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Just what the legislature ordered

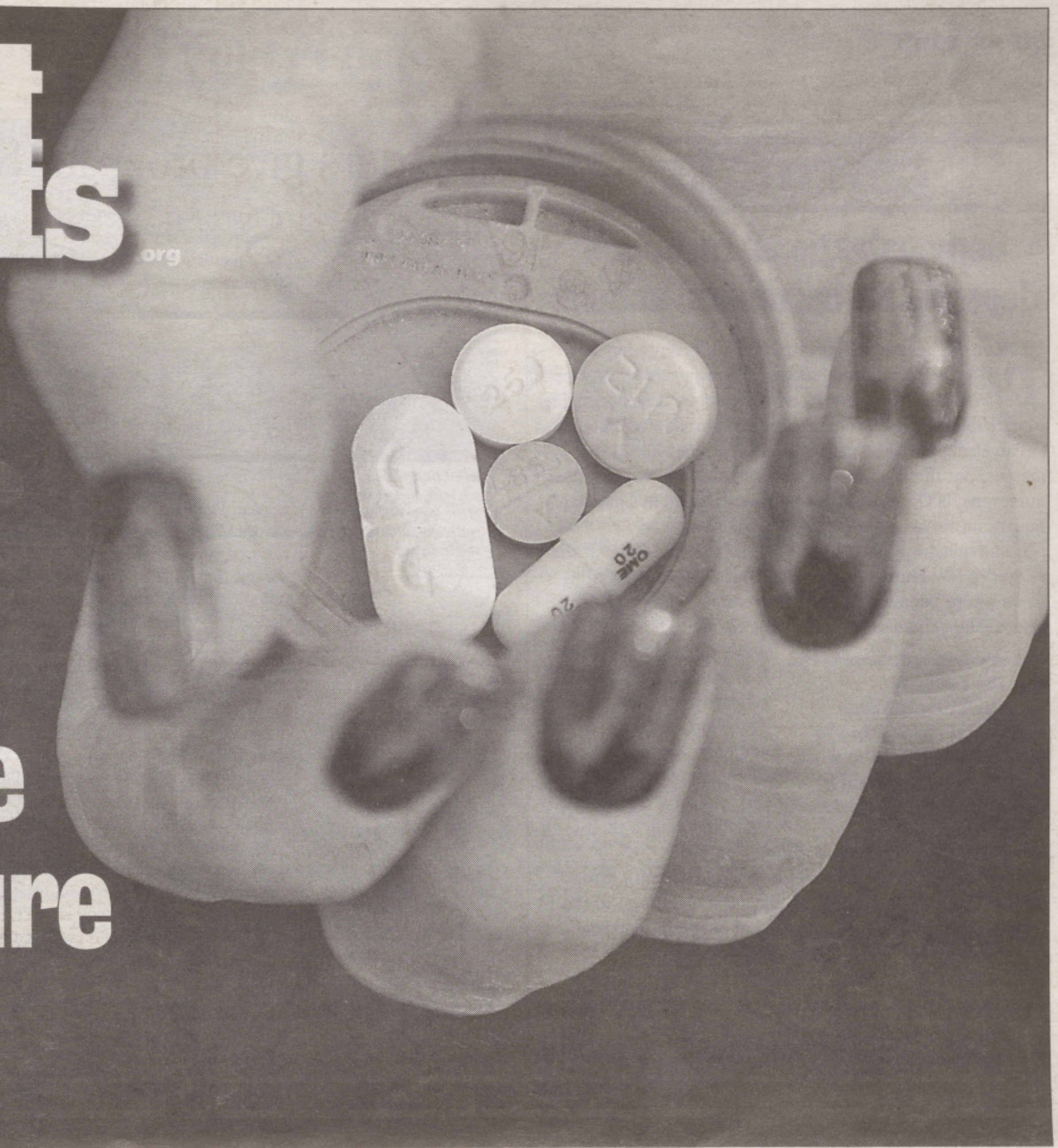

PHOTO BY KEN HAWKINS

Oregon races the clock to restructure its low-income health care system to cut nearly a quarter of a billion dollars from its budget

BY AMANDA WALDROUPE
STAFF WRITER

Autumn Bolds begins the day's huddle by telling Dr. Rachel Solotaroff, the medical director of Central City Concern's Old Town Clinic, that her patient schedule that afternoon has changed dramatically.

