

Robert Wood Johnson Foundation Payment Reform Evaluation Project
High Value Patient Centered Care Initiative
Oregon Health Leadership Council

Executive Summary: Autumn 2012 Site Report

Context

The development, implementation, and future of the High Value Patient Centered Care Initiative (HVPCC) have been and will continue to be shaped by larger health system reforms in Oregon. In addition to HVPCC, five other payment reform initiatives are running simultaneously:

- Aligning Forces for Quality (AF4Q), a program funded by the Robert Wood Johnson Foundation since 2007 to improve the quality of care in Oregon;
- Oregon health system reforms, created when the Oregon legislature authorized Coordinated Care Organizations (CCO), which are providing care to Oregonians with Medicaid insurance through global health budgets.
- Comprehensive Primary Care Initiative (CPCI), where Medicare offers bonus payments to medical groups that better coordinate primary care for their Medicare fee for service patients.¹
- Patient-Centered Primary Care Institute (PCPCI), which began in August 2012 to support the transformation of medical groups to primary care medical homes through technical assistance and other mechanisms;
- Patient-Centered Primary Care Home Program (PCPCH Program), where primary care homes receive supplemental payments to support enhanced care provided to Medicaid patients with selected chronic conditions (ends September 2013).

The not-for-profit Oregon Health Care Quality Corporation (Quality Corp), a contractor and partner in the HVPCC, is also involved in the AF4Q, PCPCI, and PCPCH. Founded in 2000 and funded by AF4Q since 2007, Quality Corp has developed a comprehensive, multi-payer system for measuring primary care quality in Oregon.

Objective

The objective of the OHLC HVPCC initiative is to improve quality care and reduce health care costs and improve patient satisfaction through the use of nurse care managers for high-risk patients. HVPCC is directed by the Oregon Health Leadership Council (OHLC), which consists of 30 members from local and national health care organizations. The OHLC, formerly known as the Health Leadership Task Force, was formed in 2008 at the request of the Oregon business community. Its main mission is to control health care costs.

Approach

In 2010 the Oregon Health Leadership Council (OHLC) developed the High Value Patient Centered Care Initiative, which focuses enhanced care management resources on a subset of high-utilization patients identified by health plans. Five health plans and four state purchasing groups are participating, and

¹ Sources: <http://www.innovations.cms.gov/>; and <http://www.innovations.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/Oregon.html>

fourteen medical groups have enrolled 3,600 patients in November 2011. Program management is being performed by Renaissance Health.

Health plans pay medical groups per-member-per-month (PMPM) payments to cover the personnel costs of the registered nurse care manager, and a 50/50 sharing of medical group savings up to a cap, at the end of the Initiative. Due to legal and anti-trust concerns, each health plan contracts directly with each medical group; consequently, the PMPM and gain sharing arrangements vary by medical group and generally range from \$40-45 PMPM. There are two salient features of the payment arrangements. One is that HVPCC is being implemented through the existing contractual relationships that health plans have with each medical group, which simplifies implementation of the enhanced care management payments. Second, because of the contracts, medical groups are accountable legally to provide health care coordinated by nurse care managers to a defined population of high risk patients with expected outcomes for two years, which enables standardization of the care management model.

Quality Corp is a data source for the Initiative. At the request and in collaboration with the OHLC, Quality Corp developed interactive, graphically based utilization reports for use by clinic staff at participating medical groups; these reports are released within four weeks of obtaining claims. Medical groups use the reports to track their enrolled patient panel's progress in achieving performance benchmarks. All reports are accessed through the existing Quality Corp secure portal. Quality Corp also has developed quarterly health plan reports and periodic summary reports for the Council and participating groups reporting aggregated data from the utilization reports for the health plans sponsoring the activity.

Logic Model

The project is expected to achieve its goals because of the following considerations: (1) use of nurse care managers who are trained in changing patient behaviors; (2) greater opportunity for cost savings with the high-cost patients; (3) emphasis on transitions in care; (4) nurse care manager payment as a step toward paying for care outcomes; (5) shift in physician leadership model to a team care approach; and (6) improvement in primary care, which will improve quality and satisfaction and reduce costs.

Facilitators and Barriers

Facilitators:

- Oregon's history of collaboration and innovation.
- Leadership of the health plans and the OHLC agreement on the care model, payment approach and contract.
- Physician leadership.
- Well-qualified nurse care managers in all medical groups.
- Trust in and credibility for all members of the team implementing the Initiative, including Quality Corp as a credible and respected data provider of information about system performance.

Barriers:

- Competition for time and attention: when HVPCC began, there were few health reforms operating; now there are several.

- Payment environment: health plans and medical groups operate in a FFS environment and have limited capability for making and receiving capitated payments.
- Attribution and ongoing enrollment: identifying high-risk patients and attributing them to a health plan is challenging because patients may change employers and health plans.
- Risk identification methodology: health plans identify high risk patients through a computer algorithm. Medical groups also may define patients as high risk based on their clinical histories.
- Data timeliness and accuracy: utilization data are reported quarterly to medical groups, but reporting data in real time would aid in managing care transitions especially for emergency room visits and hospitalizations.
- Data literacy: some medical group staff had limited spreadsheet skills and required assistance in understanding and applying information in quarterly reports.
- Nurse retention: the skills the nurses gained from care management have made them strong candidates for other positions. This has led to some turnover among the nurse care managers.
- Patient preferences: not all high-risk patients want to be in a medical home or participate in the project, and some believe they are healthy.

Evaluation and Sustainability

The project's evaluation is being led by faculty at the Oregon Health and Science University. Results will determine the amount of savings to be shared by health plans and medical groups, which ultimately may decide whether the HVPCC continues or not. Shared savings will be determined by comparing the HVPCC patient costs with patient costs in a tightly matched control group. Although descriptive analyses of HVPCC patient claims suggest the project is changing utilization in the expected direction, whether the HVPCC has reduced costs more in HVPCC than the control group will not be known until the evaluation is completed.

Lessons Learned

The HVPCC is now a mature program, and attention has shifted from putting the program into place to identifying ways to improve its features and performance. HVPCC implementation offers several preliminary insights about payment and health system reform:

- Implementing nurse care managers and team care requires a shift in the culture of the clinic.
- HVPCC has achieved its implementation goals because the health plans and medical groups have open communication and collaborate to design and manage the program, identify changes, fix problems, and share perspectives.
- Collaboration does not happen by chance but must be nurtured by local, well-known leaders who are respected by most interest groups.
- Medical groups may be more willing to participate in payment reform when the payment amounts offset their costs of implementing the project.
- Relationships between health plans and medical groups are defined partly by legal contracts, and payment reforms may be more successful when structured around those relationships.