Learning System Innovations: Oregon’s Health Reform Policy to Practice

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Overview

- Share the journey of Oregon health care reform
- Describe the key learnings from the last 5 years of reform efforts and how they impact learning systems
- Provide three examples of successful “innovations”
The Power of Story
In Health Care Transformation

Homo Narrans

“Public narrative is a leadership art. Leaders draw on narrative to inspire action across cultures, faiths, professions, classes and eras...”

- Marshall Ganz
The Burning Platform

In 2011, Oregon faced a $2 billion hole in the Medicaid budget.

- **Traditional budget balancing**
  - Cut people from care
  - Cut provider rates
  - Cut services

- **The 4th way: Change how care is delivered**
  - Reduce waste
  - Improve health
  - Create local accountability
  - Align financial incentives
  - Pay for performance and outcomes
  - Create fiscal sustainability
Oregon Health System Transformation

2009
- HB 2009: created Oregon Health Authority (OHA)

2010
- Governor Kitzhaber elected

2012
- SB 1580: created coordinated care organizations
- Federal waiver: feds invest $1.9B in Oregon’s model
- 16 CCOs created
- Community Advisory Councils – 51% OHP members
Oregon’s Coordinated Care Model

- Best Practices to manage and coordinate care
- Paying for outcomes and health
- Transparency in price and quality
- Sustainable rate of growth
- Shared responsibility for health
- Measuring Performance

BETTER HEALTH, BETTER CARE, LOWER COSTS
Coordinated Care Model Key Levers

- Benefits and services are integrated and coordinated
- One global budget that grows at a fixed rate
- Metrics: standards for safe and effective care
- Local accountability for health and budget
- Local flexibility
Access to care
- Access to Any Care, a measure based on health care claims data, decreased slightly among CCO and Washington Medicaid members;
- However, the % of patients who said it was easy to access needed care and an appt increased in 2 of 3 yrs;
- Primary care decreased slightly; Among SPMI population increased in 4 of 5 measures
- No change in number of providers serving Medicaid

Quality measure improvement
- Quality measures generally improved in three domains: Prevention and Wellness for Children and Adolescents, Emergency Department and Hospital Use, and Avoiding Low-Value Care

Experience of care
- Experience of care measures and self-reported health status for CCO members also improved.

Health Status
- Percentage reporting good, very good, excellent health increased by 12% from baseline 2011 (59.3%) in both CCO and FFS;

Total Spending PMPM
- Total Spending PMPM decreased among CCO members, more than WA; inpatient & outpatient PMPM decreased, Rx increased
- $1.4 billion saved over 2012-1017 (projected savings $10.5B 2012-2022)
- All CCO’s stayed within budget at 3.4% per beneficiary growth per year
What have we learned about **HOW** to reform healthcare?

- Local accountability and governance
- Money changes behavior: Global budget; Quality Incentive Metrics (P4P)
- Know the environment - what’s already happening that’s successful and scalable?
- The many cooks in the kitchen and need for common vision
  - State Innovation Model Grant (SIM)
  - State Transformation General Funds
  - The 1115 Medicaid Waiver
  - Comprehensive Primary Care Classic and Plus (CPC+)
  - Adult Medicaid Quality Grant; Health Commons; TopMed;
• Skill building: need to sit up, crawl before you can walk and run
• Understand the workforce needs: primary care, BH consultants, CHWs
• Creating a space for peer to peer learning
  • Quality & Health Outcomes Committee learning collaborative
  • PCPCH Program Practice Facilitation Mentors
  • Innovation Cafe
• Need for a statewide “hub” that focuses on transformation and dissemination
  • Oregon Transformation Center
  • Innovator Agents
3 Learning “Innovations”

1) Measuring Success: The Quality Incentive Measures
2) The Oregon ECHO Network
3) Council of Clinical Innovators
CCO Quality Incentive Metrics

- **Accountability & transparency**
  - Improved measurement system
  - Right metrics
  - Transparency in reporting costs & outcomes

