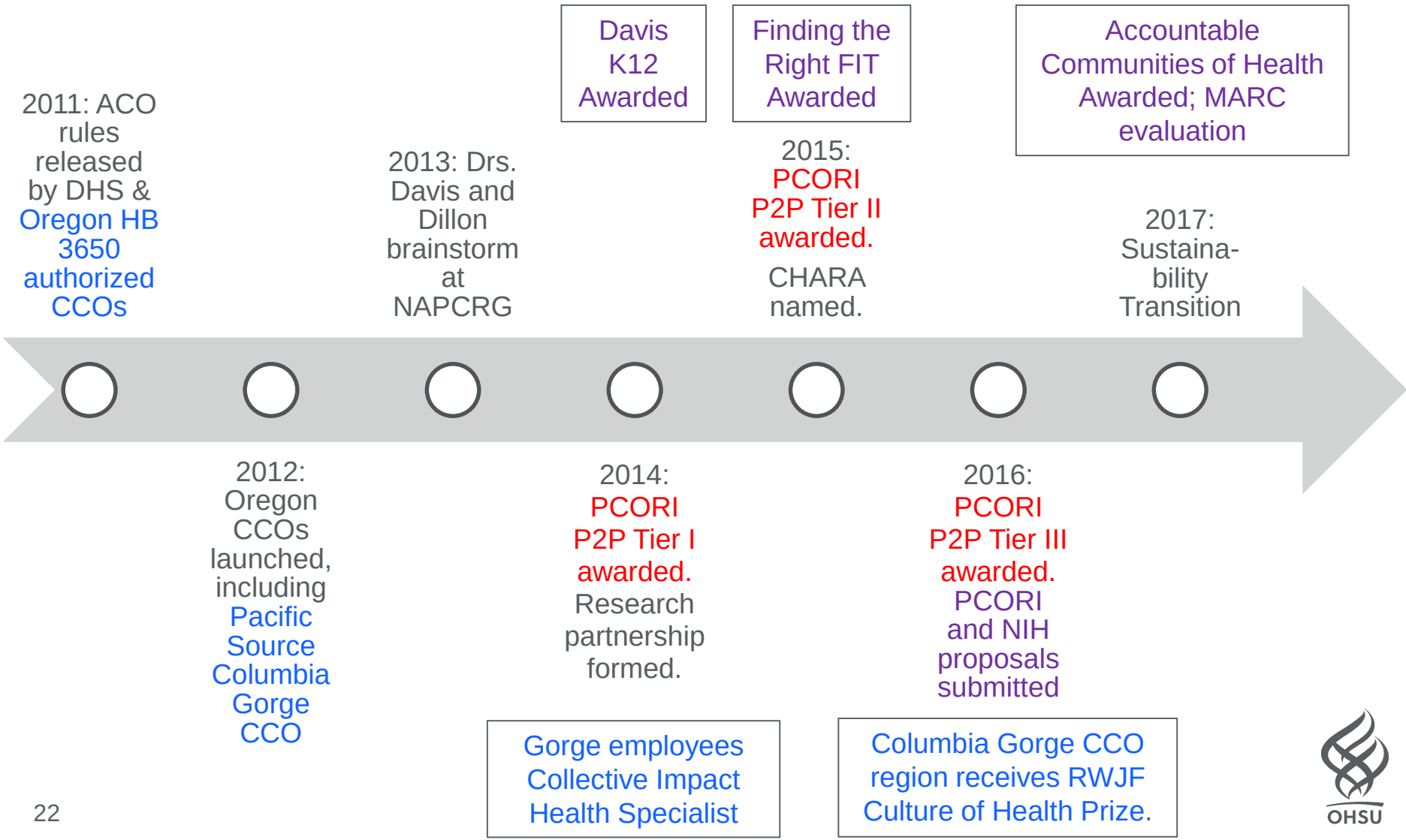
Funding: Dr. Davis has received support from an AHRQ PCOR K12 (Award Number 1 K12 HS022981 01) and National Cancer Institute K07 (1K07CA211971-01A1). The project was supported by Funding Opportunity Number CMS-1G1-12-001 from the U.S Department of Health and Human Services (HSS), Centers for Medicare & Medicaid Services. This presentation was supported by CPCRN cooperative agreements 3 U48 DP005006-01S3 and 3 U48 DP005017-01S8. The content provided is solely the responsibility of the authors and do not necessarily represent the official views of these funders nor or any of their agencies.

OHSU

Thank You

For more information: davismel@ohsu.edu

Community Health Advocacy and Research Alliance (CHARA) Timeline



CRC Screening in Oregon's CCOs