CareOregon: *The Early Years*

1993: A CRUCIAL YEAR IN OREGON HEALTH CARE

Before the implementation of the Oregon Health Plan (OHP), many health care professionals were concerned about the issue of access. Could they be sure that participants in the proposed OHP received ongoing, quality primary care—not just emergency services and hospitalization—as the state migrated from fee for service to full capitation?

Two health care leaders— Billi Odegaard, then director of the Multnomah County Health Department, and Dr. Peter O. Kohler, who served as OHSU's president at the time—ran into each other at a panel to discuss how Oregon Health Plan would affect their organizations. The two compared notes about the importance of the safety net system for Oregon's most vulnerable population and discussed the possibility of a joint venture.

CareOregon Board Meeting – Marlene Building – February 1995

At the time, Multnomah County Health Department (MCHD) focused most of its efforts on primary care, employing many primary care providers. OHSU had limited primary care, but its greatest strengths were its contracted specialists and hospital services. Both provided a safety net to Oregon's most vulnerable population. Together, the two organizations had all the components needed to create a managed care organization that could serve OHP's special needs population. Soon representatives from the two organizations began working together to form what would eventually become CareOregon.

MISSION STATEMENT

April 6, 1994

CareOregon builds on the strength of its participating organizations and strives to: Ensure that members are partners in their care.

WHY WAS CAREOREGON NEEDED?

With 18 percent of Oregonians uninsured, the health care debate was heating up in the 1980s. In 1988, Senate President John Kitzhaber initiated the Oregon Medicaid Priority Setting Project, which laid the groundwork for a prioritized list of health services. After the Health Care Finance Administration (HCFA)—now Centers for Medicare and Medicaid Services—finally approved Oregon's Medicaid waiver request in 1993, the legislature created the Office of the Oregon Health Plan Administrator. The Office of Medicaid Programs (OMAP) issued a request for proposal (RFP) inviting all comers to apply as capitated plans for the new Oregon Health Plan.

Oregon's Federally Qualified Health Centers (FQHCs) convened and put together a response to the OHP called CHCO (Community Health Centers of Oregon). According to Tom Fronk, an early advisor from MCHD and former chairman of CareOregon's board, it soon became clear that CHCO was not going to be successful. It lacked the necessary capital and, except for MCHD, few of the FQHCs had experience with managed care.

MULTNOMAH COUNTY/OHSU COLLABORATION VISION/VALUES (1/3/92)

1. Fully Capitated Health Plan

2. MultiCare and University Hospital Primary Partners. Welcome other private/governmental units. Willing to participate in a relationship to accomplish mutual visions/goals.

3. Develop a new improved model of a community based capitated health plan with emphasis on primary care case management to deliver cost-effective quality care for patients enrolled in health plan.

4. Incorporate training of health care professionals in model.

5. Health care model should strive for the holistic needs of the patient, including social and bio-psychological.

6. Model should strive to improve the continuity of health care in the primary care, specialty and inpatient care of patients.

7. Model should be creative and incorporate a variety of health care providers which provide the highest quality and cost-effective care.

8. The model should have the capacity to facilitate non-Medicaid care in the delivery system depending on funding.

9. Develop a model that responds to culturally diverse populations and clients with special needs.

10. Financially solvent – model administrative systems; best in the state, meet needs of indigent statewide setting a standard for indigent.

11. Build on strengths of organization – cost-effective.

12. Clients are partners in their care – membership services responsive to enhance overall care and sensitivity to each others' need for long-term growth.

13. The model should reflect community based needs assessment and incorporate community participation in development, policy making and management.

Many commercial plans were making applications to the state, and for MCHD, the big question remained: Would these new players eliminate access problems for Oregon's most vulnerable population?

"If the issue of access disappeared, there would be no reason for Multnomah County Health Department to offer primary care," said Odegaard. But Odegaard and her staff at the MCHD had doubts—and decided to play a wait and see game for the next few years.

VISION STATEMENT

April 6, 1994

CareOregon collaborators are committed to building a health plan that is grounded in the community, is responsive to culturally diverse populations and is a model for facilitating health care for all Oregon residents.

Another early CareOregon pioneer and former director of Oregon Primary Care Association, Ian Timm, also had serious concerns about access. The Medicaid capitation rates were based on average costs and didn't include any adjustment for interpretation. "At that time, there were still some private providers who did not think it was important to communicate with low-income patients in a language they could understand," said Timm.

