Lessons in Safety Net Delivery System Transformation: Oregon's Health Reforms

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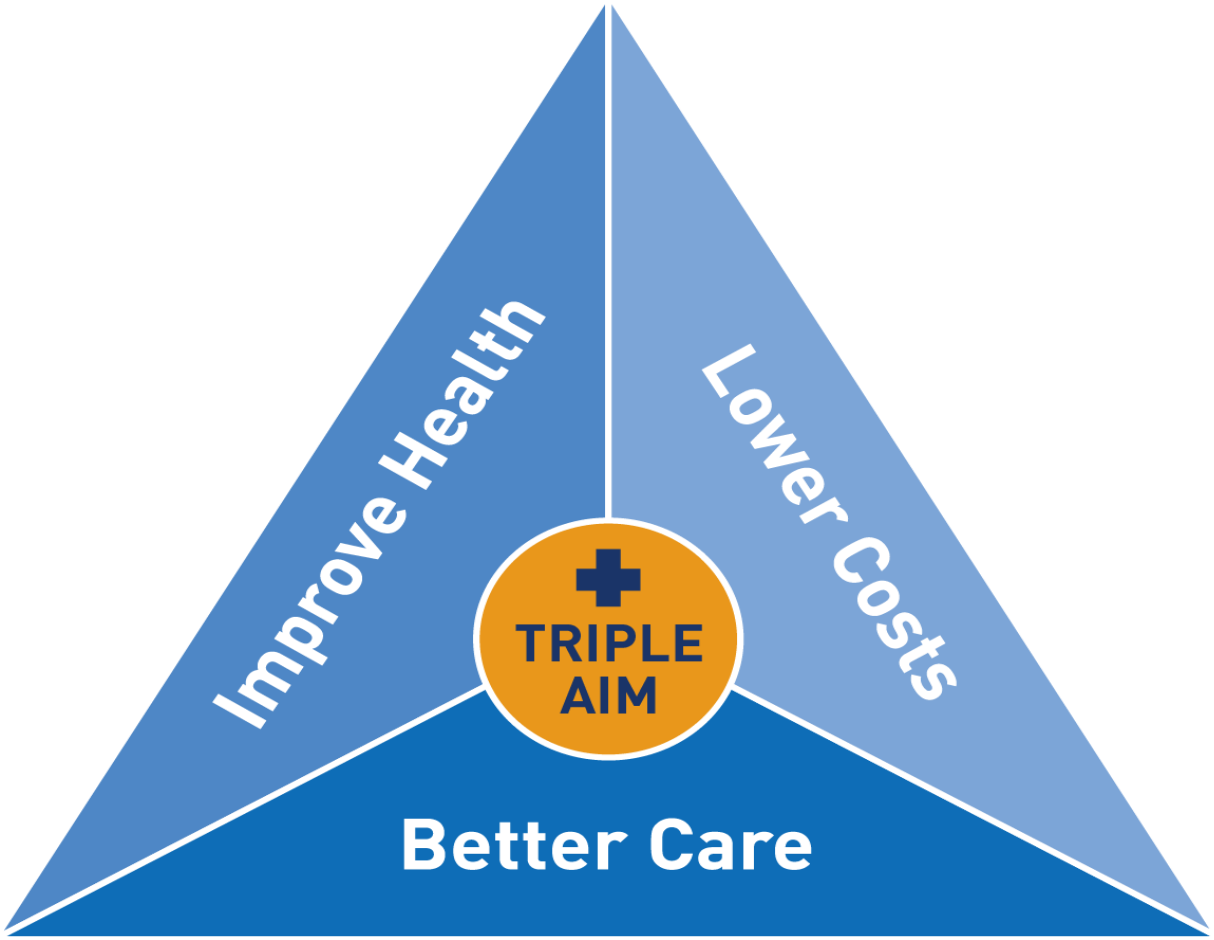
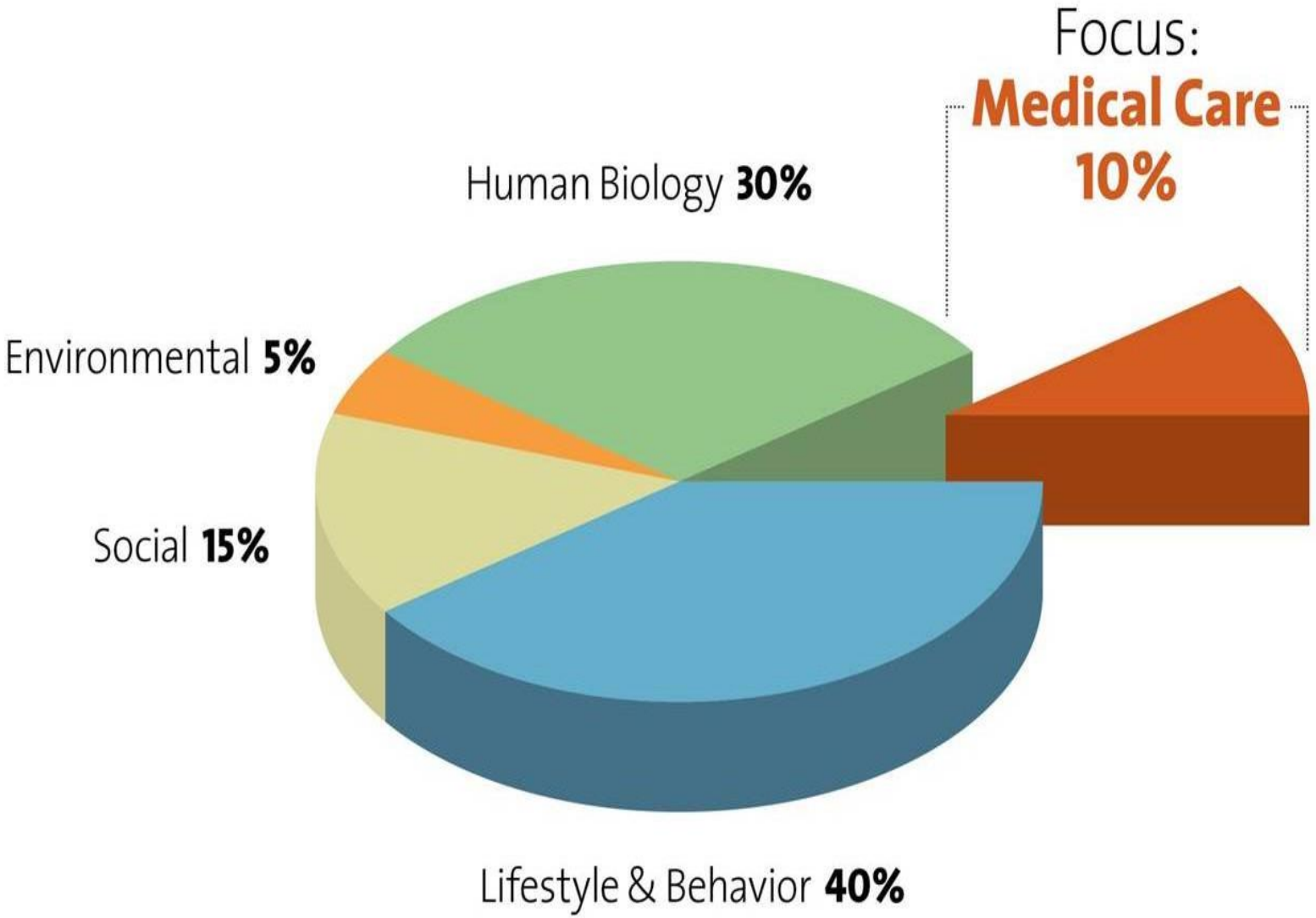
CAPH/SNI Conference

