



**Oregon's Health Reform Experience:  
Coordinated Care Organizations and  
How Behavioral Health can save Health Care Reform**

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Creating America's healthiest community, together.

- What are Coordinated Care Organizations (CCO)?
- Why and how are CCOs being created?
- How will CCOs achieve the Triple Aim?
  - *Better care*
  - *Better health*
  - *Better value*
- Current Initiatives and Early Successes
- How psychologists have played an integral role in their success

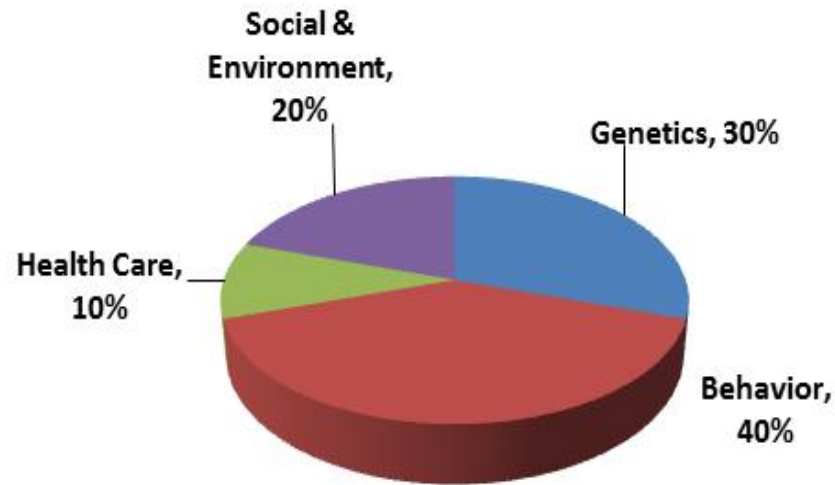
- Improving the U.S. health care system requires simultaneous pursuit of three aims: *better care, better health, better value*.
- Requires the existence of an organization (an “integrator”) that accepts responsibility for all three aims for that population.
- The integrator’s role includes:
  - Partnership with individuals and families
  - Redesign of primary care
  - Population health management
  - Financial management
  - Macro system integration



- Tunnel vision focus by those with the money that medical care is the solution to the health crisis in America
- Inadequate effort by behavioral health and human service leaders to move outside their “silos of excellence”
- The inability of both groups to create integrated and accountable systems of care that include health, behavioral health and human services.



# Why they are elephants...



## What Determines Health?

Source: New England Journal of Medicine: We Can Do Better - Improving the Health of the American People, September, 2007

- We spend \$2.8 trillion per year on health care.
- 75% of this spend is used to treat chronic health conditions (definition of “sick care system”).
- Working together, we can push \$ further upstream to create a true “health system”.

