Columbia Pacific CCO

Creating Health Together

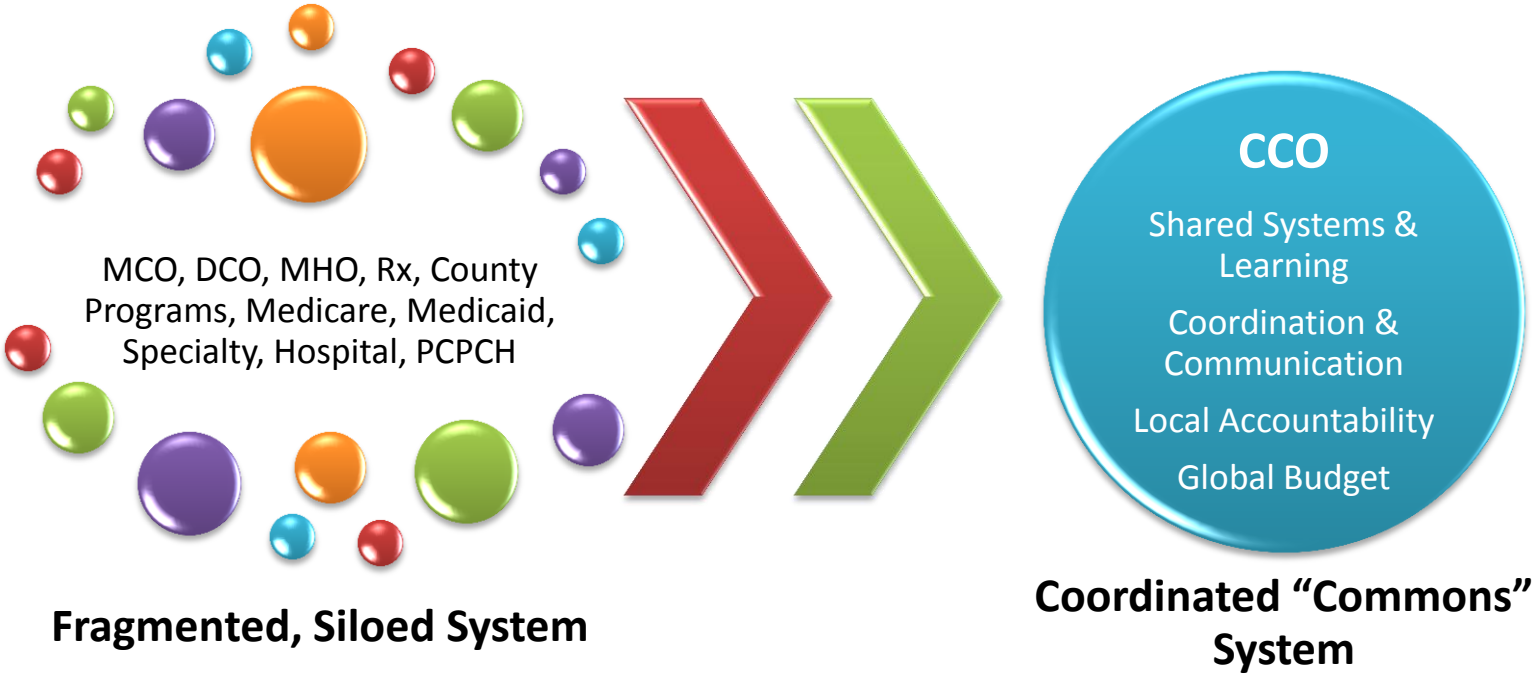
Columbia Pacific Coordinated Care Organization Background and Overview

Presentation for Coordinated Care Model Summit

CCO 101 Breakout Session, December 3, 2014

What is a Coordinated Care Organization?

- A CCO is a single organization that accepts responsibility for the cost of health care within a global budget and for delivery, management and quality of care delivered to the specific population of patients enrolled with the organization.

