Strengthening Primary Care for Patients:

CareOregon | Portland, Ore.

Background

CareOregon is a nonprofit health services organization providing health plan services, education and community-building support to its partners and their members. CareOregon provides services to five coordinated care organizations (CCOs) in Oregon, supporting and enhancing sensible, localized and coordinated care for physical and mental health. It also supports universal health care coverage by assisting in the formation of a Consumer Operated and Oriented Plan (CO-OP) to serve people on Oregon's health insurance exchange and offering Medicare plans and a small dental plan. In addition, CareOregon provides learning opportunities to health professionals designed to improve health delivery nationwide.

In the early 2000s, CareOregon — as a Medicaid managed care organization — realized that there would be rate compression over time, and that, in order to survive, the plan would have to constantly innovate and change how care was delivered. Cognizant that it was spending 60 percent of its money on only 12 percent of patients, CareOregon started its CareSupport system in 2004. This centralized, multi-disciplinary care management service focuses on integrating care with social service agencies and caring for patients with multiple co-morbid conditions. CareSupport provided the foundation for a collaborative partnership between clinics and the health plan, which garnered trust between entities during the build-up of patient-centered medical home (PCMH) initiatives.

Recognizing that many providers lacked sufficient funds to invest in practice transformation, CareOregon launched its CareSupport System Innovation program in 2005 to fund improvement projects in network provider organizations.[1] The plan noted, however, that its impact was limited as long as it only paid claims and provided the occasional grant. CareOregon therefore decided that it would lead an effort to comprehensively redesign and transform its clinics, and improve population health, cost and patient experience by implementing a PCMH model in its primary care practices.

Initiative Titles: PCR (Primary Care Renewal) and PC^3 (Patient and Population-Centered Primary Care)
Start Date: 2007
Practices: 53
Physicians: Over 330
Covered Lives: 81,000

The Alliance of Community Health Plans (ACHP) is a national leadership organization bringing together innovative health plans and provider groups that are among America's best at delivering affordable, high-quality coverage and care.

The community-based and regional health plans and provider organizations from across the country that make up ACHP's membership provide coverage and care for approximately 16 million Americans. These 22 organizations focus on improving the health of the communities they serve and are on the leading edge of innovations in affordability and the quality of care, including patient care coordination, patient-centered medical homes, accountable health care delivery and use of information technology.

Implementation

Principles

To study an example of such transformation, a delegation of 30 CareOregon leaders traveled to Anchorage, Alaska, in 2006 to observe a progressive model of primary care at the Southcentral Foundation's Native Primary Care Center, known for its successful implementation of open access, multi-disciplinary care teams and preventive care.[2] Upon the delegation's return from Alaska, CareOregon began to put into action what became known as its Primary Care Renewal (PCR) pilot.

CareOregon adopted the Southcentral Foundation's model for its own PCMH activities, with five basic design principles: patient-driven care, team-based care, proactive panel health improvement, integrated behavioral health and barrier-free access.

The PCR pilot strived to move toward a population-focused model of care built on a continuous relationship between patients and providers, and away from brief office visits. The health plan adopted the Southcentral Foundation's model for its own PCMH activities, with five basic design principles: patient-driven care, team-based care, proactive panel health improvement, integrated behavioral health and barrier-free access.

The newest phase of the PCR initiative, PC^3 (Patient and Population Centered Primary Care), harvests best practices from the PCR clinics and spreads them to a larger network of practices. This curriculum provides a greater focus on practical tools for improvement and is now being used to support several of Oregon's CCOs.

The principles of CareOregon's work include creating a common vision with providers through collaborative learning sessions; building technical and adaptive skills to support delivery system transformation; realigning incentives and co-design with constant dialogue and feedback from providers; and viewing system redesign through needs of the population rather than needs of providers. Through these principles, CareOregon aimed to:

> [shift] primary care so that it was no longer the responsibility of a physician working relatively independently and instead became the responsibility of a coordinated delivery team that would know and serve all of a patient's health needs, with each need being addressed in the lowest cost setting that the team deemed appropriate.[1]

Staff and Consultant Support

CareOregon helped support robust practice understanding of the improvement model and Lean methodology by providing consultation and training opportunities. In order to facilitate practice transformation, PCR practice sites chose two existing staff members, typically one clinical and one administrative employee, to receive change management and leadership training from an external consultant. Subsequently appointed as improvement coaches, these staff members were able to provide support and guidance to care teams in the medical home-building effort.

CareOregon also provided practices with organizational development consultants, case management support for high-risk members and clinical dashboards, which describe performance on access and clinical quality measures at the patient level. Care managers participated in a six-month learning collaborative focused on chronic disease self-management and care coordination skill development.