December 9, 2016

THE ENVIRONMENT

- Health care costs rising faster than any other economic indicator
- Stealing precious $ from other important human endeavors e.g. education and public safety
- Healthcare outcomes not what we wanted
- A belief that we could do better!


Improve Health
Lower Costs
TRIPLE AIM
Better Care


Focus:
Medical Care
10%
Human Biology 30%
Environmental 5%
Social 15%
Lifestyle & Behavior 40%

TRADITIONAL BUDGET BALANCING

- Cut people from care
- Cut services
- Cut provider rates/shift costs

THE FOURTH PATH

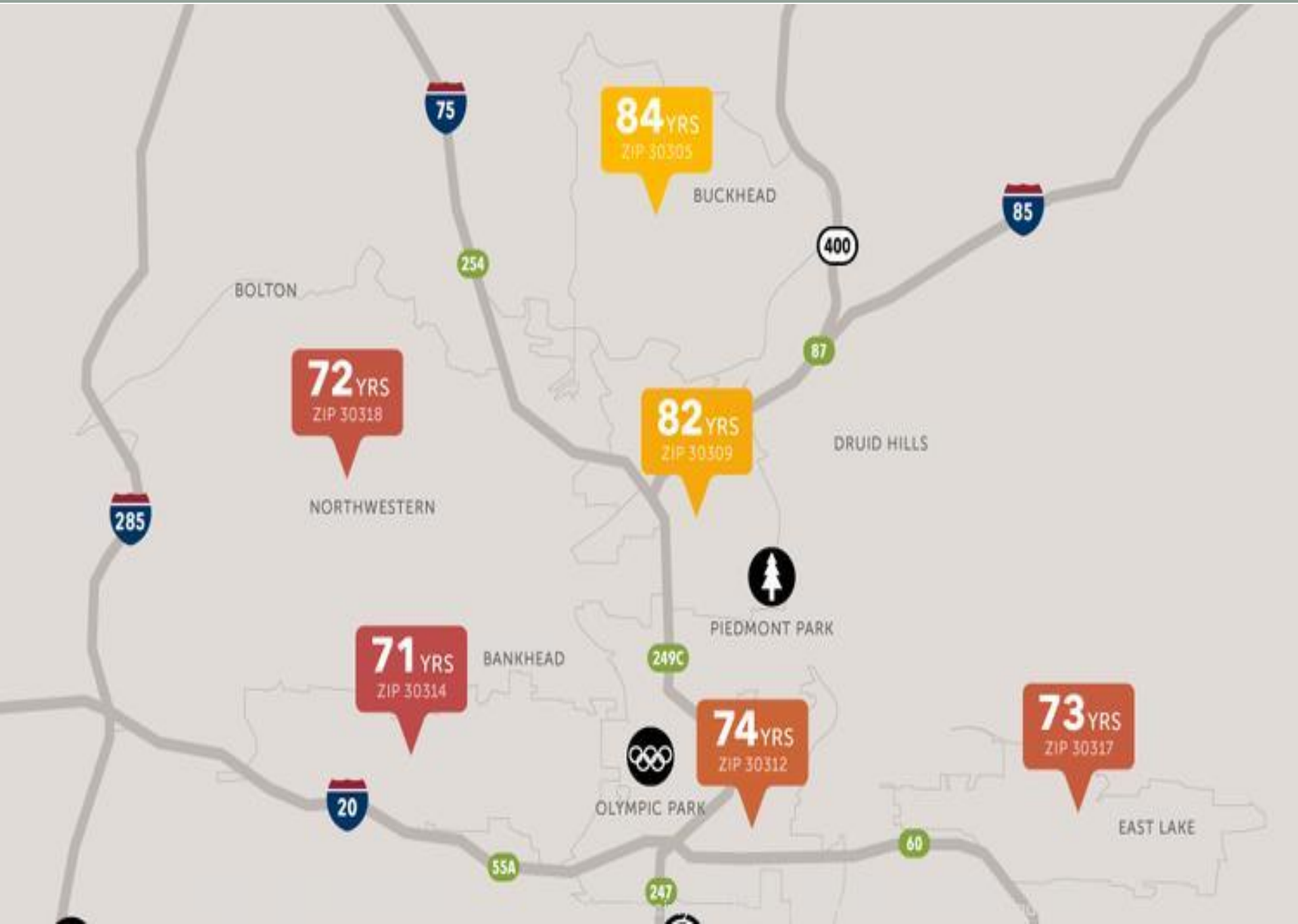
Change how care is delivered to:

- Reduce waste
- Improve health
- Create local accountability
- Align financial incentives
- Pay for performance and outcomes
- Create fiscal sustainability

DRIVING OUTCOMES

ALL HEALTH & HEALTH CARE IS LOCAL

- Scientifically: Zip Codes and the Dartmouth Atlas of Health Care
- Operationally: clinicians and patients
- Politically: local control