- **State Performance Measures: CMS Quality and Access Test**
  - Annual assessment of statewide performance on 33 measures
  - Financial penalties to the state if quality goals are not achieved

- **CCO Incentive Measures**
  - Annual assessment of CCO performance on 17 measures tied to global budget withhold 2% to 5%
  - Metrics & Scoring Committee (statute)
  - Quality pool paid to CCOs for performance + challenge pool; all funds disbursed annually
  - Compare current performance against prior baseline year
  - Originally, Incentive Measures focused on clinical care; New Incentive Measures focus on population health: Dental sealants for children, effective contraception; tobacco use prevalence
2018 CCO Incentive Measures

- Adolescent well-care visits
- Ambulatory Care: ED utilization
- CAHPS composite: access to care
- Childhood immunization status*
- Cigarette smoking prevalence
- Colorectal cancer screening
- Controlling high blood pressure
- Dental sealants for children
- Depression screening
- Developmental screening <36mos*
- Diabetes: HbA1c Poor Control
- Disparity measure: ED use of members with mental illness
- Assessments w/in 60 days for foster children*
- Prenatal care timeliness*
- Effective contraceptive use
- PCPCH enrollment
- Weight assessment/counsel in children and adolescents
Adolescent well-care visits in 2016 and 2017, by CCO.

✓ indicates CCO met benchmark or improvement target. Grey dots represent 2015.
**Emergency department utilization**

Rate of patient visits to an emergency department. Rates are reported per 1,000 member months and a lower number suggests more appropriate use of care.

**Data source:**
Administrative (billing) claims

**2017 benchmark source:**
2016 national Medicaid 90th percentile

**2017 data** (N=10,026,285 member months)
- Statewide percent change since 2016: -1.1%
- Number of CCOs that improved: 11
- Number of CCOs achieving target: 6

Rates are shown per 1,000 member months, which means that in one month, there are on average X visits occurring per 1,000 CCO members.

**By race and ethnicity (2017)**

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<thead>
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<tbody>
<tr>
<td>African American/Black</td>
<td>67.6 (n=238,682)</td>
<td>67.6 (n=238,682)</td>
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<td>67.6 (n=238,682)</td>
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<td>Am. Indian/Al. Native</td>
<td>55.6 (n=116,590)</td>
<td>55.6 (n=116,590)</td>
<td>55.6 (n=116,590)</td>
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<td>Asian American</td>
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<td>20.9 (n=424,729)</td>
<td>20.9 (n=424,729)</td>
<td>20.9 (n=424,729)</td>
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<td>Hawai’i/Pac. Islander</td>
<td>44.0 (n=38,735)</td>
<td>44.0 (n=38,735)</td>
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<td>44.0 (n=38,735)</td>
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<td>Hispanic/Latino</td>
<td>38.8 (n=421,588)</td>
<td>38.8 (n=421,588)</td>
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<td>38.8 (n=421,588)</td>
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<td>White</td>
<td>51.4 (n=4,349,400)</td>
<td>51.4 (n=4,349,400)</td>
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<td>51.4 (n=4,349,400)</td>
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<tr>
<td>Other</td>
<td>31.1 (n=113)</td>
<td>31.1 (n=113)</td>
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<td>31.1 (n=113)</td>
<td>31.1 (n=113)</td>
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<tr>
<td>Unknown/undetermined</td>
<td>43.9 (n=4,109,045)</td>
<td>43.9 (n=4,109,045)</td>
<td>43.9 (n=4,109,045)</td>
<td>43.9 (n=4,109,045)</td>
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n = subpopulation denominator
Each race category excludes Hispanic/Latino

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**By household language (2017)**

