Progress Report–July 2012

The Oregon Health Leadership Council is pleased to provide updates on the key Council initiatives to moderate health care cost increases in the short and long-term. More information is available on our website: www.ORHealthLeadershipCouncil.org

Acute Low Back Pain Pilot Launched

Beginning January 1, 2012, the Council launched a two-year initiative to allow direct access to physical therapists for patients with uncomplicated acute low back pain. The pilot is being offered to fully insured and self-insured commercial members of Cigna, LifeWise, ODS, PacificSource, Providence, Regence and UnitedHealthcare as well as the employees of hospital system Council members – Asante, Providence and St. Charles Health.

The pilot is a community-based approach to a standardized care process for the identification and treatment of patients with acute low back pain. The care process uses a standardized screening tool and offers appointments within 24 to 48 business hours to patients who would benefit from this care. Treatment focuses on exercise, education and self-management tactics.

The pilot's goals of allowing direct access to physical therapists for the quick treatment of uncomplicated, acute low back pain are to:

1. Reduce time loss from work
2. Improve functional status of the patient
3. Improve patient satisfaction
4. Reduce downstream medical costs

Physical therapy clinics representing more than 70 locations with more than 250 therapists are participating. They are:

- Adventist (Portland)
- Asante (Southern Oregon)
- Capitol PT/Hand (Salem)
- Eugene PT (Eugene)
- Optimal Results (Portland)
- Progressive Rehab (Portland)
- PT Northwest (Salem/Corvallis)
- Rebound (Bend)
- Sandy PT (Sandy)
- Alpine PT and Spine (Bend)
- C.H. Physical Therapy (Portland)
- Chehalem (Newberg)
- Laurelhurst (Portland)
- Oregon PT/Spine (Eugene)
- Providence (Portland, Medford)
- PT Solutions (Eugene)
- Salem Health Rehab (Salem)
- Slocum Ortho (Eugene)

- Tigard Ortho/Fracture (Tigard)
- Tuality Health Care (Hillsboro)
- Willamette Spine (Salem)

The clinics provide solid geographic coverage down the Interstate 5 corridor and in Bend.

While we are still early in the roll out of the pilot, volume remains low. We continue our efforts to communicate the availability and value of the program. The health plans, major business associations, the Oregon Coalition of Health Care Purchasers and the Oregon Health Care Quality Corporation have worked to spread the word of this opportunity.

In addition, the nurse care managers working on the Oregon Health Leadership Council's High Value Patient Centered Care demonstration have been provided information about the program to help manage their patients, and we are continuing to develop awareness among primary care physicians and their offices through an announcement in the Oregon Medical Association electronic newsletter followed by a direct mailing to primary care physicians.

If you are interested in having a focused approach for your own employees, please contact your health plan representative or Sue Brickey, low back pain project manager, at sab97206@comcast.com. Information about the program and a list of participating physical therapists can be located on the plan websites or at www.ORHeatlhLeadershipCouncil.org.

High Value Patient Centered Care Demonstration

The multi-payer High Value Patient Centered Care (HVPCCM) demonstration initiative for patients with complex and chronic conditions is now in its second year of operation.

The demonstration project implements a new model of care that integrates intensive care management within primary care using a specially trained nurse care manager. This nurse acts as a navigator and develops a personal relationship with each patient to understand exactly how best to care for that individual. The care manager also coordinates with other members of the health care team – including the patient's primary care physician, specialists, other health care professionals, hospitals and health plans.

Five health plans, four of the state's purchasing groups and 14 medical groups are participating in the demonstration. Twenty-three nurse care managers have been working with the 3,600 patients enrolled in the demonstration. The demonstration runs through February 2013, at which time an evaluation will be completed.