At that time, Multnomah County Primary Care clinics were spending more than $1 million a year on interpreters in more than 20 languages, according to Timm. "OHSU and the FQHCs had also made substantial investments in language and cultural competence to serve the Medicaid population," Timm said. "So there was widespread doubt among safety net providers that the commercial plans entering the Medicaid managed care market were seriously committed to serving the sizeable non-English speaking populations or other difficult to serve populations, such as homeless people and immigrant workers."

MCHD and the FQHCs had also adopted the "health care home" philosophy and used multidisciplinary teams. "The goal was to provide effective primary care to the populations who lacked access in the ordinary medical system," said

Timm. "We were concerned that this infrastructure would be lost in the discounted reimbursement environment common in the commercial insurance plans competing for the Medicaid capitation payments."

"Government should not necessarily compete with the private sector," said Billi Odegaard, but she was determined MCHD would stay in primary practice until they could be sure that it was no longer needed. To help expand its services, MCHD considered aligning with a commercial plan, such as Blue Cross/Blue Shield, but finally, MCHD decided to create its own fully capitated program as a division of the county system. It was still missing the hospitalization component, until Odegaard and Kohler had their fateful talk.

In the days before OHP, OHSU had traditionally served as the statewide safety net hospital for the underinsured. It had a relatively small primary care program and was eager to take an active role in the evolving new capitated system.

According to Sandy Leybold, for the first time OHSU needed to take a more competitive stand in attracting both commercial and Medicaid patients. The challenge was to change OHSU's business model without changing its mission. Together OHSU's and MCHD's strengths and goals seemed a perfect match.

CareOregon Board Meeting – Yeon Building - Spring 1997

THE EARLY DAYS

Mary Lou Hennrich, MCHD's director of primary care, and Jim Walker, OHSU's CFO, began what Hennrich calls a series of tea parties, sitting around a table discussing what form this new MCO should take.

ON OCTOBER 1, 1993, THE ADVISORY BOARD INCLUDED:

Billi Odegaard, Chair Director, MCHD

Bruce Bliatout, Manager, International Health Clinic, MCHD

Patsy Kullberg, Medical Director, MCHD

Jim Walker, Chief Financial Officer, OHSU

Tom Heckler, Chief Executive Officer, University Medical Group, OHSU

Paul Kirk, Chair, University Hospital Medical Board, OHSU

Tom Troxel, Director, Clackamas County Health Department

Mike Herron, Executive Director, Southern Oregon Rural Health Network (OPCA Representative)

Millie Lane, Executive Director, Virginia Garcia Memorial Clinic (OPCA Representative)

CAREOREGON'S FIRST MANAGEMENT TEAM

Mary Lou Hennrich, Plan Administrator

Kathleen Fuller-Poe, Member Relations Manager

Sandy Leybold, Associate Plan Administrator

John Saultz, MD, Medical Director

Ian Timm, Associate Plan Administrator

Karen Maki, Chief Financial Officer

Pam Waldman, Provider Relations Co-Manager

CAREOREGON'S FIRST STAFF AS OF FEB. 1, 1994

Judd Anthony, Office Assistant

Janie Ellison, Member Services

Nita Freeman, Receptionist

Robin Kelly Williams, Member Services Representative

Myrsa Montoya, Provider Relations

Chantay Reid, Provider Services

Carol Romm, RN, Quality Assurance and UR

Genie Uebelaker, Office Assistant

Rick Wagner, Technology/Provider Relations

IT'S NOT YOUR FATHER'S OLDSMOBILE (OR HEALTH PLAN)

- According to Tom Fronk, one of the greatest innovations was bringing in the FQHCs as collaborators at the ground floor. "They were not contractors," said Fronk. "They were full equals at the table."
- "From the very beginning we consciously took the word 'managed' in managed care seriously, in terms of managing toward improved health rather than just being a payer," said Fronk.
- According to Sandy Leybold, the way Multnomah County treated its partner groups on the advisory board was remarkable. Although CareOregon was a legal division of Multnomah County Health Department, all members of the Advisory Board were treated as full partners in the operations. "They always wanted it to be a collaboration," said Leybold.
- The MAC (Member Advisory Council) was another early innovation, based on county and federal qualified health center consumer advisory boards. "We decided it was a little presumptuous of us to [assume we] know what the clients needs were," said Hennrich. "And we wanted to develop things that met their needs, but how could we know without having been in their situation?"
- One of the first innovations was in the treatment of homeless patients due for release from the hospital. In the past, homeless patients stayed in the hospital past the usual discharge dates, because they had nowhere safe and comfortable to recover.