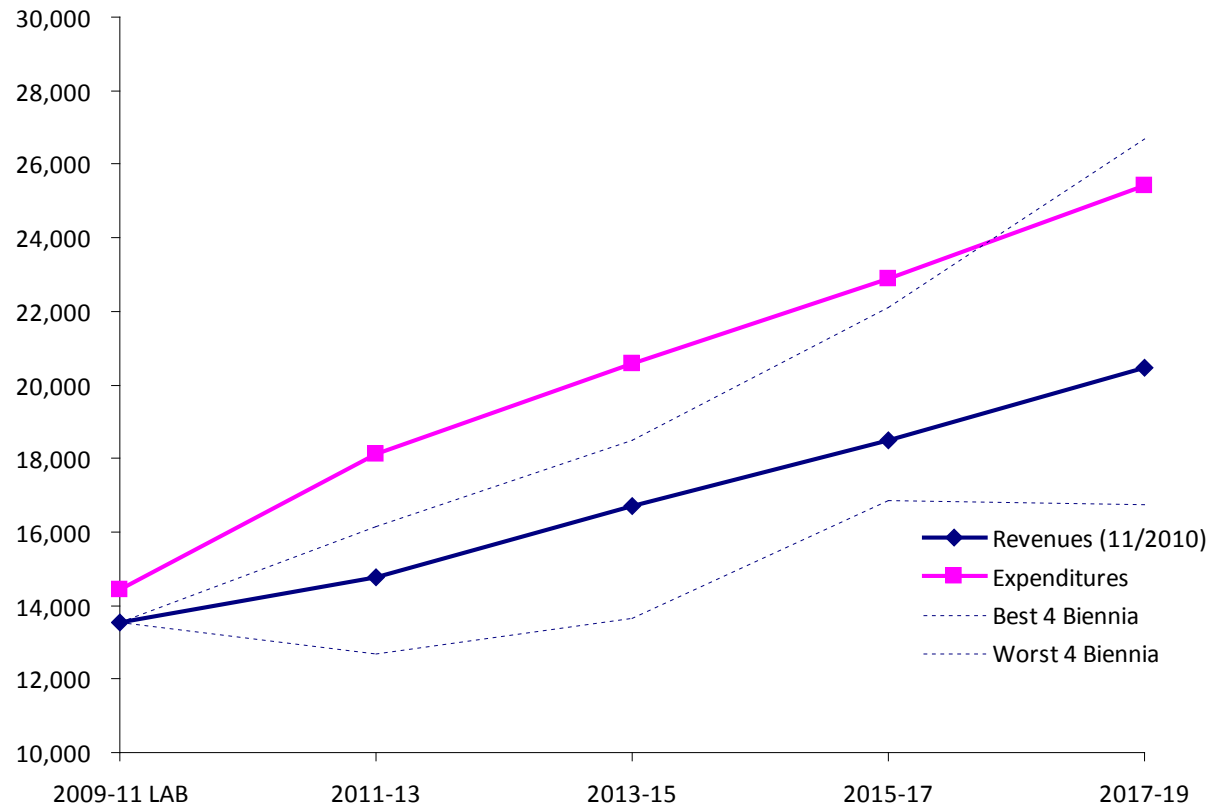
- The future of health lies not in *medical care systems*, but in locally designed and operated systems of care that address the **whole health** of individuals, families and communities.
- Organized around **one-stop health and wellness centers**, supported by **health neighbors**, and sustained by accountable care organizations.
- These **health and human service** partners are delivering integrated and accountable care supported by payment reform.



Nadine Burke at her San Francisco clinic. Photograph by Alessandra Sanguinetti.



# Oregon's budget realities



- SB 1580 became law in 2012, laying the foundation for CCO development with aggressive timelines
- \$1.9 billion in Federal funds over 5 years to support healthcare transformation efforts
- Agreement with federal government to reduce projected state and federal Medicaid spending by \$11 billion over 10 years
  - Oregon will lower the cost curve by two percent over the next two years or face stiff penalties





## Savings:

- 2% reduction in per capita Medicaid trend
- Baseline is calendar year 2011 Oregon spend
- Trend 5.4% as calculated by OMB for President's Budget
- State to achieve 4.4% by end of year 2 and 3.4% there after.
- No reductions to benefits and eligibility in order to meet targets
- Financial penalties for not meeting targets

## Quality:

- Strong criteria
- Financial incentives (sticks and carrots) at CCO level

## Transparency and workforce investments

**A local network of all types of health care providers working together to deliver care for Oregon Health Plan clients.**

**Care is coordinated at every point – from where services are delivered to how the bills are paid.**

**16 CCOs now up and running, accounting for 90+% of Medicaid population**

Benefits and services are integrated and coordinated

One global budget that grows at a fixed rate

Metrics: standards for safe and effective care

Local accountability for health and budget

Local flexibility

# Who is impacted in Central Oregon?

- 35,000 Medicaid (Oregon Health Plan) beneficiaries in Deschutes, Jefferson, Crook, and part of Northern Klamath and Lake counties, predicted to grow to 52,000 by 2019
  - 150 miles north to south
- 200,000 residents, expected to grow to 250,000 by 2019
- Approximately \$120m coming into the community
- Oregon Health Plan (Medicaid) beneficiaries only, in 2012
- Inclusion of additional State sponsored health benefits programs in the future (Public employees)
- Potential implications on non-Medicaid lines of business in Central Oregon