84 YRS
ZIP 30305
BUCKHEAD
72 YRS
ZIP 30318
NORTHWESTERN
82 YRS
ZIP 30309
DRUID HILLS
71 YRS
ZIP 30314
BANKHEAD
74 YRS
ZIP 30312
OLYMPIC PARK
73 YRS
ZIP 30317
EAST LAKE
PIEDMONT PARK
BOLTON
75
85
400
254
87
285
20
55A
247
249C
60

The vision ultimately extends beyond clinician's walls

Source: Public Health Institute

THE COORDINATED CARE MODEL

Local Accountability & Governance

Global Budget with Fixed Rate of Per Capita Growth

Integrated and Coordinated Care

At Risk for Quality (Metrics)

Flexibility

Local Accountability & Governance

- Governance Board must include:
  - All entities within the CCO taking financial risk
  - At least two health care providers in active practice (representing primary care and mental health/chemical dependency)
  - At least two community members
  - At least one member of the CCO's Community Advisory Council (CAC)
- The CAC is required to:
  - Have more than 50% of members be consumers;
  - Must include representative from each county government in service area
  - Duties include Community Health Improvement Plan and reporting on progress.
- CCO also needs MOUs with local public health, tribes and area agency on aging.

Global Budget with a Fixed Rate of Growth

- Behavioral health, physical health and dental care integrated into a single budget
  - Long Term Supports & Services statutorily excluded.
- Global budgets that grow at no more than 3.4% per capita per year
  - Growth rate is statewide not per CCO

Integrated and Coordinated Care

- Global budget helps drive integration and coordination
- Emphasis on team-based patient-centered primary care
  - The right care at the right time
  - Special emphasis on patients with complex health care needs
- More care outside the clinic walls, including community health workers
- Increased adoption of HIE/HIT

At Risk for Quality (Metrics)

- Statutorily created Metrics & Scoring Committee establishes CCO incentive metrics, benchmarks & improvement goals.

- CCO Incentive Measures
  - Annual assessment of performance on 17 incentive measures.
  - Quality pool paid to CCOs for performance.
  - 3% of global budget held at risk for quality.
  - Currently, measures largely process-based and focused on quality primary care.

Flexibility

- Each CCO given room to transform delivery of care in whatever way makes most sense to that community as long as quality and financial goals are met.

- Workforce – community health workers, peer counselors

- Increased ability to use funds for “flexible services”
  - Must offer Medicaid covered benefits, but have flexibility to create alternative solutions.
  - Governor Kitzhaber’s air conditioner story

Oregon's 1115 Medicaid Waiver

- 1115 Medicaid demonstration waiver
  - Submitted March 1, 2012, Approved July 5, 2012
  - Establishes CCOs as Oregon's Medicaid delivery system
  - Flexibility to use federal funds for improving health
  - Oregon's accountabilities
    - 2 percentage point reduction in per capita Medicaid trend
    - No reductions in benefits or eligibility
    - Financial penalties for not meeting cost savings or quality goals
    - Quality metrics – 33

Supports for Transformation

- Transformation Center and Innovator Agents
- Learning collaboratives
- Peer-to-peer and rapid-cycle learning systems
- Community health assessments and community improvement plan
- Non-traditional healthcare workers
- Each CCO submitted a “Transformation plan”
- Primary care home support
- Technical assistance in addressing health equity

What we are seeing so far…

- Every CCO is living within their global budget.
- The state is meeting its commitment to reduce Medicaid spending trend on a per person basis by 2 percentage points.
- State-level progress on measures of quality, utilization, and cost show improvements in quality and cost and a shifting of resources to primary care.
- Race and ethnicity data shows broad disparities for most metrics – points to where efforts should be focused to achieve health equity
- Progress will not be linear but data are encouraging.