These activities have continued through the more recent PC^3 phase of the initiative, although as of February 2013, they were being led by CareOregon's own staff rather than by consultants.

Patient-Centered Care and Coordination

PCR practices provide customer-driven care, which continuously involves patients in their care, taking into account their opinions and needs. Each clinic agrees to empanel patients to care teams that include mid-level staff to free up physicians' time. Care team duties and responsibilities are designed so all team members can work to the top of their license, and each patient is always seen by a member of his or her care team. Teams "scrub" patient files before appointments to determine which preventive and acute services are needed by patients, and morning and afternoon team huddles allow teams to communicate and make decisions regarding patient care. Registries, supplemented by health plan claims data and population-based reports, track patient care needs and allow practices to perform patient outreach.[3]

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The PCR practices work to ensure open access, including same-day appointments and telephone contact, to help prevent costly emergency department visits. In addition, behavioral health services are offered through an on-site behavioral health provider or a referral to a nearby provider. Whether on- or off-site, behavioral health services are integrated with a patient's primary care.

From the beginning of the pilot, the health plan facilitated practice collaboratives. However, once the practices began to grow beyond the pilot phase, CareOregon moved from the learning collaborative model to a monthly steering committee comprising two representatives from each practice and four CareOregon leaders.

Payment Model

CareOregon's payment model was co-developed with practices. The first iteration of its quality improvement program, Care Support and System Innovation, allocated seed money to pilot practices, ranging from $75,000 to $125,000 annually. In 2009, based on mutual understanding that fee-for-service was not adequate to support PCR work, CareOregon and participating practices developed a payment model based on quality measures, under which PCR practices are eligible for up to a $5 per member per month (PMPM) reimbursement enhancement based on reporting, improving or meeting targets on Triple Aim outcomes (including cost, quality and patient experience measures).

Pilot practices had the option of either accepting an across-the-board increased fee-for-service (FFS) relative value unit (RVU) reimbursement rate, or continuing with the lower FFS reimbursement rate but incorporating the up to $5 PMPM performance incentive. All six of the pilot practices chose the lower FFS rate with the performance incentive.

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One of the challenges encountered during the medical home transformation was the diversity found across the practices involved in PCR. The participating practices ranged from one with a largely rural-based migrant population to a practice operating in an urban area where homelessness was a frequent burden, to one with a population largely comprising international refugees. These differences made it difficult to implement generalized change management support and challenged the health plan to figure out how to reimburse and offer support to groups with such divergent needs. In response, CareOregon designed its payment mode to be responsive to the needs of each practice.

CareOregon incentive payments are based on a three-tiered model. Tier One incentives require that providers participate in collaboratives, work groups, learning sessions and report outcomes data.

Tier Two incentives are rewarded when practices hit metrics goals based on HEDIS® measures and access to care indicators. Tier Three bonuses are earned by decreasing ambulatory care sensitive hospital admissions or emergency room visits, or for achieving HEDIS® benchmarks at the 90th or greater percentile. In total, across the six pilot sites, CareOregon pilot practices received approximately $950,000 in incentive uplifts.[2]

The plan has revisited its payment model based on how prepared practices have been to report on quality outcomes; a larger, secondary pilot payment model is now being tested among more than 50 practices based on what has been learned from the initially developed model. The focus remains on clinic-based population level reporting and improvement.

Sustainability

Rebecca Ramsay, B.S.N., M.P.H., director of Community Care, notes that sustainability is closely linked to physician leadership, stating, "probably as with any of this kind of work there are the really high achievers and then there are the clinics that struggle or the organizations that struggle … it all boils down to leadership."[4] CareOregon's administrators believe that to ensure sustainability, practices benefit from improved reimbursement models that are closely aligned with leadership development. The health plan hopes that more formal and structured leadership from the state will help sustain the PCMH model.

Currently, through the development of the PC^3 collaborative and curriculum, CareOregon is broadening the reach of primary care transformation in Oregon. In the PC^3 collaborative process, the plan meets with all of its clinics every other month via one-on-one coaching sessions, phone calls and site visits. During every learning collaborative, clinics report where they are in each key area and discuss whether any changes have occurred.

In October 2012, CareOregon launched a new payment model and began receiving outcome measures, and will analyze data in early 2013 to see its effects on emergency department utilization and hospital admissions. CareOregon is also continuing to work with its PCR practices on implementing disease management and care management, encouraging use of community outreach workers and identifying each practice's highest-risk members.