## How will we be paid?

- Pay for outcomes
- Shared savings and gain-sharing agreements
- Case Rate bundles
  - *Do increased outpatient visits reduce hospitalizations?*

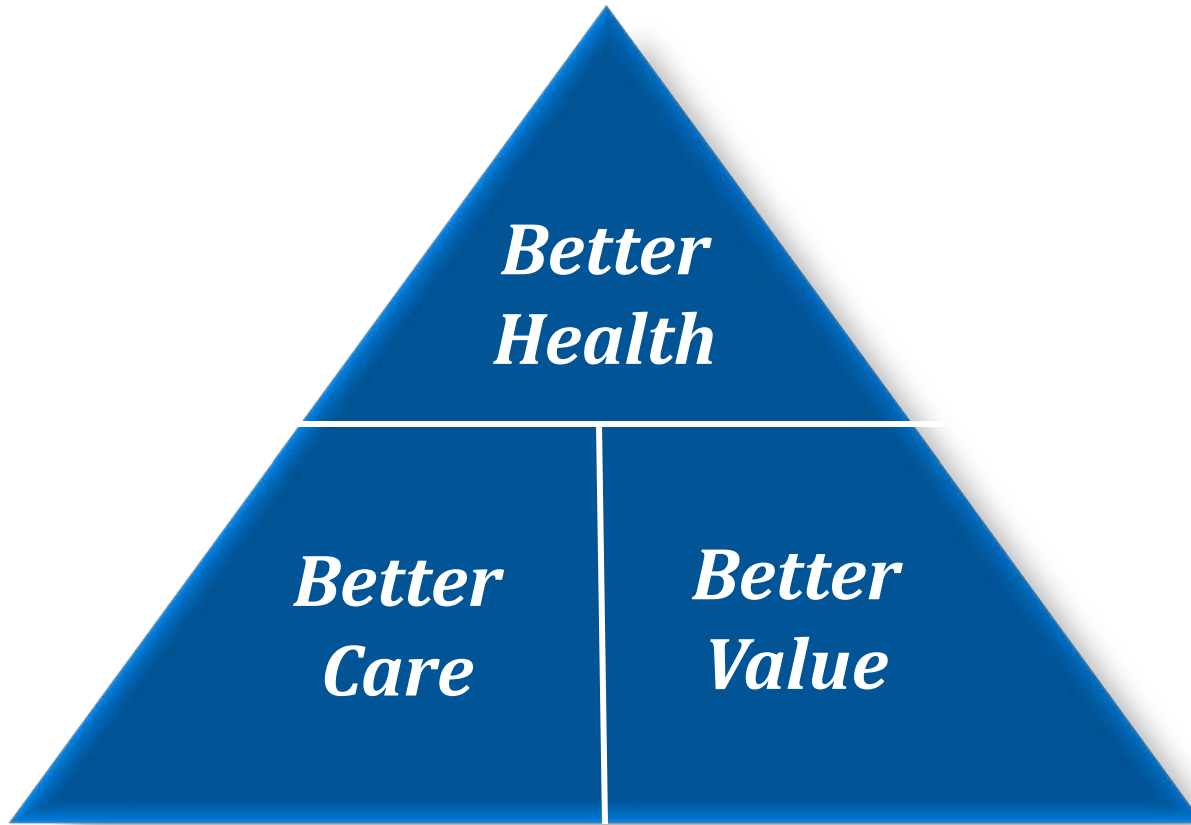
## Traditional big dogs changing:

- Hospitals become the cost centers rather than profit centers
- Insurers become facilitators of care rather than barriers to care