Progress to Date

(from baseline prior to CCO)

- ED utilization down 29%
- Hospital readmissions for adults with 30 days: down 33%

- Adult hospital admissions for:
  - adult asthma down 50%,
  - chronic lung disease down 62%,
  - heart failure down 32%,
  - short-term complications from diabetes down 29%

- Patient-centered primary care homes enrollment up 69%
- Children receiving dental sealants up 65%
- Developmental screening of children up over 100%
- Member satisfaction with care up 10%

*Data for 2015

Before CCOs	With CCOs
Fragmented care	Coordinated, patient-centered care
Disconnected funding streams with unsustainable rates of growth	One global budget with a fixed rate of growth
No incentives for improving health (payment for volume, not value)	Metrics with incentives for quality and access
Limits on services	Flexible services
Health care delivery disconnected from population health	CCO community health assessments and improvement plans
Limited community voice and local partnerships	Local accountability and governance, including a community advisory council


Health care
collaborators
not competitors

Better Health and Value Through

- Innovation
- Focus on chronic disease management
- Focus on comprehensive primary care and prevention
- Integration of physical, behavioral, oral health
- Alternative payment for quality and outcomes
- More home and community based care, community health workers/non-traditional health workers
- Electronic health records – information sharing
- Tele-health
- New care teams
- Use of best practices and centers of excellence