Because CareOregon is only a year into its PC^3 initiative, it has been focusing much more on processes than outcomes with that group. The joint work between PC^3 and PCR practices has been influenced and affected by the structure of Oregon's coordinated care organizations. CCOs were developed in Oregon to reduce fragmentation between systems of care, such as managed care organizations, dental health and Medicaid, and combine them into a global "commons" system to encourage accountability, coordination and communication. The ultimate goal of such organizations is to create mediating structures at the local level to bring health care consumption back to a sustainable yield point.

The CCO model is designed around natural referral systems that will manage populations at the community level. Such a model brings neighborhood providers together, supplying them with the resources and data necessary so that they can begin to view their communities on a population level. Through redesigned payment systems, including global sub-capitation provided to networks throughout the community, CareOregon, partnered with other payers, is creating incentives for focusing on population health. The plan is looking at how to spread community care teams across regions, even though they are tied to the CCO leadership.

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Outcomes

The pilot practices report Triple Aim metrics quarterly. Population health is measured health plan-wide, from avoidable emergency department visits to ambulatory care sensitive hospitalizations to HEDIS® measures. Practices also report clinical quality data out of their EMR systems. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys are collected across the health plan annually for Medicaid and Medicare members, and practices use multiple experience-of-care measures from surveys and indicators, including clinician, clinic team and patient satisfaction surveys. CareOregon also measures health plan-wide per capita costs, including total cost, dual-eligible PMPM and average PMPM costs of emergency department visits.

Even though hospital admissions in the clinics chosen for CareOregon's Primary Care Renewal initiative were initially almost 1.5 times higher — and rising at a faster rate — than in non-PCR clinics, the launch of the model reversed these trends. After the one-year implementation period, hospital admissions began decreasing more rapidly in PCR than non-PCR clinics, and as of April 2011 had decreased to the non-PCR rate.

In Multnomah County, a federally qualified health center, PCR reduced waiting days for appointments from four in February 2009 to only one in February 2011, and has improved diabetes and behavioral health care outcomes as well as scores on patient engagement surveys.[1] CareOregon also decreased inpatient days between January 2007 and October 2010 for PCR clinics (see Figure 1).

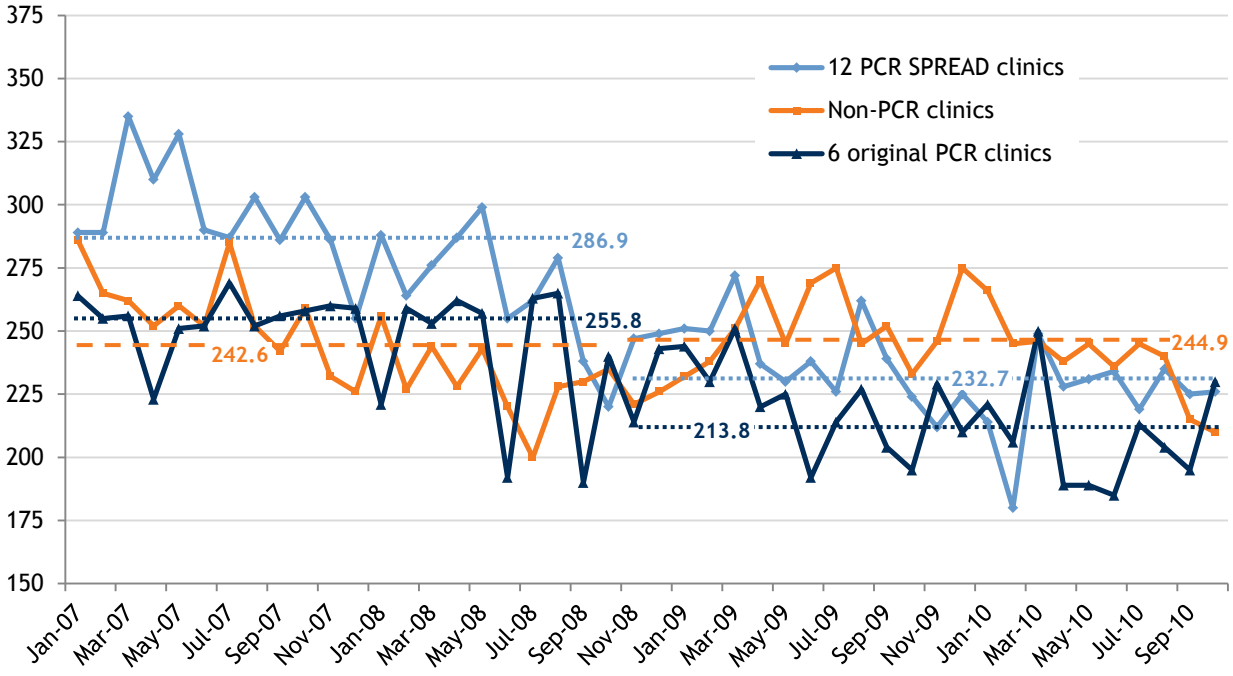

Figure 1: Medicaid Adults: Inpatient Stays per 1000 Members per Year, Jan 2007-Oct 2010

Scale

PCR started out as one team in each of the four clinic networks; after a year, the model spread throughout the entire clinical system, then spread to 23 clinics over another two to three years (see Figure 2). The leadership teams in the systems themselves decided when and how they were ready to spread the model to new clinics in the system. Each clinic then had to fill out an application in order to participate in the PCR initiative.

