Relationships, Data, and Quality Improvement Infrastructure

Three Key Dimensions When Medicaid Accountable Care Organizations Partner with Primary Care Clinics to Improve Colorectal Cancer Screening
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 Question: How are clinics and ACOs/CCOs working together to improve care → colorectal cancer screening?
CRC Screening in Oregon’s CCOs

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

- Columbia Pacific: 31.6%
- AllCare Health Plan: 29.7%
- Primary/Health of Josephine County: 40.9%
- Yamhill CCO: 40.7%
- Willamette Valley Community Health: 40.4%
- FamilyCare: 40.5%
- Umpqua Health Alliance: 48.4%
- Jackson Care Connect: 48.0%
- Eastern Oregon: 35.3%
- PacificSource - Gorge: 49.7%
- Health Share of Oregon: 47.0%
- Intercommunity Health Network: 47.7%
- Western Oregon Advanced Health: 47.3%
- PacificSource - Central: 47.3%
- Trillium: 38.8%
- Cascade Health Alliance: 54.0%

Benchmark: 47.0%
Methods

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

• Data Collection & Participant Sample:
  — Technical assistance consults with 10 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

- 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)

- CCOs implemented multicomponent interventions to improve CRC screening

<table>
<thead>
<tr>
<th>CRC Intervention Strategy</th>
<th>Component</th>
<th>Evidence-based?*</th>
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<tbody>
<tr>
<td></td>
<td>Client reminders</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Client incentives</td>
<td>Insufficient</td>
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<tr>
<td></td>
<td>Small media</td>
<td>Yes</td>
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<tr>
<td></td>
<td>Mass media</td>
<td>Insufficient</td>
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<td></td>
<td>One-on-one education</td>
<td>Yes</td>
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<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>
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<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>
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<tr>
<td></td>
<td>Provider incentives</td>
<td>Insufficient</td>
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* Based on the Guide to Community Preventive Services
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 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 and Implications

• CCOs and ACOs need to consider relationships, data, and QI infrastructure when working with clinics to increase CRC screening → improve care

• Not all interventions were evidence-based, most CCOs were using multicomponent strategies

• Prior history and expertise should inform partnership goals

• Health system and policy leaders must consider these factors and set realistic improvement targets when implementing population health initiatives across diverse CCO and clinic settings
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