Oregon's Health System Transformation: CCO Metrics 2015 Final Report

June 2016

Oregon Health Authority

MEASUREMENT PERIOD:
Calendar Year 2015
Version 1.3
June 23, 2016

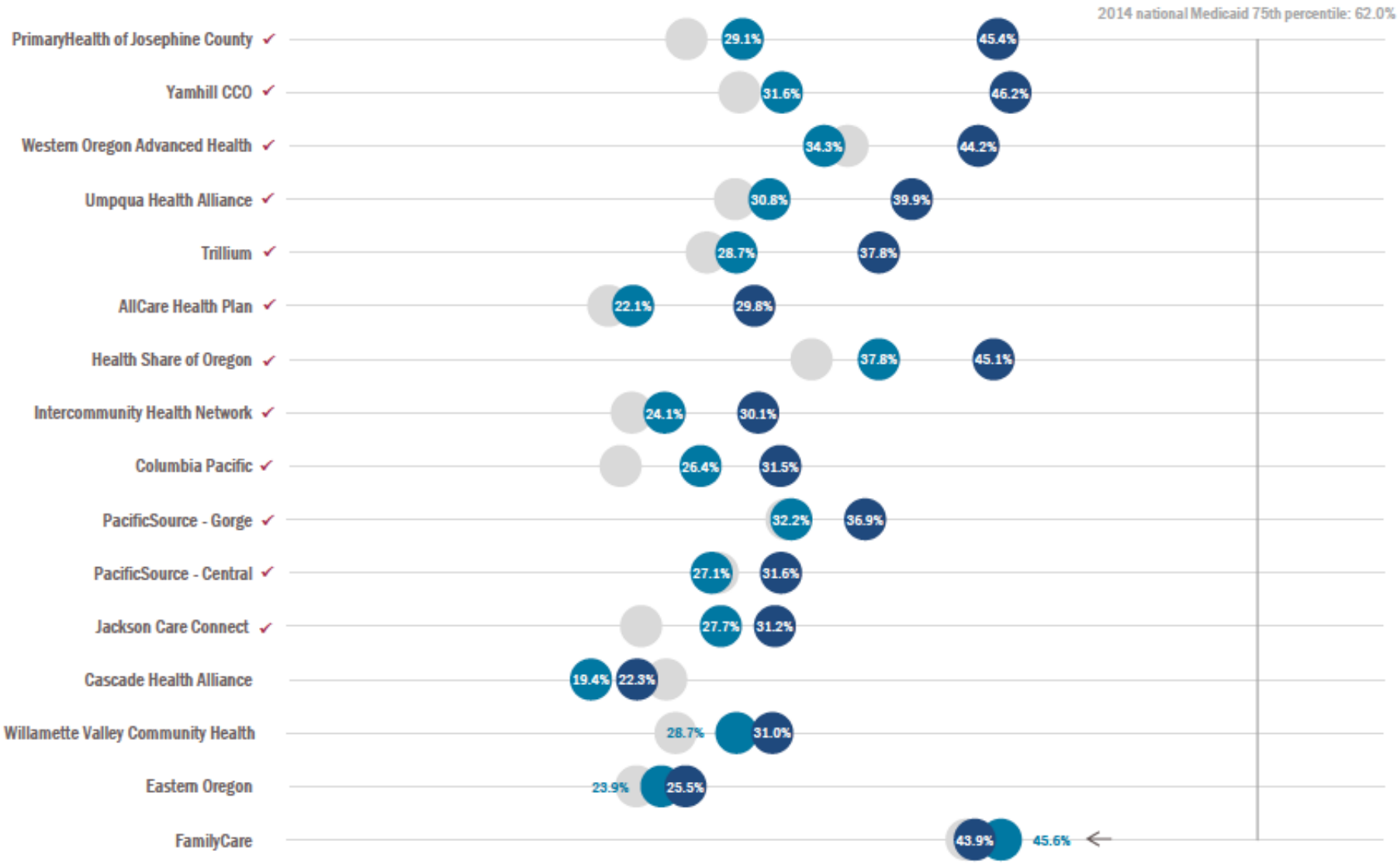
Statewide

	2011 baseline	2013	2014	2014 revised	2015	2015 benchmark	# of CCOs met benchmark	# of CCOs met improvement target	% change 2014-2015
Access to care (CAHPS)	83.0%	83.6%	83.8%	83.0%	83.8%	87.2%	2	4	⇧ 0%
Adolescent well care visits	27.1%	29.2%	32.0%	n/a	37.5%	62.0%	0	12	⇧ 17%
Alcohol and drug misuse screening (SBIRT) 12+	0.1%	2.0%	7.3%	6.4%	12.7%	12.0%	9	5	⇧ 98%
Ambulatory care - ED utilization	61.0	50.5	47.3	-	43.1	39.4 (lower is better)	7	5	⇩ -9%
Colorectal cancer screening	10.7	11.4	46.2%	-	46.6%	47.0%	10	3	⇧ 1%
Controlling high blood pressure	-	-	64.6%	-	64.7%	64.0%	10	1	⇧ 0%
Dental sealants for children	-	-	-	11.2%	18.5%	20.0%	4	12	⇧ 65%
Depression screening and follow-up plan	-	-	27.9%	-	37.4%	25.0%	13	2	⇧ 34%
Developmental screening	20.9%	33.1%	42.6%	-	54.7%	50.0%	12	4	⇧ 28%
Diabetes HbA1c poor control	-	-	21.8%	-	26.7%	34% (lower is better)	16	0	⇩ 22%
Effective contraceptive use (ages 18-50)	-	-	-	33.4%	36.3%	50.0%	0	9	⇧ 9%
Electronic health record (EHR) adoption	28.0%	53.7%	67.7%	-	76.5%	72.0%	14	2	⇧ 13%
Follow up after hospitalization for mental illness	65.2%	67.6%	66.7%	71.8%	75.3%	70.0%	13	0	⇧ 5%
Assessments for children in DHS custody	53.6%	63.5%	70.0%	27.9%	58.4%	90.0%	14	0	⇧ 109%
Patient-centered primary care home (PCPCH) enrollment	51.8%	78.6%	81.0%	-	87.5%	60.0%	16	0	⇧ 8%