New Developments

Health Plan and Medical Groups to Develop a Sustainable Model. At a joint meeting of the HVPCCM medical group and health plan leadership in early April, a decision was made to explore how this model could be transitioned into a long-term, sustainable approach for managing patients with complex care needs. This strategic transition planning includes incorporation of lessons learned during the HVPCCM demonstration and from other national experiences, and continues to be approached with a collaborative multi-stakeholder group. The joint group is now working at what changes in the care model, reimbursement approach, patient selection process and other administrative issues should be considered.

Additional Support for Nurse Care Managers. In addition to ongoing care manager community and training events throughout the first year, in early February, nurse care managers began participating in weekly collaboration calls known as "Office Hours." During these hour-long calls, nurses discuss what is working well and share strategies to address challenges. The calls have also included topics such as case studies, patient and physician engagement, pain management, specific care management skill building (e.g. motivational interviewing), effective time management, tips in working on electronic medical records, onboarding of new care managers and more. The Office Hour calls are coordinated by Renaissance Health faculty, including Pranav Kothari, MD; Jay Shah, MD; and adjunct faculty member Joleen Rodgers, RN, who works for the Everett Clinic and has led the implementation of care management in Puget Sound, including with the Boeing Company. Each week, eight to 12 nurses participate in the call. The group's discussions based on real life experiences allow for greater support of the effort and sharing of best practices.

Data Reporting. Since the last progress report, additional improvements have been made in utilization reports being provided to medical groups. The report includes information about their patients such as emergency room visits, hospitalizations, prescription drugs, imaging and lab procedures and physician visits. In addition, a summary report was developed that looked at data for the first year of the demonstration.

While still too early to make any conclusions, and without a control group to compare results, the preliminary data show lower utilization of the emergency room and fewer admissions to the hospital than at baseline for this population. Ultimately, the final evaluation to be completed at the end of the demonstration will include a control group as a comparison to the HVPCCM population. At that time, a more robust interpretation of the data will be made possible.

Administrative Simplification

The Administrative Simplification Work Group continues its concentration on several key initiatives – increasing the use of electronic data exchange for claims and eligibility, secure single sign on and credentialing.

New Developments

Health Plans and Providers Using the Secure Single Sign On. We continue to see an increase in use of this service in Oregon. This service allows providers to sign on once and use multiple health plans' web portals to transact business.

Plans currently offering this service for Oregon providers are: Aetna, CIGNA, First Choice Health, LifeWise Health Plan of Oregon, PacificSource Health Plans, Providence Health Plans, Regence Blue Cross Blue Shield of Oregon, HealthNet and Samaritan Health Plans. CareOregon is implementing the service in July 2012. United Healthcare is still working on a date for implementation, and ODS is conducting internal assessments with no target date set yet.

With these additional plans offering secure single sign on by the end of the year, a total of 12 major health insurers will be participating. This will help the continued growth in adoption and use of the service and subsequently an increase in the transactions conducted via the Internet.

As of June 30, 2012, over 6,400 Oregon provider organizations with more than 13,500 individuals were active subscribers to the service. This represents an increase of more than 1,500 active subscribers, a 12.5 percent increase, since our April report. Between January 1, 2012, and the end of March, over 682,000 transactions were completed. Between April 1, 2012, and June 30, 2012, more than 796,000 transactions were completed. The total number of transactions – close to 1.5 million – in the first half of 2012 is significantly higher than the 1.2 million transactions that occurred during the first 14 months offering the service.

Electronic Data Transaction Standardization. In the first half of 2012, the work group completed the draft of the Oregon Companion Guide (OCG) that will be established as a statewide standard for the Claims Status transactions (276/277) under the regulatory umbrella of Senate Bill 94. In the second quarter of 2012, the Eligibility transaction guide (270/271) was updated to reflect the recent release from the national industry group, Committee on Operating Rules for Information Exchange (CORE). Our key objective is to keep Oregon standards consistent with national industry efforts and other federal rules, thus providing a streamlined process that will promote adoption of electronic transactions.