Continued on page 5

The OHSU Foundation gave funds to support development and the County Commissioners promised to back the effort. They began pulling together pairs of medical professionals—one from each side— starting with John Saultz, M.D., OHSU's Family Practice Director, and Patsy Kullberg, M.D., Medical Director for Primary Care for MCHD. Tim Goldfarb, OHSU's CEO of the Health System and Tom Heckler, University Medical Group, also took active roles in the planning process. With a dozen or so participants, the two groups sat down to discuss values.

The first hurdle was perception. Some saw OHSU as isolated on "Pill Hill." MCHD was stereotyped as a dingy government entity catering to indigents. To break down these false impressions, the group began discussing commonalities. Together, they identified the basic values that would drive this initiative.

THE TURNING POINT

In the months to come, the group would continuously return to the value system they'd crafted in the first meeting. Everyone had agreed that the emphasis would be on preventive and primary care, to help members avoid the need for hospitalization. This was especially critical as decisions about funding were made.

"Historically, OHSU gave the lion's share of its money to the hospital, since that was the most expensive piece," said Mary Lou Hennrich. But, it became clear that if the group was going to redesign health care—with the emphasis on preventive care—this

L to R: Carole Romm, RN, Marylou Hennrich, Ian Timm, Pam Waldman, Sandy Leybold, Karen Maki, Kathleen Fuller-Poe

could no longer be the case. They had to ignore the Medicaid actuary's analysis—based on the past—and look to the future. If primary care became the emphasis, hospital costs should drop.

By returning to the defined values, they were able to compromise and redirect greater funds toward primary care.

Early in the development process, Sandy Leybold, newly appointed to OHSU, brought her extensive experience with California MCOs to

L to R: Rick Wagner, Chantay Reid, Nita Freeman, Jane Ellison, Robin Kelly Williams, Myrsa Montoya

the table. When OPCA's Ian Timm, called Kohler and Odegaard to ask if the Federally Qualified Health Centers could join the party, the partnership was complete.

Although initially a division of Multnomah County Health Department, from the very beginning, CareOregon acted almost as an independent organization—with its own advisory board. (See sidebar.) There were three representatives from OHSU, three from MCHD and three from OPCA: Tom Troxel from Clackamas County Health Department, Mike Herron from Southern Oregon Rural Health Network, and Millie Lane from Virginia Garcia Memorial Clinic. OPCA's Timm and OHSU's Leybold, joined plan administrator Mary Lou Hennrich, as associate plan administrators during the months leading up to opening day: Feb. 1, 1994.

WHAT'S IN A NAME?

At the second meeting of the OHSU/MCHD group, they created a workgroup to tackle the issue of a name. Both organizations had PCOs (primary care organizations) already; MCHD's MultiCare and OHSU's University Care. Neither group fancied taking on the other's name, so someone suggested Oregon Care. Pam Waldman, a MCHD staffer, suggested flipping the two words—and CareOregon was christened.

It's Not Your Father's Oldsmobile *continued*

- CareOregon decided to place the newly discharged homeless in a local motel, where they could receive visits from home help nurses and healthy meals. This reduced costs, while avoiding the issue of discharging patients to the streets.
- The purchasing of Healthwise handbooks in English and Spanish was a major step in member education, along with developing information for pregnant moms, the first formulary, physician education and more. These things seem rudimentary now, but were huge in the early days, according to Hennrich.
- According to Leybold, whose experience was more traditional and business-oriented, it was sometimes a strain to adapt to the CareOregon philosophy. "There was more attention to broader social interests, than in a managed care business model," said Leybold.
- Staffing decisions were also less traditional than in the average health plan. Member Services staff were hired for their ability to meet the needs of the clients. They weren't just expected to answer the phones and deal with simple questions. "There was a focus on advocacy and support for vulnerable people that threaded through everything we did," said Leybold.
- CareOregon was the only health plan to ask its claims administrator, ODS, to design its process around the OHP's Prioritized Lists. According to Leybold, most payers just paid for services regardless of whether they were above or below the line. "We believed in the principles of the OHP...and tried to follow the spirit and letter," said Leybold.

On CareOregon's opening day, the Wall Street Journal *called to talk about the Oregon Prioritized List—considered controversial outside of the state. Hennrich tried to explain that the list wasn't the story. Instead, the real story was the fact that they'd brought a university, a county health department, and community migrant health centers together to focus on primary care and prevention, and to manage care and not cost, while remaining cost-effective.*

The first day was a bit chaotic as all members switched from their old plans and Hennrich commented, "It's pretty exciting, but somewhat chaotic. I feel like I have one nostril above the water." Of course, the "nostril" comment was the only quote to make it to the WSJ, which led to the creation of the Golden Snorkel Award. In the early days, the Golden Snorkel became the prize for any staff member facing a particularly challenging task.