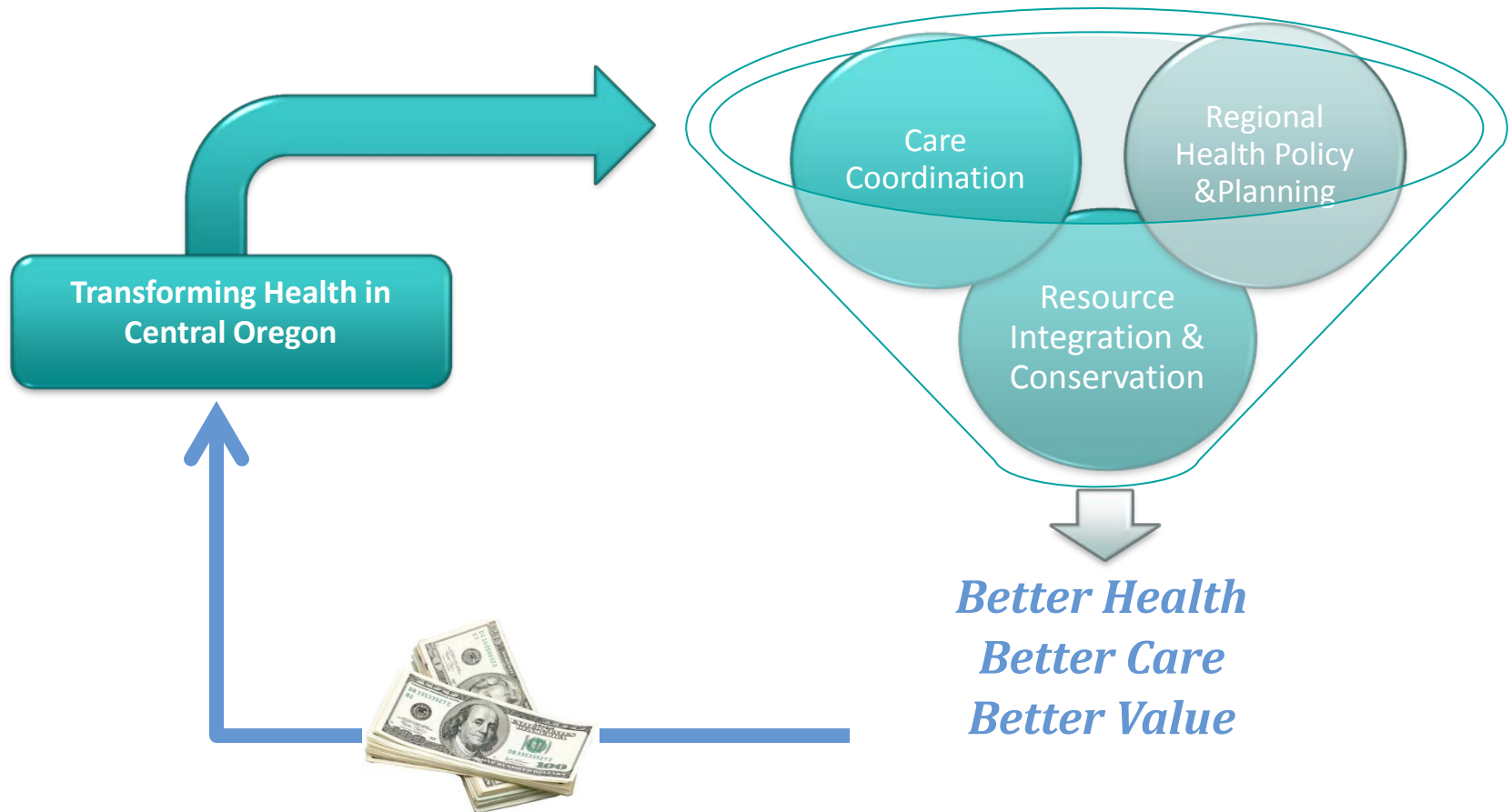
## Goal: Value-Based Payment System

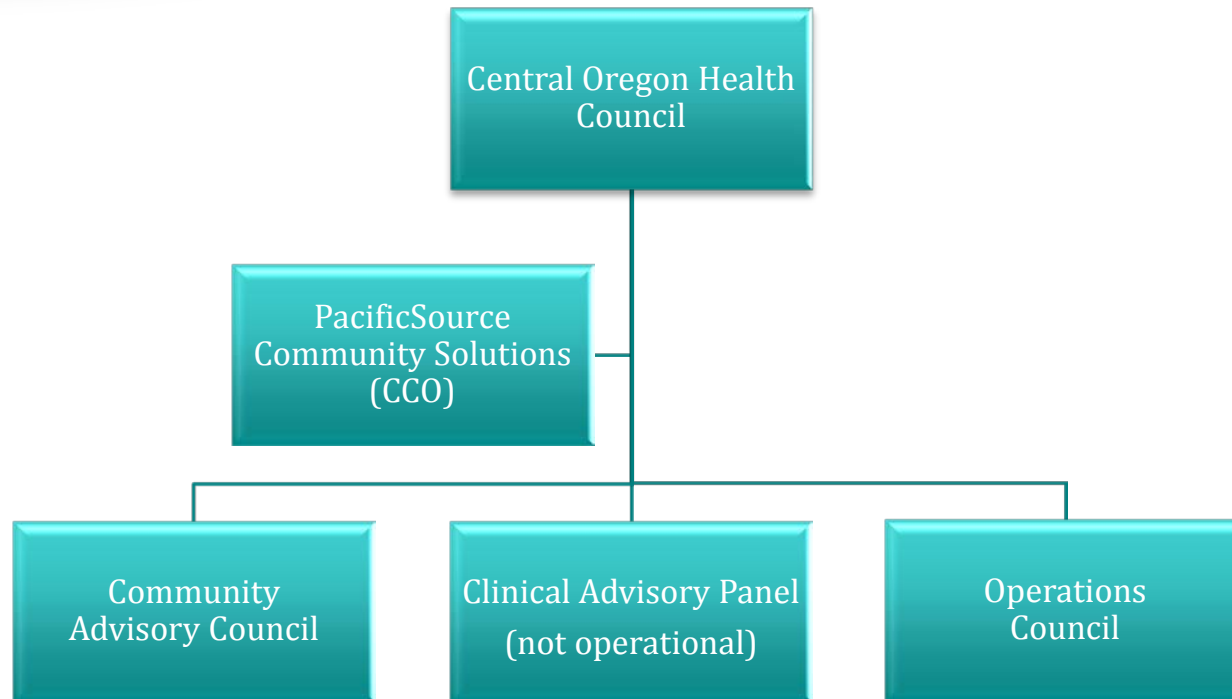


# Vision: The Triple Aim



Creating America's healthiest community, together.





