

September CCO Learning Collaborative Minutes

HSB 137 A-D, 500 Summer St. NE, Salem, OR 97301

September 8, 2014

11 a.m. – 12.30 p.m.

Session/Objectives

Participants will:

- 1) Discuss the use of CAHPS Access to Care data to measure outcomes and drive improvement
- 2) Identify strategies, best practices, tools and resources for improving member access to care

List of Meeting Attendees

Attendees: 54

AllCare Health Plan: John Kolsbun, Mark Bradshaw

Cascade Health Alliance: No attendees were present.

Columbia Pacific CCO: No attendees were present.

Eastern Oregon CCO: Laurence Colman (GOBHI), Cynthia Lacro

FamilyCare, Inc: Resa Bradeen, Anna Stern

Health Share of Oregon: Barbara Carey, David Labby

Intercommunity Health Network: Kevin Ewanchyna, David Engen, Ellen Altman

Jackson Care Connect: Anne Alftine, Matthew Hough

PacificSource Community Solutions – Central Oregon: No attendees were present.

PacificSource Community Solutions – Columbia Gorge: No attendees were present.

Primary Health of Josephine County: Jennifer Johnstun, Andrew Luther

Trillium Community Health Plan: Holly Jo Hodges, Lynnea Lindsey-Pengelly

Umpqua Health Alliance: Kristi DePriest, Ruth Galster, Rose Rice, Christine Seals, Debbie Standridge

Western Oregon Advanced Health: Tracy Muday

Willamette Valley Community Health: Kathryn Leuken

Yamhill Community Care Organization: No attendees were present.

Other/Unknown Affiliation: Darren Coffman (HERC), Cat Livingston (HERC), Deborah Loy (Capitol Dental Care), Bruce Austin (Capitol Dental Care), Bobbie Mellor (THA), Erin Schwartz (Acumentra), Priscilla Swanson (Acumentra), Amy Fellows (We Can Do Better), Melinda West (Access Dental Plan), Mark Whitaker (Providence Health Plan), Molly Johnson (Advantage Dental), Corinne Thayer (Moda Health), Tiffany Dorsey (Kaiser)

Oregon Health Authority Staff: Dana Hargunani (Transformation Center), Summer Boslaugh (Transformation Center), Laura Kreger (Transformation Center), Emilee Coulter-Thompson (Transformation Center), Chris DeMars (Transformation Center), Ty Schwoeffermann (Transformation Center), Joell Archibald (Transformation Center), Keri Mintun (DMAP), Roger Citron (DMAP), Hank Hickman (DMAP), Chris Norman (DMAP), Wally Shaffer (DMAP), Barbara Ries (DMAP), Denise Taray (DMAP), Tracy Robichaud (AMH), Michael Dystes (AMH), Ellen Pinney, Tammy Sona, Deborah Larkins

(DAS)		
Topic	Notes	Action
1. Introduction <i>(Ron Stock, Director of Clinical Innovation, Transformation Center)</i>	Ron Stock began the meeting by giving an update on using videoconferencing at QHOC meetings. The technology is in beta testing and would provide live interaction for phone participants. Our hope is to pilot test it at the October meeting.	
2. Measuring Access with CAHPS <i>(Summer Boslaugh, Transformation Analyst, Transformation Center)</i>	<p>This learning collaborative topic was chosen based on the “clicker” vote at the July meeting.</p> <p>Summer Boslaugh introduced the importance of access to care by sharing a story about her daughter’s experience with appendicitis. She then gave an overview of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey:</p> <ul style="list-style-type: none"> • Satisfaction vs. Experience <ul style="list-style-type: none"> ○ Experience asks what happened, satisfaction asks to rate the experience (whether care measured up to expectations) ○ Experience helps identify improvement areas and what to do • The CAHPS family of surveys focuses on topics only consumers can answer and experiences rather than satisfaction • Supplemental item sets are available (cultural competency, health literacy, etc.) • CMS does not require CAHPS for ambulatory care , but it is required for health plans and hospitals; primary care clinics using CAHPS can earn points towards PCPCH certification • The Oregon CAHPS surveys 900 adults and 900 children per CCO by mail and phone • Composite of two questions: usually/always got care as soon as needed (routine and emergency) • Four CCOs met the benchmark 	<p>See Summer’s presentation slides</p> <p>For more information on the Oregon CAHPS and understanding your Banner Books, view these webinars:</p> <ul style="list-style-type: none"> • Webinar 1 Oregon CAHPS 2014: Overview • Webinar 2 Interpreting Your CAHPS Data • Webinar 3 (slides only) Applying CAHPS: Moving Information into Action
3. Strategies to Improve Access to Care <i>(Mindy</i>	<p>Mindy Stadlander began her presentation by clarifying definitions:</p> <ul style="list-style-type: none"> • Capacity: how many members a clinic can take • Assignment: matching between what you said you can take and what the 	See Mindy’s presentation slides