The next step was to write a proposal to the state; "They had a huge RFP," said Hennrich. "And wanted it in a ridiculously short period of time," said Leybold. Pam Waldman and Marilyn Streeter, OHSU, took leadership roles in writing the state proposal. "Because we wanted to be so collaborative and no one wanted to say who was in charge, the first proposal was rejected. [OMAP] couldn't figure out who we were."

"No one wanted to say, CareOregon is Multnomah County or CareOregon is OHSU," said Hennrich. But the state wanted to know who would be financially responsible for the funding. [The state wanted to know,] "if we didn't spend it wisely, whose deep pocket they were going to take it out of?"

Early on, the two organizations had agreed that if CareOregon wasn't accepted as a separate entity, ownership should fall to the primary care (MCHD) rather than the tertiary care (OHSU) provider—so MCHD took on responsibility for the new MCO.

SHOW ME THE MONEY

At the beginning and for a number of years to come, OHSU took all financial risk for hospitalization—which, according to Leybold, shows the measure of OHSU's commitment and contribution to the fledging operation.

Billi Odegaard was charged with convincing the Multnomah County board that it was safe for Multnomah County to take on the risk for primary care. Gladys McCoy, then county board chairman, agreed. But before CareOregon's state application was approved, McCoy died, leaving a giant question mark for the future.

There was no county chairman of the board and no assured commitment to CareOregon. Beverly Stein, who eventually became the new board chair, had serious concerns about Multnomah County taking on the financial risks for patients from other counties. "But she took a leap of faith," said Hennrich. Hennrich is quick to point out, however, that Stein wasn't acting on faith alone. First, she had the budget office and legal department research the proposal thoroughly to ensure that it was a safe venture.

The county board agreed not to interfere with the day-to-day management of CareOregon—leaving oversight of management to the advisory board.

Tom Fronk, who worked in MCHD's fiscal office, worked with the county budget office to have CareOregon designated as an enterprise

fund. This allowed CareOregon to be run as an independent business from the beginning. "We never took any general ledger funds," said Hennrich. "From the very beginning we were planning on how to spin it off to [become] a non-profit organization."

OFF AND RUNNING

On Nov. 1, 1993, CareOregon's new staff moved into office space loaned by OHSU in the Crown Plaza Parking Building, and on Feb. 1, 1994, they began serving their first clients. On that

L to R: Tom Heckler, John Saultz and Bruce Goldberg

date, all University Care and Multi Care PCO members switched to CareOregon and there were 10,000 clients on the rolls. In the months leading up to CareOregon's opening day, Hennrich, Leybold and Timm worked as a management triumvirate, but in February, Hennrich took on the role of executive director. Leybold continued to support CareOregon part-time, moving between CareOregon and OHSU for the next few years. Initially, Timm worked half-time as CareOregon associate plan administrator while acting as advisory resource to OPCA. Eventually he returned to his full-time role as OPCA's director.

In the early days, working on leftover furniture provided by OHSU's dental school in a tiny office, everyone pitched in to do the most basic functions. University and county volunteers would help stuff envelopes with member handbooks. "One of the biggest challenges and gifts was taking something from just a thought into really making an organization and watching it grow," said Hennrich.

For all of the early staff and board members, the primary goal was to continue to grow, while maintaining the focus on client needs and concerns, according to Hennrich. While the staff and advisory committee greatly appreciated Multnomah County's financial and moral support, there came a time when it made more sense to become an independent entity. And, according to Fronk, it made sense to get the risk out of the county.

It was also important for CareOregon to have the freedom to develop financial and human resources departments that tracked more closely with the business/health plan/insurance world, than with government. County requirements to use public purchasing rules, government-based salary and recruitment methods, and inappropriate accounting procedures made it "a horrible mismatch," said Fronk.

Leybold, who had returned to OHSU, was brought back to oversee the transition and, on April 1, 1997, CareOregon Inc., spun off from Multnomah County and became a fully independent non-profit organization.

Today, CareOregon continues as an independent non-profit, serving almost 100,000 Medicaid and Medicare members. The once tiny staff now numbers over 200. While the intervening years have seen many developments and innovations the vision has never changed. CareOregon remains committed to ensuring Healthy Oregonians regardless of their income or social circumstances. Our mission today: To assure Oregon's vulnerable populations receive access to high quality healthcare from a stable network by a well managed, financially sound organization.

EARLY LOCATIONS IN PORTLAND, OREGON

1994: Crown Plaza Parking Lot Bldg.

1995: Commerce Building on Fifth Ave.

1999: 522 SW Fifth Ave.

2005-2007: 315 SW Fifth Ave.