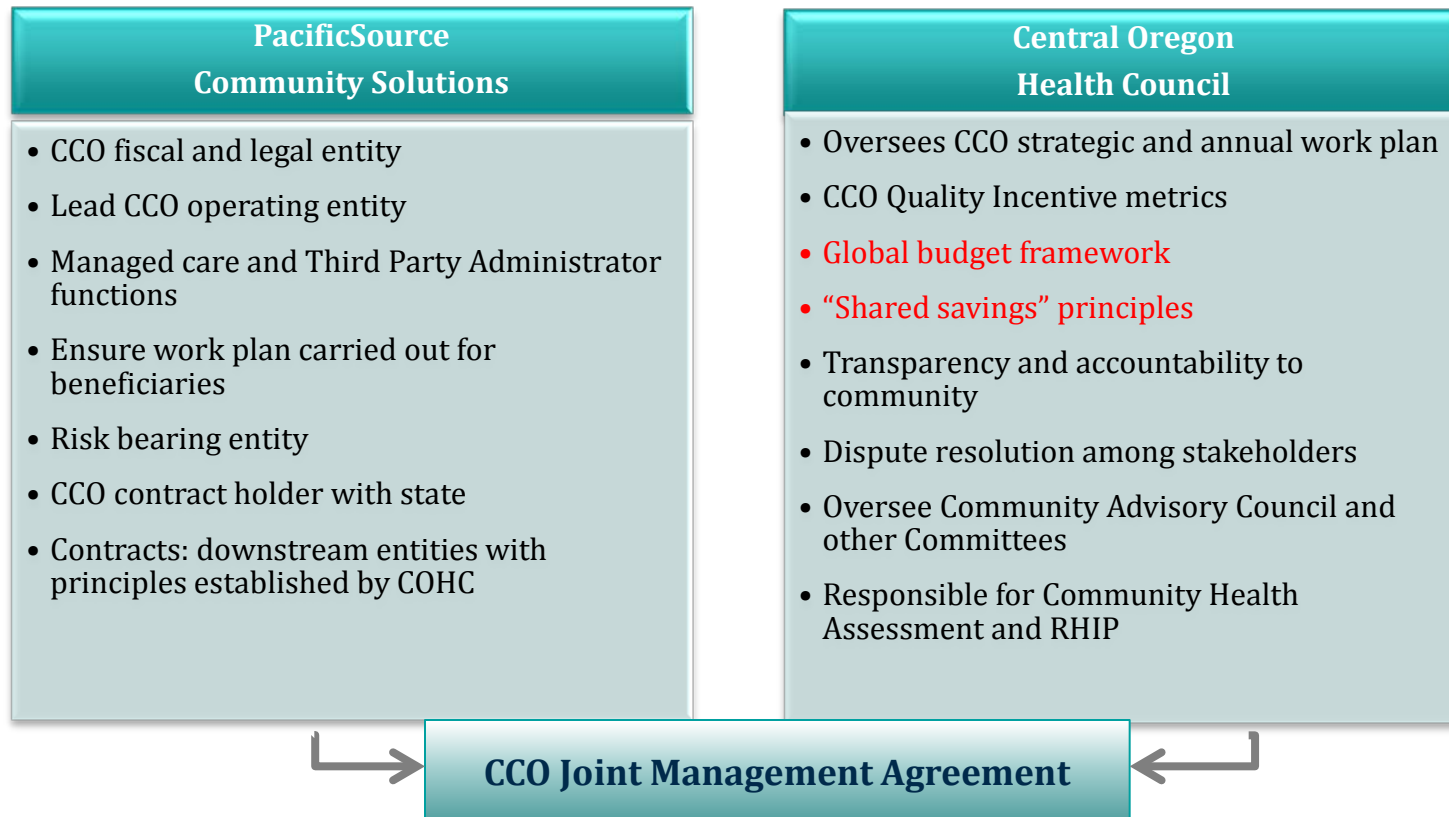
The COHC is the governance body of the CCO. The Councils of the COHC report to the COHC and are advisory to the CCO.



- Governance
  - CCO Board—9 of 12 members are risk bearing
    - *Through contract arrangements*
  - COHC meetings are public
    - *Executive Session only for personnel matters*
  - Materials posted on website
  - Always allow for public testimony
  - Open to the press
  - All voting members are EQUAL



# Roles and Responsibilities



## Primary focus has been on initiatives

- COHC can get granular in operations

## Communication can be challenging

- Many at Oregon Health Authority are not aware of unique structure
- All CCO communication goes to the CCO

## What is the role of governance?

- Global Budget
- Shared Savings
- Transformation

- CCO
- Education (K-12)
- Emergency Services
- Health Services Director--  
Deschutes
- Health System
- HIE/EHR
- Indigent Care
- Long Term Care
- Mental Health Director--Crook
- Mental Health Director--Jefferson &  
Chemical Dependency
- Obstetrics
- Oral Health
- Pediatrics
- Primary Care
- Public Health Director--Crook
- Public Health Director--Jefferson
- Safety Net clinics (FQHC/RHC)
- Multi-Specialty Care

## Implement the operational decisions of COHC

- Regional Health Improvement Plan
- Strategic Initiatives
- Transformation Plan
- Quality Incentive Measures

Coordination between agencies to reduce duplication of effort and increase collaboration

Oversees workgroups

- More than 50 individuals in regional workgroups

15-17 members

Majority consumers

- Bend
- Redmond
- LaPine
- Culver
- Prineville
- Madras
- Warm Springs
- Sunriver

Chair COHC member

Other representatives

- School District
- Mosaic Medical (FQHC)
- United Way
- Crook County Health Department
- Indian Health Services
- Kemple Dental Clinic
- St Charles Health System
- Full Access