Prenatal and postpartum care: Prenatal care	65.3%	67.3%	82.9%	75.0%	84.7%	90.0%	3	13	⇧ 2%
Satisfaction with care (CAHPS)	78.0%	83.1%	84.6%	84.4%	85.4%	89.6%	0	8	⇧ 1%

ADOLESCENT WELL CARE VISITS

Twelve CCOs achieved their improvement target for adolescent well-care visits between 2014 & 2015.

✓ indicates CCO met benchmark or improvement target / Grey dots represent 2013



Hispanic / Latino

	2011 baseline	2013	2014	2014 revised	2015	2015 CCO Benchmark	2015 Statewide
Access to care (CAHPS) - Adults	81.0%	73.4%	79.0%	n/a	79.4%	87.2%	83.8%
Access to care (CAHPS) - Children	81.0%	84.0%	82.6%	n/a	84.5%	87.2%	88.7%
Adolescent well care visits	29.2%	31.9%	35.6%	n/a	40.9%	62.0%	37.5%
Alcohol and drug misuse screening (SBIRT)	0.0%	1.9%	7.1%	6.1%	13.0%	12.0%	12.7%
Ambulatory care - Emergency department utilization	42.0	36.6	35.2	-	34.7	39.4 (lower is better)	43.1
Dental sealants on permanent molars for children	-	-	-	13.3%	21.2%	20.0%	18.5%
Developmental screening in the first 36 months of life	18.7%	28.7%	41.1%	-	56.0%	50.0%	54.7%
Effective contraceptive use (ages 18-50)	-	-	-	34.7%	37.2%	50.0%	36.3%
Follow-up after hospitalization for mental illness	63.3%	67.6%	66.3%	70.1%	69.7%	70.0%	75.3%
Assessments for children in DHS custody	56.4%	~	65.2%	32.1%	64.8%	90.0%	58.4%
Satisfaction with care (CAHPS) - Adult	76.0%	82.8%	81.9%	-	85.9%	89.6%	84.8%
Satisfaction with care (CAHPS) - Child	77.0%	85.4%	87.0%	-	85.1%	89.6%	85.4%

