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in August and September, and meet again in October and November. They will give their recommendations to the Oregon Health Policy Board, which advises the Oregon Health Authority.

The Oregon Health Policy Board will use the recommendations to finalize a plan that must be approved by the Legislature in February in order for reform to move forward.

"We're waiting with bated breath," says Rep. Mitch Greenlick (D-Portland), another legislator heavily involved in HB 3650's writing.

If the Legislature gives approval, the state will work to have CCOs operational by July. It is a fast timeline, but Greenlick and others think it's enough. "It's very exciting," Monnat says. "But, like any change, it's also daunting and hard to get your head around."

Much depends on Oregon's health transformation. Many critique the Oregon Health Plan for being fragmented and not patient-focused. The legislature also took a risky gamble in budgeting $239 million in savings from the effects of integrating care.

If care coordination does not work, then care will remain fragmented, leaving a population of people who are poor and sicker than the average, challenged with navigating a massive system, bouncing from provider to provider, and falling through the cracks.

"We have a moral imperative to make health care more efficient," says Gideonse, the medical director of Oregon Health & Sciences University's Richmond Clinic.

"We're not talking about people who live in the west hills of Portland," says Thomas Aschenbrenner, the president of the Northwest Health Foundation, and a member of the CCO workgroup. "These are people who have struggled their whole life. They don't have the emotional energy to put up a fight, and if we don't put up a fight for them, they will suffer even more."

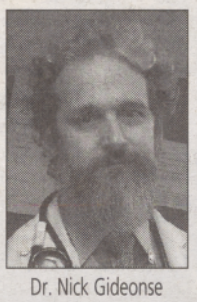
Cranking out visits in fragmented silos

To understand why such radical change is being undertaken, it is important to understand whom the Oregon Health Plan serves. The plan is available to people with an income 138 percent below the federal poverty line, or roughly $15,000. Living in poverty, people on the Oregon Health Plan have barriers to transportation, childcare, and other obstacles to accessing healthcare.

"They're demonstratively sick patients," Gideonse says. "The sicker you are, the less attention points you can lend toward navigating complex systems."

"They end up ignoring diseases that should be treated," Greenlick says. "They don't have the ability to get good preventive care. Then they end up using the emergency room. It's a huge problem."

The Oregon Health Plan currently provides services through "managed care organizations." Similar to insurance companies, managed care organizations develop health plans it offers to patients on the Oregon Health Plan, and contracts with medical providers. Patients have separate health plans for their physical, mental and dental care. That means patients may go to three different places for their health care.


Dr. Nick Gideonse

"None of those plans talk to each other," says Erin Fair, the manager of state and federal policy at CareOregon, a Portland-based managed care organization. "That creates not only siloed care and administrative hassle" but also leaves the patient very confused.

"You could not create a more convoluted system," says Mike Bonetto, Gov. John Kitzhaber's health policy advisor.

Solotaroff can say from experience that the lack of communication among the silos directly affects patients.

One example she offers is a patient in long-term care with congestive heart failure, whose weight must be checked every day to determine whether fluid is building up in his body. A staff person at the long-term care facility might weigh him every day, but then not call it in to his doctor, nor e-mail, but rather send a fax.

"Two or three pounds could be a big deal," Solotaroff says. "And I might not see it unless I'm running around saying, 'where is that piece of fax paper?'"

"The hope of a CCO is that they will be able to deliver a much more integrated package of services," Greenlick says.

The way providers are paid has also presented significant challenges to the quality of care under the OHP. In the current "fee for service" model, providers are paid the same per patient visit, regardless of what services are provided, how sick the patient may be, or how much care they need.

That creates a tension between providing adequate care and generating enough revenue to keep a clinic financially viable. "The cost per visit is the same, so you do it through visits," Gideonse says.

"It's volume driven and not value driven," says Ern Teuber, the Richmond Clinic's executive director.

The choice between "10 sore throats versus a very sick person," is thus very clear. "That's not necessarily good health care," Gideonse says.

Solotaroff agrees. "It's so inefficient now because it is almost entirely based on cranking out visits and not better outcomes."

The new "global budget" plan for CCO's is viewed as a key solution. One budget, given to a CCO, will pay for the care of a specified number of patients during the year. Legislators and others hope it will motivate CCOs to carefully manage the money they're given and provide the most efficient care possible.

"It's a powerful tool," Greenlick says. "Right now, there's just no discipline."

Solotaroff agrees.

"The idea of the global budget that pays you to take care of a person rather than spend 15 minutes to listen to a patient and write down what they're saying is very appealing,"

Searching for structure — and criteria

One of the elusive puzzle pieces to developing coordinating care is the structure of a CCO. How big will it be? What will it do? Who will be a part of it?

"It's more than just one clinic. It's hospital care, specialty care, mental health, dental care," says Greenlick. "You need to bring all the people into a CCO that need to be there to provide all the health care services."

Teuber, the Richmond Clinic's executive director, says there are at least a couple ways a CCO can be structured.

What is known with certainty is that managed care organizations will cease to exist. Teuber says a CCO may be a fairly small organization that simply contracts with provider groups to provide care, with the contract requiring collaboration and coordination. Money would funnel through the organization to the various providers, and the organization would provide some type of oversight and accountability.