- **Integrated Primary Care Model**
- **Advancing Patient-Centered Primary Care Home**
- **Consistent Alternative Payment Methodologies**
- Community Health Assessment & Annual Health Improvement Plan
- Electronic Health Records & Health Information Exchange
- **Tailoring Communications & Services to Cultural, Health Literacy & Linguistic Needs**
- **Diversity and Cultural Competence**
- Quality Improvement Plan to Reduce Health Disparities
- **Primary Care & Public Health Partnership (COHC only)**

# Quality Incentive Metrics: \$3.3 Million Challenge

- **SBIRT Screenings**
- **Screening for clinical depression and follow up**
- **Poor control of Diabetes HbA1c**
- **Follow up care for ADHD meds**
- **Ambulatory Care utilization in ED and Outpatient per 1000**
- **Colorectal Cancer Screening**
- **Adolescent Well-care visits**
- **Developmental Screenings during first 36 months**
- **Timeliness of prenatal and postpartum care**
- **Mental and Physical health evaluation of children in DHS custody**
- **Elective delivery before 39 weeks**
- **Controlling High BP**
- **EHR Meaningful Use adoption**



## Program for the Evaluation of Development and Learning

- Three years of multi-disciplinary assessments on children with special healthcare needs
- Wait list of more than a year

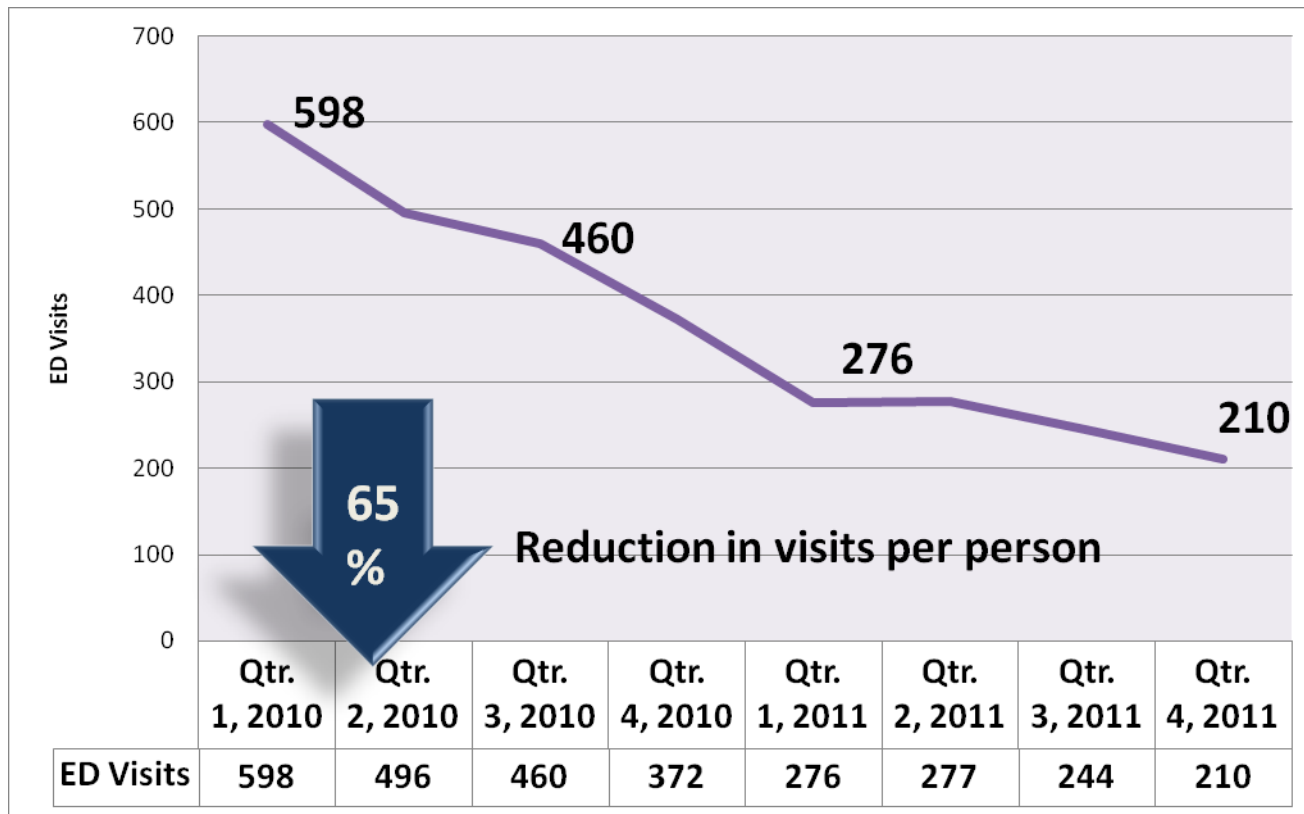
## Neonatal Intensive Care Unit follow up clinic