During the second half of the year, the work group will pursue the development of an OCG for Remittance Advice (835) and associated Electronic Fund Transfers. CORE rules for this transaction are expected to be released for public comment during the third quarter. Our guide will be consistent with these rules while addressing any statewide issues or improvements relating to this important transaction.

The work group will also be beginning collaborative initiatives with the Oregon Medical Association, other provider groups and intermediaries who enable the transfer of electronic information. The goal is to develop and execute business and technical strategies to increase the adoption of EDI transactions.

Advancing Common Credentialing. The committee continues to monitor the progress of credentialing by OneHealthPort (OHP) in the state of Washington. Recent conversations with OHP indicate that many of the changes necessary for implementation in Oregon have been made, but adoption still remains slow. Since physician adoption is critical to the success of this effort, the committee is looking at how an effective adoption plan can be developed. The Committee will make a progress report to the OHLC in July.

Simplifying the Pre-Authorization Process. The Administrative Simplification's Claims and Eligibility work group has established a subcommittee to inventory existing forms, tools, and processes that health plans use for prior authorization, develop a list of common terms including types of requests, and develop a common education approach for clinicians to understand the prior authorization process and a checklist of required information by payer. This initial work is expected to be completed by the third quarter of 2012. The subcommittee is currently creating an inventory of regulatory time frames and definitions, and is reviewing the Washington Best Practice Recommendations for their

applicability to Oregon. A payer survey will be sent out in July to identify the scope of current practices on time frames, processes and definitions currently used. This inventory will be used to determine reasonable goals for an Oregon best practices recommendation.

Metrics. The Administrative Simplification Executive Committee adopted a standard set of metrics at their February meeting and is working with the plans to report this information on an ongoing basis. The metrics include payer call volume, payer web traffic volume from providers, number of electronic eligibility transactions and percentage of claims submitted electronically. Nearly all payers have responded to the Claims and Eligibility work group with data from 2010 and 2011 to create a baseline from which to measure future progress. Early industry-wide data show a modest decrease in overall call volume and a modest increase in electronic benefits and eligibility transactions during the latter part of 2011. Traffic to payer website benefit and eligibility pages initially increased as the single sign on was implemented, and has recently begun to swing back down as the electronic 270/271 transactions have increased. We will be looking at the trends related to electronic claims activity as the Oregon Companion Guides are adopted.

Other Work. The Claims and Eligibility work group continues to evaluate payer websites against previously determined best practices and evaluating variances in Coordination of Benefits (COB) practices. The work group also inventoried payer processing of COB electronic transactions in comparison to the COB best practice recommendation developed last year by the Electronic transactions (EDI) work group and is happy to report there now seems to be universal compliance with that best practice in Oregon.

Evidence-Based Best Practices

In addition to the Acute Low Back Pain pilot, the Evidence-Based Best Practices group continues its work with the March of Dimes and the hospitals on reducing elective deliveries before 39 weeks, continues to work on high-cost imaging and is exploring initiatives to support the reduced use of opiates.

New Developments

More Hospitals Support Policies to Reduce Elective Deliveries before 39 Weeks. Work continues in hospitals around the state to reduce the rate of elective deliveries occurring before 39 weeks. As of the end of March, the March of Dimes reports 33 hospitals have put in

place, or have committed to implement, the new community-wide standard to place a “hard stop” on non-medically indicated early deliveries. The Oregon hospitals are: Adventist, Asante, Blue Mountain, Columbia Memorial, Good Shepherd, Harney District Hospital, Kaiser Permanente, Legacy, McKenzie-Willamette, OHSU, Peace Harbor, PeaceHealth, Providence, Salem Health, Samaritan Health, Silverton, Sky Lakes and Tuality.

With a hard stop, elective deliveries will no longer occur unless there is clear medical evidence to the contrary. Research shows that performing these elective procedures before 39 weeks can be harmful to the full development of the child and can result in higher costs from stays in neo-natal intensive care units.