Another possibility is that a CCO could be a non-profit. In such a scenario, all categories of providers would be in the CCO.

"As long as the CCO holds itself and all players accountable for doing only that which is in the patient's best interest, then that will be quite different from what the average managed care organization has been doing," Teuber says.

Another vexing question is what the criteria for a CCO will be. An organization will have to apply to the Oregon Health Authority in order to become a CCO. The organization will need to prove that it meets certain criteria and guidelines.

A balance must be struck between flexibility and concrete criteria so that CCOs can be flexible enough to address particular health problems in its particular community. But some fear that if the criteria are not strong enough, there will be less of an incentive for the CCOs to truly change how health care is delivered.

"It's probably going to look pretty loose," says one member of the CCO workgroup who did not want to be named. "As we move forward, I hope something will happen that will make it clear to people that this is about behavior change."

Broad criteria, this member said, could cause some organizations that become part of CCOs to simply make up their own rules. If they have particular religious or ideological leanings, that could mean, for example, less access to reproductive and family planning services. It's possible that the Oregon Health Authority could intervene, but it is not clear yet where the Authority would, or could.

"Good criteria will not allow somebody to get in the game without taking care of the whole patient population," says Lillian Shirley, the director of Multnomah County's public health department and vice-chair of the Oregon Health Policy Board, during the board's meeting on October 11.

During that meeting, the Oregon Health Policy Board discussed for the first time in some detail what the criteria and structure of a CCO will be. Much emphasis was placed on the need for CCOs to reduce health inequities due to race and ethnicity, geography, disability, sexual orientation, income, homelessness, and a variety of other factors.

Nothing will be set in stone until a plan is delivered to the Legislature this winter. There continue to be, Fair says, "a lot of unknowns."

Of teams and touches

The Old Town Clinic adopted its coordinated care model in 2007. The clinic has three teams made up of a medical doctor, a physician assistant or naturopath, a behavioral health counselor, a panel manager who keeps track of all the patients, a medical assistant, and an acupuncturist.

The clinic currently has three patient teams, each responsible for between 800 and 900 patients. Solotaroff says a fourth team will be created when an addition to the Old Town Clinic opens late this winter. A fifth patient team is planned to start sometime in 2012.

Each team member has specific responsibilities in relation to a patient's health. If something is outside the realm of that person's specialization, he or she communicates with the person on the team most qualified to address that issue.

The patient will interact with each team member to varying degrees. An individual may visit a clinic multiple times when first admitted to discuss multiple health problems and have exams, lab tests, screenings and other procedures done.

"I might see them every week or two until they are stabilized," Solotaroff say. "There's just pent up demand. If someone has been in a decompensated state for some time, there's a lot of stuff you need to take care right out of the gate."

The intensive engagement in the beginning, Solotaroff and Gideonse say, has multiple benefits: a closer relationship forms between patient and provider; the patient begins learning how to manage their illnesses; and, most important, providers

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State already banking on savings in health care reform

No one is certain health reform will save $239 million – not even the legislators who voted for it

BY AMANDA WALDROUPE
STAFF WRITER

State legislators and other groups watching the overhaul of the Oregon Health Plan that would begin providing integrated, coordinated care are hoping that $239 million will be saved, as the state's budget has already pressumed.

It is unknown how many organizations will become coordinate care organizations, or CCOs in July, the earliest date that CCOs could begin operating. If there are not many, or they start late, it will be harder to find savings.

The assumed savings were caustically criticized by Republican legislators. Even Democratic legislators and community members wholly supportive of the changes the new policies make are skeptical. "There is a lot of risk in the budget," says Rep. Tina Kotek (D-Portland). "We have to try because we don't have another option."

The state faced a $3.5 billion shortfall in its budget this latest cycle. Legislators cut the reimbursement rate paid to Oregon Health Plan providers by 11 percent and made cuts to administrative costs and health plan benefits.

For the rest of the deficit, policy makers hope that CCOs will make it up in more efficient care.

At best, says Rep. Mitch Greenlick (D-Portland), it's a hope. "They're not going to save that money in the first year they're getting started."

"You don't realize the savings in things like that overnight," says Erin Fair, the manager of state and federal policy at CareOregon, a Portland-based managed care organization.

The unlikelihood of savings has already caused people to start thinking about what will be cut instead.

Federal rules prohibit simply kicking people off the Oregon Health Plan, Greenlick says. Savings could be found in further reducing provider's reimbursement rate and increasing the tax on private hospitals..

Another avenue is to ration the care and health services people receive – essentially, choosing which procedures and medications they receive, based upon medical necessity and the cost.

Dr. Nick Gideonse, medical director of OHSU's Richmond Clinic, said that he wants the choice made "to ration care, not people."

But he says simple changes can be made in the clinic to save money. Two years ago, the Richmond Clinic changed the way it did urine screens. At that time, the clinic sent the urine to an outside lab. It took five days for results to come back, and cost $500. The clinic began using a different technology allowing the screens to be done the same day at the clinic. The cost was $30.

But no one is skeptical that CCOs will have long-term savings. "I think anytime you integrate care you see better quality care and you reduce costs," Kotek says. "In the long term, we're going to see savings for sure."