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<tr>
<td>Chinese</td>
<td>19.9 (n=42,159)</td>
<td>19.9 (n=42,159)</td>
<td>19.9 (n=42,159)</td>
<td>19.9 (n=42,159)</td>
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<td>English</td>
<td>49.4 (n=8,693,130)</td>
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<td>Russian</td>
<td>27.5 (n=67,170)</td>
<td>27.5 (n=67,170)</td>
<td>27.5 (n=67,170)</td>
<td>27.5 (n=67,170)</td>
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<td>Spanish</td>
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<td>29.2 (n=810,303)</td>
<td>29.2 (n=810,303)</td>
<td>29.2 (n=810,303)</td>
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<td>Vietnamese</td>
<td>15.5 (n=50,060)</td>
<td>15.5 (n=50,060)</td>
<td>15.5 (n=50,060)</td>
<td>15.5 (n=50,060)</td>
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<tr>
<td>Other</td>
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<td>37.9 (n=90,386)</td>
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<td>30.1 (n=273,068)</td>
<td>30.1 (n=273,068)</td>
<td>30.1 (n=273,068)</td>
<td>30.1 (n=273,068)</td>
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n = subpopulation denominator
Chinese includes Cantonese, Mandarin, Other Chinese/Asian, TaiChleow
## 2017 QUALITY POOL DISTRIBUTION

<table>
<thead>
<tr>
<th>CCO</th>
<th>Phase 1 Distribution</th>
<th>Challenge Pool</th>
<th>Total payment (Phase 1 + Challenge pool)</th>
<th>Total quality pool earned</th>
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<tbody>
<tr>
<td></td>
<td># Measures met</td>
<td>Payment earned in Phase 1*</td>
<td>% Quality pool funds earned</td>
<td># Challenge measures met</td>
</tr>
<tr>
<td>Advanced Health</td>
<td>10.7</td>
<td>$3,072,442</td>
<td>70%</td>
<td>3</td>
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<tr>
<td>AllCare Health Plan</td>
<td>12.7</td>
<td>$9,248,658</td>
<td>100%</td>
<td>3</td>
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<tr>
<td>Cascade Health Alliance</td>
<td>10.7</td>
<td>$2,455,669</td>
<td>70%</td>
<td>2</td>
</tr>
<tr>
<td>Columbia Pacific</td>
<td>14.8</td>
<td>$5,799,384</td>
<td>100%</td>
<td>3</td>
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<tr>
<td>Eastern Oregon</td>
<td>13.7</td>
<td>$11,974,183</td>
<td>100%</td>
<td>3</td>
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<tr>
<td>FamilyCare</td>
<td>12.7</td>
<td>$19,910,457</td>
<td>100%</td>
<td>3</td>
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<tr>
<td>Health Share of Oregon</td>
<td>13.7</td>
<td>$43,141,732</td>
<td>100%</td>
<td>3</td>
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<tr>
<td>Intercommunity Health Network</td>
<td>12.6</td>
<td>$12,428,525</td>
<td>100%</td>
<td>3</td>
</tr>
<tr>
<td>Jackson Care Connect</td>
<td>12.6</td>
<td>$5,428,848</td>
<td>100%</td>
<td>3</td>
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<tr>
<td>PacificSource – Central Oregon</td>
<td>15.8</td>
<td>$10,349,928</td>
<td>100%</td>
<td>3</td>
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<tr>
<td>PacificSource – Gorge</td>
<td>14.7</td>
<td>$2,844,691</td>
<td>100%</td>
<td>3</td>
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<td>Primary Health of Josephine County</td>
<td>14.9</td>
<td>$1,902,503</td>
<td>100%</td>
<td>3</td>
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<tr>
<td>Trillium</td>
<td>13.6</td>
<td>$18,906,370</td>
<td>100%</td>
<td>3</td>
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<tr>
<td>Umpqua Health Alliance</td>
<td>13.7</td>
<td>$5,271,510</td>
<td>100%</td>
<td>3</td>
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<tr>
<td>Willamette Valley Community Health</td>
<td>12.8</td>
<td>$18,368,465</td>
<td>100%</td>
<td>3</td>
</tr>
<tr>
<td>Yamhill Community Care</td>
<td>13.7</td>
<td>$4,826,661</td>
<td>100%</td>
<td>3</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>175,930,026</strong></td>
<td><strong>2,369,190</strong></td>
<td><strong>178,299,214</strong></td>
<td></td>
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</tbody>
</table>

