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Collaborative members and advocates alike do not expect the Collaborative to fully begin integrating and coordinating care in the short term.

The Centers for Medicare and Medicaid Services is allowing CCOs to be more flexible with how it spends its Medicaid dollars. Because of that, interim-CEO Janet Meyer says the Collaborative, like the rest of the state's CCOs, will be able to invest some of its dollars in "flexible benefits" — methods to help patients maintain their health but not traditionally covered by insurance companies.

An example often used by Gov. Kitzhaber is that of an older person with congestive heart failure, living in an apartment that easily becomes hot during the summer. The hot, stuffy air exacerbates the person's illness, which could easily be prevented if the apartment had an air conditioner.

While some details have yet to be ironed out, Meyer says buying air conditioners for the congestive heart failure patient, or vacuums for patients whose asthma flares up because of dust, will bring immediate benefit to Oregon Health Plan patients.

But what will fundamentally change a patient's relationship with their provider and their health will be the Collaborative's use across the tri-county area of a coordinated care model already proven to work: medical homes.

A "medical home" employs a team of multiple health providers, including doctors, nurses, physician assistants, mental health and addiction providers, and various support staff who track data and communicate with patients.

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 team member most qualified to address that issue. Patients interact with each team member to varying degrees, depending on the care they need.

"(Patients are) known and they have stronger relationships," says David Labby, the Collaborative's chief medical officer.

Labby is spearheading the Collaborative's efforts to create medical homes, and says every Oregon Health Plan patient will eventually belong to one. Within a year, he says, the majority of the Collaborative's medical homes should be operational.

"We have a lot of practices that are pretty advanced health home practices," he says.

Creating a medical home depends on the providers thinking of their patients as a defined group of people for whom they are responsible. Identifying who their patients are and what their various health needs are determines the providers on the medical team. "You design the team around the group you're taking care of," Labby says.

Medical homes are touted for their

## FamilyCare forms its own Portland CCO

While the Tri-County Medicaid Collaborative will be the biggest game in town, it won't be the only CCO in the Portland metro area. FamilyCare, which has served metro area patients for decades, is forming its own CCO after considering joining the Collaborative, then deciding to strike out on its own.

Jeff Heatherington, FamilyCare's president, decided to leave the Collaborative when the Collaborative's board members were asked to sign an agreement that they would not be a part of another CCO in the metro area — essentially, not be a part of an organization that would compete with the Collaborative.

Heatherington refused to sign the agreement, and left the Collaborative. The CCO FamilyCare is

starting is expected to begin on August 1.

In some ways, FamilyCare has a head start on the Collaborative in terms of its ability to provide coordinated care. The organization already coordinates the physical and mental health care of its 50,000 patients. And for years, FamilyCare has used patient navigators to work directly with patients and help them find the appropriate care and services they need.

FamilyCare and the Collaborative won't necessarily compete, because they have separate patient populations. But it does allow Oregon Health Plan patients a choice — if a member of the Collaborative is unhappy with the care they're receiving, they could enroll in FamilyCare.

responsiveness: If a patient needs to see their primary care doctor, they can within a couple weeks, if not days. Whether the Collaborative can make that sort of access possible remains to be seen.

"We need all the (health center) capacity as possible," Blackburn says. "There is not enough access. That is a key issue."

The Collaborative might have been off to a slow start, were it not a three-year, \$17.3 million grant from the Center for Medicare and Medicaid Innovation (CMMI), an offshoot of the Centers for Medicare and Medicaid Services that funds projects throughout the nation designed to provide more effective health care at a lower cost.

The money will fund five pilot projects to be launched by September.

The first pilot program will embed up to 15 community health workers in existing medical home practices. Community health workers don't have medical training, and are similar to outreach workers — they work closely with a caseload of up to 30 patients with multiple illnesses and barriers to accessing care.

"(Patients) are going to be seeing a lot more of those people in their lives," Meyer says.

The workers visit patients at their homes, and communicate with them by e-mail, text messages, and phone calls to make sure, for instance, that the patient does not forget about an upcoming doctor visit and that they're taking medication regularly. Home visits can also reveal whether a patient is experiencing other issues, such as social isolation or nutrition problems that can impact their health.

"In a standard office visit, those things aren't apparent," Labby says.

Similarly, the second pilot program will place outreach workers in the emergency departments of three hospitals in an effort to decrease the number of patients using

the emergency department. The workers will help people in the emergency room connect with a primary care doctor, possibly that same day.

The third pilot program will create three teams that will work in three separate hospitals to identify people at risk of quickly destabilizing and becoming unhealthy again once they are discharged. The team will work intensively with the patient to appropriate follow up care and related services.

The fourth pilot program will create a standardized method of discharging a patient from a hospital. Often, Labby says, primary care doctors may not know for months, if ever, that one of their patients went to the hospital for emergency or specialty care. A standardized "transition document," to be used by all the Collaborative's providers, will be created to record each hospital visit.

When a patient leaves the hospital, the document is sent to the patient's primary care provider. The communication between hospital and primary care doctor, via paper trail, will ensure that the doctor is able to "reliably follow up" with the patient in a "timely fashion," Labby says.

The fifth pilot program will embed outreach workers in hospital psychiatric units who will work with patients with acute mental illnesses who can destabilize easily, and help them enter behavioral health treatment and stabilize.

The Collaborative expects to save \$32.5 million dollars over the three years the pilot programs will be tested, simply by virtue of coordinating care, focusing on prevention, communicating more effectively and often with patients, and focusing more compassionately on their health care.

Although the pilot programs are funded by the grant for three years, the Collaborative can decide to fund, expand and standardize a program across the Collaborative before then, if any or all of them prove effective.

Connecting the Collaborative's partners will be a new information sharing system. A digital database containing information about a particular patient — where their medical home is, what physical or mental conditions they have, and a record of care they've received. All the Collaborative's providers will be able to use the database and add information to it.

If a patient living in Portland somehow ends up in a Beaverton hospital and is cared for by a doctor who has never met that person before, that doctor will easily be able to access the patient's information and, for instance, not prescribe medication they may be allergic to, or conflict with other medication they already take. And that doctor can enter information about the visit into the database, which the patient's primary care doctor can later access.

The Collaborative's success won't be measured simply by seeing an improvement in Oregon Health Plan patient's physical health, but will also rely on whether other problems or issues that can impact health are dealt with.

Central City Concern's Blackburn has been using his membership on the Collaborative's board of directors to help educate others about the importance of developing partnerships with service providers not necessarily related to health, including housing and employment services.

He has helped form an informal association of 35 mental health and addiction treatment service providers, all of which could possibly contract with the Collaborative. Blackburn is also working to create a group of housing agencies, which is expected to begin meeting in the next couple weeks.

"There's a lot of people who depend on housing services, social services, employment services," Labby says. "Those things are really important for people's health."

"We need to recognize (those services) as part of the care team and intentionally engage with them," Meyer says

But Brown says it is unlikely that the Collaborative will contract directly with social service providers to help Oregon Health Plan patients get housing if they are homeless, for example. The reason, he says, is that the Collaborative would not be able to use its budget — made up of Medicaid dollars, the use of which is regulated by the Centers for Medicare and Medicaid Services — to pay for services not strictly health related.

"But within our scope is to find those agencies that do have the dollars ... so that we can achieve the desired end," Brown says.



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