<p><i>Stadtlander, MPH, Care Oregon)</i></p>	<p>CCO gives you</p> <ul style="list-style-type: none"> • Demand: includes how often people want to come in, phone calls, paperwork, requests for services • Supply: ability to receive patients • Open access: matching supply and demand, taking care of today’s work today • Continuity: relationship over time between team and patient <p>She then shared a framework she uses to create a dashboard of metrics for enrollment, outreach and access, which helps facilitate conversations, as well as a productivity formula:</p> <ul style="list-style-type: none"> • Each piece of the formula can be tweaked. For example, a clinic can increase panel size by increasing productivity or by decreasing visits. • Ways to increase supply: see more patients, team-based care, group visits, e-visits phone visits. • Ways to modify demand: standard of care (pain guidelines), patient complexity, practice style, wait time (between scheduling and visit; longer time = more no-shows) <p>Balancing supply and demand while building continuity requires work at both the CCO and clinic levels.</p>	
<p>4. Reflections on the 2013 Access to Care Data from CCOs (<i>Jennifer Johnstun, Primary Health of Josephine County; Tracy Muday, Western Oregon Advanced Health</i>)</p>	<p>Jennifer Johnstun and Tracy Muday reflected on how their CCOs met the CAHPS benchmark.</p> <p>Jennifer Johnstun, Primary Health of Josephine County</p> <ul style="list-style-type: none"> • I don’t really know for sure how we met the benchmark, but there are a couple of things that maybe contributed. • We worked closely with Mindy Stadtlander’s learning collaborative with PCPs on clinical microsystems – I attribute some outcomes to that. • ER utilization rates get clinics jazzed up. They’re frustrated when patients don’t take advantage of appropriate access. We have strong commitment to getting people in appropriate care in the community, especially among learning collaborative participants. • Two large clinics provide primary care to 80-85% of OHP members, and 	

both have urgent care. In 2013, one clinic saw more patients, and the other was a new clinic, so additional access. There's high satisfaction with same-day access. Those things are probably responsible for our shift, along with the local factor of being able to work with two large clinics.

Tracy Muday, Western Oregon Advanced Health

- When I was first asked to reflect, I wasn't sure why we met the benchmark. In meantime, I think a couple things contributed.
- I'm very humble looking at the metrics graph, because we're at the top of list, but that's still below where Trillium was, and they're now at the bottom of the list.
- The fundamental thing we've done over the years is being an Independent Practice Association (IPA) based organization – everybody's in, there's ownership interest, and we've been successful on the basis of peer pressure.
- Over time, we've been able to share the success of the organization with physicians. There's a very high penetration of Medicare and Medicaid as lines of business. When 25% or more of your patient population is Medicaid, it's very important that you get paid in a way to sustain a practice. We've placed a lot of emphasis on adequate provider compensation for services, which has served us well in expansion (we've grown 70% since beginning of year).
- We've been able to go to community partners. We're relatively isolated geographically. If we stop taking people into the CCO, we don't guarantee access, but they're still there. We had excellent response in 2014 along the lines of "I'll open my practice, I'll find a way." We're still stumbling toward that, but a long history of ownership and buy-in have helped us.
- For example, pediatricians got together to open an after-hours clinic. In early 2014, adult providers opened an adult urgent care for first time.
- We've always had a standard that providers for adults would take 200 patients, then we were bumping against that. Some providers said they could go to 250, then peer pressure got more to join.
- Previously we hadn't assigned panels to nurse practitioners or physician assistants, but starting in 2012 and increasing in 2013, midlevels began taking their own panels.
- We didn't have a 2013 plan to improve access, but these things laid the groundwork.

