Coordinated Care and Oral Health Integration in Oregon

Eli Schwarz KOD
DDS, MPH, PhD, FHKAM, FCDSHK, FACP, FRACDS
Department of Community Dentistry

The Massachusetts Health Policy Forum, Boston September 2016
Today’s outline

• Oregon health care transformation:

• Central Administrative Integration efforts:
  • Legislative framework
  • Quality incentive metrics

• Regional and local CCO and DCO integration efforts:
  • Integrating Oral Health with Physical and Behavioral Health
  • Children – adults – prevention and chronic disease management

• Conclusions – where to from here?
Oregon Health Plan & Managed Care (Demonstration 1.0)

- Developed in 1993 & championed by then state senator and later governor Dr. John Kitzhaber.
- Federal waivers granted by Clinton Administration
  - Managed Care capitation structure
  - Prioritization of services
- Growth
  - 240,000 1994 to approx. 1,100,000 in 2016
Agreement with federal government to reduce projected state and federal Medicaid spending by $11 billion over 10 years.

Lower the cost curve two percentage points in the next two years.

$1.9 billion from the U.S. Dept. of Health and Human Services over five years to support coordinated care model.

Creation of Coordinated Care Organizations (CCOs)

OHA and CCOs will be held to high standards for health outcomes.
Oregon Health Plan (Medicaid)
Health Care Delivery system before August 2012

Oregon Health Authority
Oregon Health Plan (OHP)

33 OHP contracts
Capitation $$.PMPM

8 Dental Care Organizations
DCO

15 Fully Capitated Health Plans
FCHP

10 Mental Health Organizations
MHO

Health care delivery
OHP benefits

Siloed care: Minimal to NO coordination/collaboration

Oregon Health Plan Members
Approximately 600,000
Oregon Health Plan (Medicaid) Health Care Delivery system in 2014

Oregon Health Authority
Oregon Health Plan (OHP)

$ PMPM Global Budget

16 Local Community CCOs
CCO contracts

Oral Physical Mental

HEALTH

Navigators

Primary Care Homes

Coordinated care – Coordination/collaboration Incentives
Shared Systems & Learning Community Health Plans

Oregon Health Plan Members
More than 1,100,000 after Medicaid expansion

Oregon Health Plan (OHP) Members

Schwarz - School of Dentistry
Transforming the health care delivery system in Oregon

- Benefits and services are coordinated and integrated
- One global budget that grows at a fixed rate
- Metrics: standards for safe and effective care
- Local accountability for health and budget
- Local flexibility
State Commitment to CMS: Quality and Access Metrics

- State is accountable to CMS for 33 metrics—significant financial penalties for the state for not improving
- CCO’s are accountable for 17 of the metrics—there are financial incentives for improvement or meeting a benchmark
- The 33 metrics are grouped into 7 quality improvement focus areas:
  - Improving behavioral and physical health coordination
  - Improving perinatal and maternity care
  - Reducing avoidable ED visits and re-hospitalizations
  - Ensuring appropriate care is delivered in appropriate settings
  - Improving primary care for all populations
  - Reducing preventable and unnecessarily costly utilization by super users
  - Addressing discrete health issues (such as asthma, diabetes, hypertension)
DENTAL SEALANTS ON PERMANENT MOLARS FOR CHILDREN (all ages)

Dental sealants on permanent molars for children (all ages)
Percentage of children ages 6-14 who received a dental sealant during the measurement year.

2015 data (n=132,569)
Statewide change since 2014: +65%
Number of CCOs that improved: all 16
Number of CCOs achieving benchmark or improvement target: all 16
Dental sealants is a new incentive measure beginning in 2015. A benchmark of 100 percent for this measure is not realistic, due to the limitations of administrative data in identifying teeth that are not candidates for sealants (e.g., those already sealed, not yet erupted, or with active decay).
See pages 161 and 168 for results stratified by members with disability and mental health diagnoses.

Back to table of contents.

Dental sealants for children ages 6-14 increased across all racial and ethnic groups between 2014 & 2015.