- Nationally recognized best practice to identify high risk children
- Expanded Behavioral Health Consultants into NICU to reduce length of stay
- First kids are turning four this year

## SCHS: Psychopharmacology Project

- Free generics in safety net clinics
- Legislation in 2013

# Emergency Department Visits per Quarter 2010-2011



- Current Behavioral Health Consultants in primary care
  - Primary Care—3 St Charles Family Care sites
  - FQHCs—3 Mosaic Medical sites
  - Pediatrics—Central Oregon Pediatric Associates
  - Two Critical Access Hospitals
  - Internal Medicine—Bend Memorial Clinic
- Development of consistent metrics to measure outcomes
  - Evaluate efficacy of integrated care models
- Global mechanism for payment

- Behavioral Health Consultants in Person-Centered Primary Care Homes
  - Increased patient satisfaction
  - Increased provider satisfaction
  - Decreased visits with PCP
  - Initial results show trend reduction in spend
- ADHD Medication project
- Chronic Pain Initiative
- Psychopharmacology Consultation
- SBIRT

# Primary Care: Mental Health Home of the (present) future

- **Community Mental Health**
  - Serves 5% of population
  - Primary focus is chronically mentally ill
  - Impact in the global budget: negligible
- **Primary Care**
  - 70% of all primary care visits involve health behaviors
  - Integrated behavioral health movement
    - The primary care provider for mental health
    - Referral mechanism to the specialty mental health

- Psychologist embedded in NICU
  - Early identification of NICU Follow Up babies
  - Early intervention with families
    - Begin training in health engagement from the start
    - Reduce family stressors
  - More consistent than other NICU team members
  - Advocacy
- Early results
  - Reduced length of stay

- Psychologist consult becomes “House Expert”
- Different than a traditional consult/liaison
  - Patient mental health needs
  - Staff mental health needs
    - CISD
    - OD consultation
  - Liaison to Community Mental Health
- Behavioral Health Consultant to rural PCPCH

- Maternal Child Health
- **Behavioral Health/Primary Care**
- **Chronic Pain**
- **Transitions of Care**
- **Complex Care Coordination**
- **Pediatric RN Care Coordination**
- **Integrating Care for Children with Special Healthcare Needs**



- Oregon Legislature approved \$30 million for the 2013-15 biennium to support transformation in the Coordinated Care Organizations across Oregon
  - Central Oregon received \$1.65 million through the Central Oregon Health Council
- Central Oregon Health Council approved a Request for Proposals (RFP) process to stimulate innovation in the community
- All funds must be encumbered by February 1, 2014, but do not need to be spent until July 2015—and must all be spent by then.

- Put the patient first
- Among patient's, put the poor and disadvantaged first—those at the beginning, the end and the shadows of life
- Start at scale—flood the zone
- Return the money
- Act locally

**Make what is possible real**

**American Psychological Association**

[www.apa.org](http://www.apa.org)

**Community Health Improvement Plan**

[www.cohealthcouncil.org](http://www.cohealthcouncil.org)

**Central Oregon Healthy Communities**

[www.healthiercentraloregon.org/](http://www.healthiercentraloregon.org/)

**Collaborative Family Healthcare Association**

[www.cfha.net](http://www.cfha.net)

**St Charles Health System**

[www.stcharleshealthsystem.org](http://www.stcharleshealthsystem.org)