	<p>Questions/Comments:</p> <p>David Labby – Some providers should be seeing fewer patients without insurance. Tracy – It’s not as disruptive to many people, but demand increases with coverage. Bruce Austin (Capital Dental) – One big hindrance we have is 25-30% failed appointments, which hurts efficiency. How does that compare to the medical side?</p> <ul style="list-style-type: none"> • No-shows mean different things, but they can be a buffer; in my own clinic, the no-show rate isn’t that bad, but it’s higher at the FQHC. • Christine Seals – Our FQHC is struggling with this. Our focus is on the culture of poverty and why people can’t make their appointments. • The farther out, the more likely patients won’t show up; we’ve also found that automated call reminders make huge difference to decrease no-shows. • Not sure we can threaten no-show fee. <ul style="list-style-type: none"> ○ We can’t with OHP. <p>David Labby – An onboarding process might help access – a structured way to get a sense of where people are at and if they have an urgent need, who will need to be seen when, and a way to triage the population.</p>	
<p>5. Small group discussion</p>	<p>Participants broke into three groups by CCO to discuss three questions about access in their CCO or organization.</p> <p>Group 1: WOA, Columbia Pacific, UHA, PacificSource, Trillium</p> <p>What key places do you need to focus to improve access in the coming year?</p> <ul style="list-style-type: none"> • Fear about 2014 when measuring same access metrics from last year to this year • How to incentivize practices to see more patients <p>What are 1-2 ways you can partner with the delivery system to improve access?</p> <ul style="list-style-type: none"> • Can you make two or more same-day visits in a practice? More concrete question/stats • Financial incentive to have more patients on panel; incentivize above 150 members <p>What strength does your CCO have in managing access?</p> <p>Group 2: PHJC, IHN, All Care, Yamhill, Health Share</p> <p>What key places do you need to focus to improve access in the coming year?</p>	

- IHN – Focused on team care, added behaviorist to some practices. Paying additional \$10 per touch regardless of mode (phone, email, in person). Clinics send in Excel spreadsheet listing touches. Studying level of engagement. 3 clinics are piloting onboarding visits to acquaint with new members, conduct screenings (SBIRT, depression), and explain what PCPCH is.

- Kaiser – Shifting visits to phone when possible to free up schedule

Dental care needs to incorporate an urgent care model and triage. **What are 1-2 ways you can partner with the delivery system to improve access?**

- IHN – Looking at member use of NEMT to identify opportunities to streamline and coordinate care
- David Labby – Nursing Board limits nurses’ use of standing protocols which limits ability to expand their role. Similar limits from other licensing boards (such as pharmacists). Can OHA facilitate dialogue to expand roles?
- Deborah Loy – SB738 allowed pilots testing of dental hygienist role outside of current scope of practice. Could be model.

David Labby – Could OHA sponsor learning collaborative on access?

What strength does your CCO have in managing access?

Group 3: JCC, WVCH, FamilyCare, EOCCO, CHA

What key places do you need to focus to improve access in the coming year?