To support this effort, the March of Dimes has recently hired Yvonne Gordon, RN, who will be the Quality Improvement Consultant for the Perinatal Quality Care Collaborative. In this role, Ms. Gordon with work to facilitate coordination and move forward the March of Dimes Healthy Babies Are Worth the Wait campaign in Oregon.

Ms. Gordon has more than 24 years experience as a registered nurse in maternal child health. She has held progressive leadership roles for the past 12 years including managing a neonatal ICU and as director of the operations and quality departments of a neonatal/perinatal utilization management company. She holds a specialty certification in high-risk neonatal nursing and has a deep passion for quality healthcare delivery and improved outcomes. We are fortunate to have Yvonne joining this effort.

High Cost Imaging. The five health plans currently working with American Specialty Health (formerly known as American Imaging Management) continue to evaluate aggregate data to identify opportunities to improve quality of care, avoid the use on unnecessary imaging test and minimize harmful radiation exposure to patients. Based on a recently announced national effort focused on the overuse and misuse of tests and procedures that offer limited benefit to patients and may have negative consequences, the group identified local areas for improvement. The effort, called “Choosing Wisely” (www.choosingwisely.org), was launched by the American Board of Internal Medicine (ABIM) and Consumer Reports. In May, the Council sent letters to physicians about where improvement could be made to meet new national standards established by professional medical organizations.

New Work under Consideration

Reducing the Inappropriate Use of Opiates. In January, the committee reviewed work being proposed by the Oregon College of Emergency Physicians (OCEP) to implement statewide guidelines on the appropriate use of prescribing narcotics in emergency departments. Using guidelines implemented in Washington state, the OCEP has been working with different physicians, hospitals and emergency room nurses to finalize guidelines and garner support for implementation of these guidelines statewide. This work, recognized by the Council as important work, is moving forward through the leadership of Dr. Sharon Meieran, president of the OCEP, and the help of many organizations including the Oregon Medical Association and the Oregon Association of Hospitals and Health Systems.

Value-Based Benefits

Value-Based Benefit Designs are now being offered by all health plans that had committed to offer them when this initiative was first launched. The health plans are:

- ODS 2+ employees
- Providence 51+ employees
- Regence 100+ employees
- PacificSource 250+ employees

These types of designs reduce the financial barriers for employees and their families to seek both preventive care and care for costly, chronic conditions, while at the same time increasing the cost share for treatments that do not have the medical evidence to support increased use. These plan designs encourage participants to get the care they need – preventive care, and treatment for chronic conditions – while engaging patients more in the decision-making process to decide whether treatments are necessary or useful. We hope more employers will consider adopting these designs.

Updates

Legacy Health's Value-Based Benefit Design. In our last report we outlined the value-based benefit design Legacy Health had implemented for 7,700 employees effective Jan. 1, 2012. This design moves the focus from treating illness to improving health. In addition to having higher levels of medical and pharmacy benefits for preventive and chronic care,

Legacy has also implemented stronger incentives for employees with chronic conditions to participate in their disease management program.

While they recognize it may take one to two years to see positive trends, they are seeing some early impact from their design. One area that is making an impact is in their fourth tier of benefits where preference-sensitive conditions, such as elective spine surgery, require both a pre-authorization and reduced benefits for not following a defined care protocol. As of June, 23 percent of participants have avoided elective spine surgery.

In addition, 38 percent of their eligible population is receiving richer benefits for engaging in a disease management program, and they continue to see increases in participation of their tobacco cessation program. As planned, beginning June 1, Legacy implemented a premium surcharge – a $25 per pay period premium ($650 annually) surcharge if participants do not attest to being tobacco free.

These features demonstrate the intent of the Council's Value-Based Benefit design – focus on creating a healthy workplace, creating the right financial incentives for preventive treatment and the treatment of chronic care and additional cost sharing for treatments driven by preference or supply rather than evidence.

For more information: www.ORHealthLeadershipCouncil.org