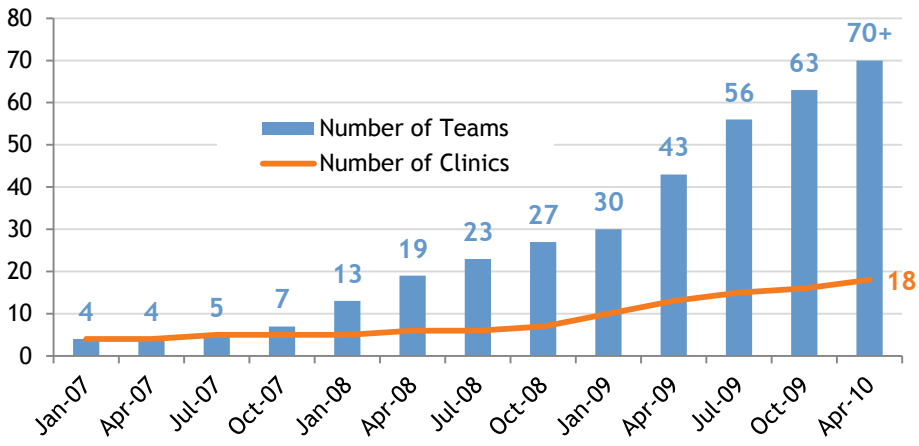

Figure 2: Spread of the PCR Model between January 2007 and April 2010

Once the PCR clinics all had a few years' experience, CareOregon wrote its PC[3] curriculum for future spread by asking practices what they would have done differently in implementing their medical homes, as well as in what order they would have implemented the processes. Even though every clinic was different, there were many similarities among the clinics' responses. For example, clinics generally agreed that important preliminary steps were getting leadership on board, developing a vision of what the clinic would like to achieve and determining the target population. Once the population was decided, the clinics could determine the composition of their care teams. Following development of care teams, clinics needed to be able to improve systems that cross multiple teams, like implementing open-access scheduling. This PC[3] curriculum was combined with tools and tips from the initial pilot clinics and is being used at learning collaboratives.

As of February 2013, 53 practices with over 330 providers were part of PCR or PC[3]. Not only have existing clinics been retrofitted to support the new care delivery design, but as new clinics are being built, they are designing architecture around supporting patient-centered medical homes in line with the curriculum CareOregon developed.

Two groups from the first five pilot clinic networks continue to meet regularly to exchange ideas and best practices. One group, the PCR steering committee, comprises operations and medical leadership from each system, in addition to CareOregon staff, while the other includes staff who are involved in data analysis, quality improvement and infrastructure development. Both groups were involved in developing the PC[3] curriculum and will be more involved in the CCO work.

As of 2012, CareOregon was transforming its medical home initiative to a train-the-trainer model. The plan has been identifying people from the communities where the clinics are located, inviting them to learning collaboratives and training them to be in-between coaches, facilitating transformation work for the health plan. In this model, local resources are invested in the primary care transformation, while building community capacity for this work.

In its next phase, CareOregon is looking at how to scale the medical home model to multiple collaboratives more effectively; new clinics will be part of CareOregon's CCO network and beyond, and the plan will be expanding with more trainers through 2013.

A copy of the full ACHP report on strengthening primary care for patients, supplementary profiles on member plan initiatives, a one-page fact sheet and other resources are available online at www.achp.org or by emailing innovations@achp.org.

[1] Bisognano, Maureen and Kenney, Charles. *Pursuing the Triple Aim: Seven Innovators Show the Way to Better Care, Better Health, and Lower Costs*. Jossey-Bass, 2012. Print.
[2] Klein, Sarah and McCarthy, Douglas. "CareOregon: Transforming the Role of a Medicaid Health Plan from Payer to Partner." *The Commonwealth Fund*. 50 (2010).
[3] Miller, Julie. "Unlocking Primary Care: CareOregon's Medical Home Model." *Managed Healthcare Executive*. May 1, 2009.
[4] Participant interview with Rebecca Malouin, Ph.D., 2011

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