- Family Care – We started paying commercial rates to PCPs. Still per member per month, but paying on top of that for hitting metrics on quality measures. This is competitive with commercial payers, and there’s no disincentive for taking Medicaid patients. It’s a very new initiative and just announced a month ago.
- It’s not just getting patients in the door; we’re expected to do a whole lot more, doing quality work.
- At our CCO, new people are assigned a higher weighted if they’re in ACA, and then assigned to higher-tiered PCPCHs.
- FamilyCare – We have to give money back to the state if don’t use it (unlike at Trillium, an IPA, where unused money goes back to practitioners).
- JCC – We have urgent care and open access and extended hours. We did better to CAHPS than we should have because we have 5000 patients in the FQHC, but 2000 haven’t seen anyone yet. We have a progressive visit: first a

low-level call for quick triage to determine if care is needed, then higher level calls to determine what kind of care to get them (simple questions). We're just starting this now. However, though this is good work and needs to be done, it's not reimbursable or valued in a tangible way.

What are 1-2 ways you can partner with the delivery system to improve access?

- Group appointments – Jackson Mental Health and the community health center are looking at opportunities for this, but it's very early on.
 - Things like that are happening around the country, like for kindergarten assessment.
- Are school-based health centers good places for easy access?
 - The access problem is really more for adults, not pediatrics. Children were already on OHP, so it's not a new population.
 - School-based health centers almost serve different functions – mental health, sexual health, issues that require degree of anonymity
 - Moda is using school-based care for the well visit metric, but not access.
- We have barriers reaching our members. We don't always have contact information, and the phone isn't very effective (changed phone numbers). We have a huge struggle contacting people.
 - At our out-patient rehab, it's very difficult contacting patients. The back-up number isn't usually a true back-up. There's no consequence to not come. This population is harder to schedule and follow-up, so our no-show rate went up. We're not reaching full-term plans of care, so our patient outcomes are getting worse. This is new for the rehab realm.
 - Moda – We're working with home-based strategies with traditional health workers to get in people's homes. Texting has also proven more efficient than phone calls
 - FamilyCare – We're currently looking at texting and how to still be compliant with HIPAA.
 - Texting has been helpful with Spanish-speaking populations because it's easier to translate.

What strength does your CCO have in managing access?

	<ul style="list-style-type: none"> • Other places in the country have tried giving patients cell phone packages for medical use • PacificSource graduated 28 traditional health workers for new capacity in the community. <p>Any other ideas that surfaced?</p> <ul style="list-style-type: none"> • Ron – The importance of knowing your population and the importance of pre-visit planning and onboarding – how does that impact perceived access? CAHPS is patient perception. One topic that did not come up in discussion is electronic strategies. What experiences do folks have leveraging IT to improve access? <ul style="list-style-type: none"> ○ Christine Seals – We use pingmd, some struggles, how you deal with emergencies, test patients with tech-savvy patients, only in office hours) . Ping is free. It’s encouraging with behavioral health providers. You can’t track unless you pay though. Some of this may be solved through meaningful use and patient portals; perception of connection that someone is there if I need it. ○ ○ Lynnea Lindsay-Pengelly – We’re in talks with Ginger.io about mood monitors. It’s hard to discern value with vendors. The financial cost is pretty high. Our community health workers definitely text their patients. • How does dental integration improve access? That may impact true access and perception. 	
<p>7. Next steps and announcements <i>(Summer Boslaugh, Transformation Center)</i></p>	<p>CCO Technical Assistance Bank The Transformation Center has launched the Technical Assistance Bank for CCOs. Each CCO has available 35 free hours, and we encourage 10 of those hours be used for CACs. CCOs will work with their Innovator Agents to look at technical assistance areas and then contact us with requests.</p> <ul style="list-style-type: none"> • Question: If a CCO has identified a facilitator, can we use them for these hours? <ul style="list-style-type: none"> ○ Ron Stock – Start by talking to your Innovator Agent. <p>October 13 Meeting: Depression Screening The next Statewide CCO learning collaborative meeting will be October 13, 11:00</p>	<p>See the Technical Assistance Bank FAQs handout and Technical Assistance Bank website for more detailed topic areas and a request form.</p>

a.m.-12:30 p.m.

- Email summer.h.boslaugh@state.or.us if you have topics you'd like covered related to depression screening.

**November 10 Meeting: Alternative Payment Methods and Incentive Measures
with Michael Bailit**