* Quality pool distribution is based on number of measures met and CCO size (number of members). See page 14 for CCO enrollment.
Launched at University of New Mexico in 2003.
“Virtual grand rounds” - a tele-mentoring program that combines 15-20 minute didactic presentations with case-based learning through “Hub” (specialist team) and “Spoke” (clinicians/practice teams)
Builds the capacity of primary care clinicians to manage common conditions that they typically refer to specialty care
De-monopolizes knowledge: “Move knowledge rather than patients”
Builds on “Force Multiplier” effect
The Project ECHO® Model

1. Use Technology (multipoint videoconferencing and Internet) to leverage scarce resources
2. Sharing “best practices” to reduce disparities
3. Case-based learning to master complexity
4. Program evaluation and data tracking
5. All teach, all learn
   • Clinicians learn from specialists
   • Clinicians learn from each other
   • Specialists learn from practicing clinicians

Arora (2013); Supported by N.M. Dept. of Health, Agency for Health Research and Quality HIT Grant 1 UC1 HS015135-04, New Mexico Legislature, and the Robert Wood Johnson Foundation.
ECHO Program Offerings in Oregon

Program offerings for 2018 and 2019:
Substance Use Disorders in Ambulatory Care
Adult Psychiatry I and II (OEN Supported)
Nursing Facility Behavioral Health
Hepatitis C and Liver Care
Child Psychiatry (OEN Supported)
Persistent Pain and Opioids
Addiction Medicine in the Hospital Setting
Tobacco Cessation Processes in Clinical Settings

Previous offerings:
Child Development
EOCCO Community Health Worker Quality Improvement Team
Team-based Care for Integrated Primary Care Practice
Oregon ECHO Network

- **Statewide utility for ECHO programs and services**, e.g. supports participant recruitment, evaluation, IT support, faculty engagement and contracting, curriculum development, delivery of sessions, CME, Maintenance of Certification Part 2 for internal medicine

- Hosted at Oregon Rural Practice-based Research Network (ORPRN)

- “One-stop shop” website ([www.oregonechonetwork.org](http://www.oregonechonetwork.org))

- Hybrid business model
Council of Clinical Innovators

“Build future state Coordinated Care Model leaders and support them to implement innovative health system transformation projects in their communities”
Clinical Innovation Fellows

- Multidisciplinary (Physical, behavioral, oral)
- Emerging leaders from across the state
- Local innovation projects that align with CCO priorities
- Curriculum: leadership, quality improvement, implementation, dissemination science
- Fellow projects implementation and sustainability
  - 96% of projects were being sustained at 6 months and 1.5 years after graduation (first two cohorts)
  - 52% of projects had grown in scope
  - 22% had spread to other organizations
Impact

Skill building
- “I was able to turn an idea into something real – a viable, transformational delivery model that made a real difference.”

Mentorship
- “...maybe the most valuable part of the entire program”

Cross-discipline learning
- “This fellowship has enhanced my work tremendously alone in that I have had feedback from nurses, nutritionists, social workers, behavioral health specialists, etc.”

Project implementation
- “Without the connections to the right people through networking of CCI faculty and the prestige that comes with being a fellow, I feel fairly certain this project would not have taken off.”
Impact

Big picture and spread
- “I learned how to place my project in the context of the entire CCO as well as all CCOs.”

Leadership
- “Although I have been in medical practice for over 20 years, my supervisory roles have been quite limited. The fellowship has given me confidence and skills to act as a leader.”

“The CCI fellowship has been the highlight, to date, within my professional career.”
• Be Curious & Creative
• The “Edge” effect
• Patient/Community “Voice”
• Leadership
• Story of “Us”