(Not all CCO incentive measures are available by race/ethnicity)

~ Results suppressed (N<30)

A Few of the Challenges

- Time, resources and expectations
- Change is hard….change is very hard
- Behavioral health / physical health integration
- Integrating dental care
- Ensuring robust provider networks to meet client needs
- Transforming care and paying for outcomes
- Accounting for “flexible” services
- Anti-trust
- Actuarial soundness

And Some More…..

- Penalties for failure to achieve cost, quality and access benchmarks
- Training and using new health care workers
- Increasing consumer engagement
- Personal responsibility for health
- Health information exchange
- Integrating with early learning and education systems

TUESDAYS WITH MORRIE

Lessons Learned

- **HAVE A COMMON VISION.**
  - Common vision for reforms/changes/interventions amongst partners is critical
  - Leadership (legislative, executive, stakeholder) commitment to the goals and deliverables
  - Engaging stakeholders around that common vision is critical – CEO's, consumers, CMS
- **DON'T UNDERESTIMATE THE INVESTMENT NEEDED IN CHANGE MANAGEMENT TECHNICAL SUPPORT.**
- **NEED TO RECOGNIZE AND HELP HEALTH CARE INSTITUTIONS TRANSITION AND PLAN FOR NEW BUSINESS MODELS.**
- **CHANGING PAYMENT IS CRITICAL – DON'T EXPECT NEW METHODS OF CARE WITH OLD METHODS OF PAYMENT.**
  - Payment needs to help drive efficiency
  - Payment/financing needs to reward effective collaborations
  - Payment/financing must foster accountability to outcomes
  - Payment must drive the new transformation

Lessons Learned (cont'd)

- **OUR MAJOR HEALTH PAYMENT SYSTEMS ARE VERY MUCH CONNECTED AND SERIOUSLY MISALIGNED.**
- **MULTI-PAYER INITIATIVES CAN ACCELERATE CHANGE IN DELIVERY SYSTEMS.**
- **PAYMENT AND STRUCTURES NEED TO INCREASE COMMUNITY ACCOUNTABILITY FOR POPULATION HEALTH OUTCOMES THAT REFLECT PHYSICAL, MENTAL AND SOCIAL WELL BEING.**

Lessons Learned (cont'd)

- **DON'T EXPECT NEW METHODS OF CARE WITH SAME WORKFORCE**
  - Help to develop a workforce that meets the goals of reforms
  - Provider engagement and training are critical
- **CHANGE IS HARD AND TAKES TIME - DON'T SLOW DOWN**
- **GOVERNANCE**
  - Pay careful attention how projects are governed – governance is critical for engagement
  - How are decisions made, do you have the right people governing?

Lessons Learned (cont'd)

- **COMMUNICATE EARLY OFTEN AND IN MULTIPLE MODALITIES**
- **THEN COMMUNICATE AGAIN**
- **BE CLEAR ABOUT GOALS – ESPECIALLY AS IT RELATES TO IMPROVING HEALTH VS. IMPROVING THE HEALTH SYSTEM, ACCESS, QUALITY, COSTS ETC.**
- **ON THE JOURNEY TO IMPROVE HEALTH, BE CAREFUL NOT TO "MEDICALIZE" SOCIAL INSTITUTIONS**

Lessons Learned (cont'd)

- **FOR SAFETY NET:**
  - **To be successful in value based payment takes new ways of doing business and infrastructure – develop it now**
  - **A focus on access to care and health has meant a new appreciation for safety net providers. Payers will rely on/contract with safety net providers if they can demonstrate value**
  - **Safety net providers have a long history of experience and investments in community/population health that presents a great opportunity for leadership.**

The future belongs to those who create it.