Solotaroff will see eight patients that afternoon. Bolds, a panel manager on Solotaroff's patient team, is responsible for coordinating Solotaroff's patients, and she quickly launches into briefing Solotaroff and Magadalena Juan, a medical assistant, on each patient and their health.

She goes through each patient chart, quickly saying why he or she is coming for a visit, what medications the patient is on, and whether pap smears, blood tests and other routine check-ups are up to date.

Juan scribbles notes, and Solotaroff asks some clarifying questions. The rapid pace pauses briefly as the three discuss, in the case of a couple patients, whether they have or need mental health providers, and if a particular concern the team has might be discussed with the patient at that time.

Ending with a high five, the day's huddle is over after a short 20 minutes.

Solotaroff says these daily meetings are hugely beneficial in helping her and the team prepare for each patient visit, knowing what to expect, and also what to anticipate in terms of providing the best possible health care to the Old Town Clinic's low-income and homeless patients.

"The idea is that your work of the day is not your schedule, but the population of patients you serve," Solotaroff says.

Across town at southeast Portland's Richmond Clinic, Dr. Nick Gideonse has similar daily meetings with his patient team, a group made up of doctors, nurses, medical assistants, and a behavioral health specialist.

Both clinics, and a handful of others around the state, are blazing the trail in providing this type of care to patients – health care in which a variety of providers addressing a spectrum of health needs communicate and work together. Care that is coordinated.

Oregon is adopting this model of care for its state Medicaid program, the Oregon Health Plan, in what are the most ambitious changes to the program since it began providing health care to Oregon's poor in 1994.

By July, it is expected that the physical, mental and dental health care provided to 600,000 Oregonians on OHP will be restructured in this new coordinated system, with all providers – including doctors, nurses, mental health counselors, dentists, and other medical professionals – communicating and working in tandem. Its goals are to increase access and quality of health care – and create savings, $239 million worth, by the legislature's budget.

The changes are being ushered in by House Bill 3650, called the Health Transformation Bill, which passed the Oregon State Legislature after intensive political negotiations in late June.

The cornerstone of the changes is the coordinated care organizations, or CCOs. Although HB 3650 gives no definition of what a CCO is, many describe them as being regionally-based geographic organizations that will be flexible enough to address specific health needs within a community and working multiple medical providers to coordinate care.

They will have a governance structure with representation from the providers and stakeholder groups involved in providing care. And each CCO will be given a lump, "global" budget to pay for the care of all its patients.

The expectations are high.

"Hopefully, they will create flexibility to do care differently and save money in the process," says Rep. Tina Kotek (D-Portland), who helped negotiate and write HB 3650. "Our hope is that there will be higher quality of care, more timely interventions, and more appropriate care, just by virtue of understanding the individual better."

"The idea is so good," says Solotaroff. "My really optimistic hope is that they're outcome oriented, and that the outcomes matter to the population (providers are) working with."

But no one is sure how CCOs will be structured, or how exactly they will operate.

"That's the magic question," says Mary Monnat, the executive director of LifeWorks NW, and a member of a governor-appointed workgroup to hash out criteria for CCOs.

"There's not a lot of flesh to the bone," agrees Solotaroff.

And the clock is ticking.

The Gov. Kitzhaber's signature on HB 3650 was barely dry when a whirlwind of activity began to implement the new law: The governor appointed 133 people to serve on four workgroups made up of health care workers, policy makers, advocates and consumers to develop a more detailed plan of creating CCOs, establishing quality control measures, the methodology for the budget, and how to integrate care for the roughly 60,000 people on both Medicaid and Medicare. They met

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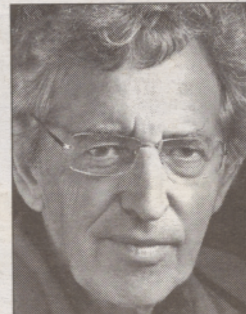

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