Collaboration Between Accountable Care Organizations and Primary Care Practices: Promising Practices for Implementing Interventions 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 achieve the triple aim for target patient populations. Research is needed to describe how ACOs interface with primary care practices and community-based partners to achieve target performance benchmarks.

Oregon's 16 Coordinated Care Organizations (CCO) - which are the single point of accountability for health care access, quality, and outcomes of Medicaid members - provide an ideal context in which to address this research question. We focus on efforts to increase CRC screening, one of 18 CCO quality incentive metrics.

Methods

Design: Cross case comparative study.

Setting: 16 CCOs are currently active in Oregon and cover more than 850,000 Medicaid lives. CRC screening has been a CCO quality incentive metric since 2013. The CRC quality benchmark was 47.0% in both 2014 and 2015.

Data Collection and Participant Sample: We conducted technical assistance consultations with leadership and quality improvement teams from 10 CCOs between June and July 2016. We conducted semi-structured interviews with a purposive sample of stakeholders working with 12 CCOs from February to August 2016.

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Methods cont.

Analysis: Interview transcripts and consultation field notes were transferred to Atlas.ti for data management and analysis. Our multidisciplinary team used multiple immersion-crystallization cycles to analyze data. First we coded key segments of text. Second, we reviewed data from a single CCO. Finally, we examined how emerging patterns manifest across CCOs with varied structures and performance on the CRC metric.

Results

We engaged 14 CCOs who ranged in size from 10,000 - 225,000 Medicaid members. The 26 key informants represented state innovator agents (n=4), CCO leadership (n=16), and primary care practices (n=6). Over 30% of the informants (n=8) worked with more than 1 CCO.

CCOs were implementing multiple interventions to improve CRC screening (see Table). CCOs developed their strategies and infrastructure over time and often started very lean; "f*or over a year and a half, they didn't lease a physical office space... They held meetings in their partners' offices ." (P12)*

Table. Intervention Strategies Used by CCOs

CRC Screening Interventions	Evidence-based
Patient reminders	Yes
Small media	Yes
Reducing structural barriers	Yes
Provider assessment and feedback	Yes
Provider reminder and recall	Yes
Client Incentives	Insufficient
Mass Media	Insufficient
Patient & provider incentives	Insufficient

CCOs were working through three key dimensions as they sought to improve CRC screening and achieve the quality metric target.

1) Establishing Relationships
Prior relationships and physical proximity were critical in building trust, buy-in, and shared decision making for improvement activities by CCO and clinic partners.
"…the [CCO] did not exist as an entity on the ground before…for us in [rural] Oregon, Portland can sometimes be a million miles away. It just doesn't matter. Versus [CCO B] that has a physician led organization and the community…you knew the players from that one." (P15)

2) Producing and Sharing Data
Multiple CCOs focused on generating and producing actionable data to inform improvement efforts. CCOs routinely, and strategically, shared data with member clinics. However, clinics varied in their ability to respond to performance data.

Results cont.

"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. Usually you would just go, 'oh, let's let everybody know…' Well, now we go, 'okay, if we approach this 1 clinic, we can get everything we need to make the measure.' …We're being very strategic about that." (P10)

3) Developing a Process and Infrastructure to Support Quality Improvement (QI)
Many CCOs supported improvement staff, including clinic-based panel managers and QI leads and CCO-level improvement staff.

"They do a lot of support for management …for implementation of metrics… They are really there to help operationalize [what] we need to do to….They come out here. They help with data collection…They're fabulous. I couldn't ask for anything more." (P11)

Implications for D&I

Relationships, data, and improvement infrastructure influenced the ability of CCO and clinic partners to implement CRC screening interventions – which were not always evidence based. Health system and policy leaders must consider these factors and set realistic metric targets when implementing population health initiatives across diverse CCO and clinic settings.

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