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic/Latino</td>
<td>9.4%</td>
<td>13.3%</td>
</tr>
<tr>
<td>Hawaiian/Pacific Islander</td>
<td>9.8%</td>
<td>17.0%</td>
</tr>
<tr>
<td>White</td>
<td>12.8%</td>
<td>16.8%</td>
</tr>
<tr>
<td>African American/Black</td>
<td>19.0%</td>
<td>21.0%</td>
</tr>
<tr>
<td>Asian American</td>
<td>15.0%</td>
<td>21.0%</td>
</tr>
<tr>
<td>American Indian/Alaska Native</td>
<td>8.6%</td>
<td>14.2%</td>
</tr>
</tbody>
</table>

2015 Performance Report
June 23, 2016

Oregon Health Authority
Office of Health Analytics
Mental, Physical, and Dental Health Assessments for Children in DHS Custody

Health assessments for children in DHS custody

Percentage of children ages 4+ who received a mental, physical, and dental health assessment within 60 days of the state notifying CCOs that the children were placed into custody with the Department of Human Services (foster care). Physical and dental health assessments are required for children under age 4, but not mental health assessments.

2015 data (n=1,830)

Statewide change since 2014: +109%

Number of CCOs that improved: all 16

Number of CCOs achieving benchmark or improvement target: 15

See pages 158 and 164 for results stratified by members with disability and mental health diagnoses.

Back to table of contents.

Percentage of children in DHS custody who received health assessments in 2014 & 2015, by race and ethnicity.

Race and ethnicity data missing for 10.2% of respondents / Each race category excludes Hispanic/Latino

2014 results have been recalculated according to updated measure specifications and differ from previously published reports

Data suppressed (n<30)

American Indian/Alaska Native 20.3% 54.5%

Hispanic/Latino 32.1% 64.8%

White 27.5% 97.7%

African American/Black 56.5% 67.9%

Asian American 20.4% 34.2%

Hawaiian/Pacific Islander 14.8% 32.9%
Progress measured from year to year
2015 is 3rd year

<table>
<thead>
<tr>
<th>Decreased</th>
<th>Increased</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ ED utilization</td>
<td>✓ Patient-centered primary care home enrollment</td>
</tr>
<tr>
<td>✓ Specialty care visits</td>
<td>✓ Primary care visits</td>
</tr>
<tr>
<td>✓ All hospital readmissions</td>
<td>✓ EHR adoption</td>
</tr>
<tr>
<td>✓ COPD admissions</td>
<td>✓ Dental sealants</td>
</tr>
<tr>
<td>✓ CHF admissions</td>
<td>✓ Effective contraceptive use</td>
</tr>
<tr>
<td>✓ Asthma admissions</td>
<td></td>
</tr>
</tbody>
</table>

ED: Emergency department
COPD: Chronic obstructive pulmonary disease
CHF: Congestive heart failure

EHR: Electronic health record

Financial implications

- With nearly 95% of Oregonians now enrolled in health care coverage, Oregon has one of the lowest uninsured rates in the nation;

- By 2017, the current demonstration will have saved the federal and state government over $1.7 billion ($1.4 billion to the federal government).

- The goal of the demonstration was to provide better care and improve health, while also lowering the rate of growth of per capita cost.

From Governor Kate Brown’s 2016 waiver submission

Integration models

• Full Integration
• Shared Financing
• Virtual Integration
• Co-location
• Facilitated referral
Integration in practice

- Early indications are that integration must be preceded by coordinated care/ case-management

- Patient-centered Coordinated care ~ Identification of high risk population ~ Case management ~ Shared responsibility for patient care ~ Mutual recognition of roles in integrated approach
Integration in practice - examples

- Kaiser Permanente: Medically and dentally insured patients: Care gap analysis – Chronic disease management – EPIC + EPIC WISDOM

- Willamette Dental DCO – Trillium CCO: Chronic Condition Dental Management of tobacco users and diabetics

- Capitol Dental DCO – Samaritan Health: Addressing rural health disparities – Expanded Practice Dental Hygienists co-located with primary care clinics

- FQHCs: Co-located Expanded Practice Dental Hygienists in a Primary Care facility: Case management – warm hand-off - +/- EHR (WISDOM)

- FQHC: Co-located Behavioral Health specialist in dental clinic

- OEBB – PEBB perspectives
Determinants for health outcomes

- Lifestyle & Behavior: 40%
- Human Biology: 30%
- Environmental: 5%
- Social: 15%
- Health Care System: 10%
In submitting the 2017 renewal request, Oregon has committed to continuing and expanding all of the elements of the 2012 waiver, particularly around integration of behavioral, physical and oral health integration, and has included a significant focus on social determinants of health, population health, and health care quality.
Thanks for your attention

schwarz@ohsu.edu