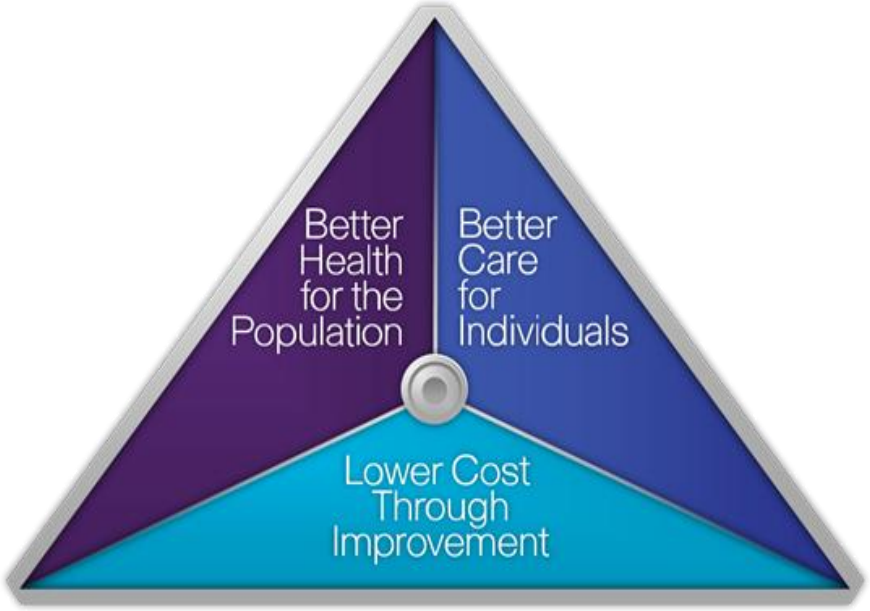


Fragmented, Siloed System

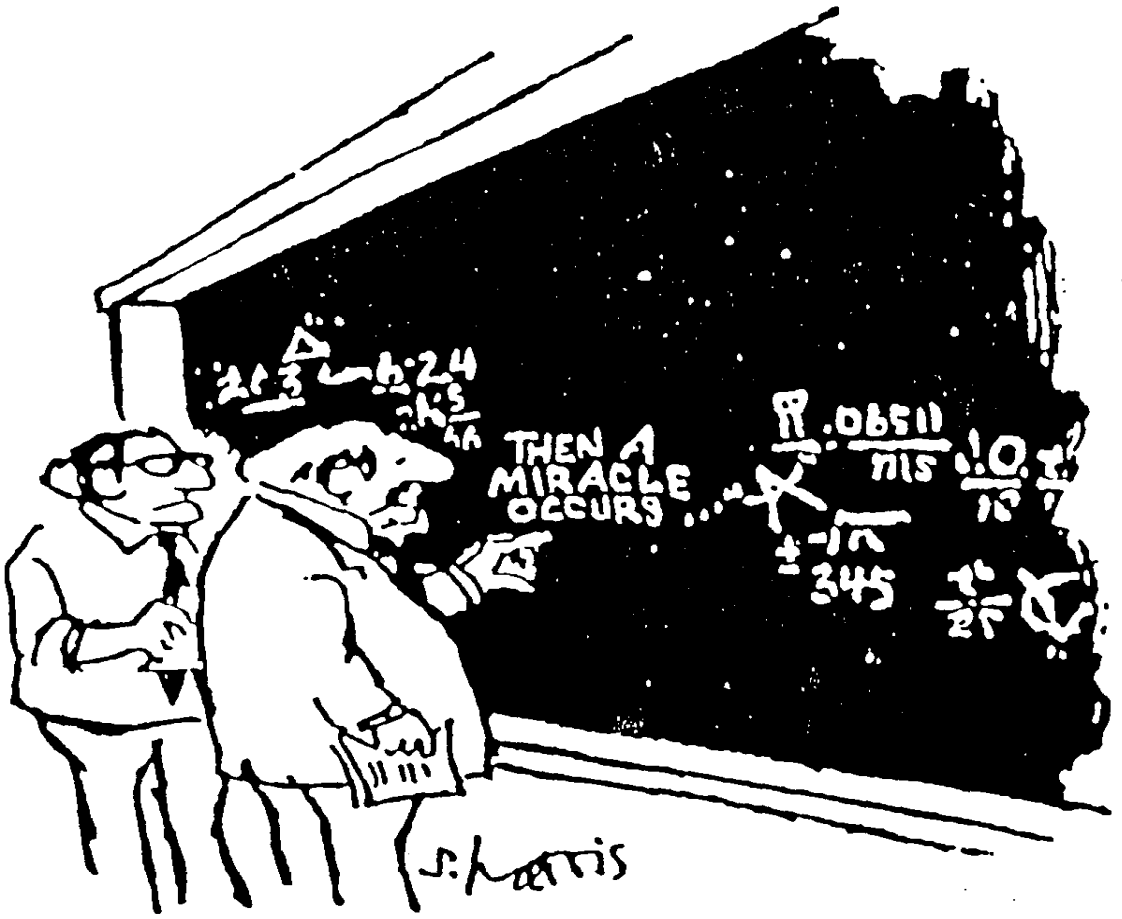
Coordinated "Commons" System

The Objective Behind CCOs

Making the "Triple Aim" Possible



Challenge → Opportunity



"I think you should be more explicit here in Step two."

Columbia Pacific CCO:

- A start-up, rather than migration of existing MCO
- Wholly owned LLC of CareOregon
- Strong partnership with Greater Oregon Behavioral Health, Inc. (GOBHI)
- Four-county Board, anywhere between 15 – 20 Directors
- Four local Community Advisory Councils
- Single multi-disciplinary Clinical Advisory Panel (considered optional)
- Sept 2012: 7,000 members → November 2014: 25,500 members

A few minimum standards to evaluate CCO transformation

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Deliver a health care model that **integrates** behavioral, medical, oral health (and other services)

Develop **alternative payment methodologies** that reward health outcomes

Conduct a community health assessment and adopt a **community health improvement plan**

Invest in electronic health records, **health information exchange**, shared care plans

Meet **culturally diverse needs** of members met, including new health workers who reflect member diversity

Transformation Priorities

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Opiate addiction → Pain Management Clinics, with behavioral supports in addition to medical

Social determinants →

- Healthy Homes assessments for patients with respiratory illnesses and falls risk
- Health outreach workers (Health Resilience)

Provider shortages →

- Primary Care Learning Collaborative
- Telehealth and provider upskilling (psych, derm, neuro)

Alcohol/drug addictions → Local detox services

Incarceration → Crisis respite programs

Stigma → Co-locate behaviorists in primary care

Polypharmacy → Clinical pharmacists

Influence Factors on Health Status

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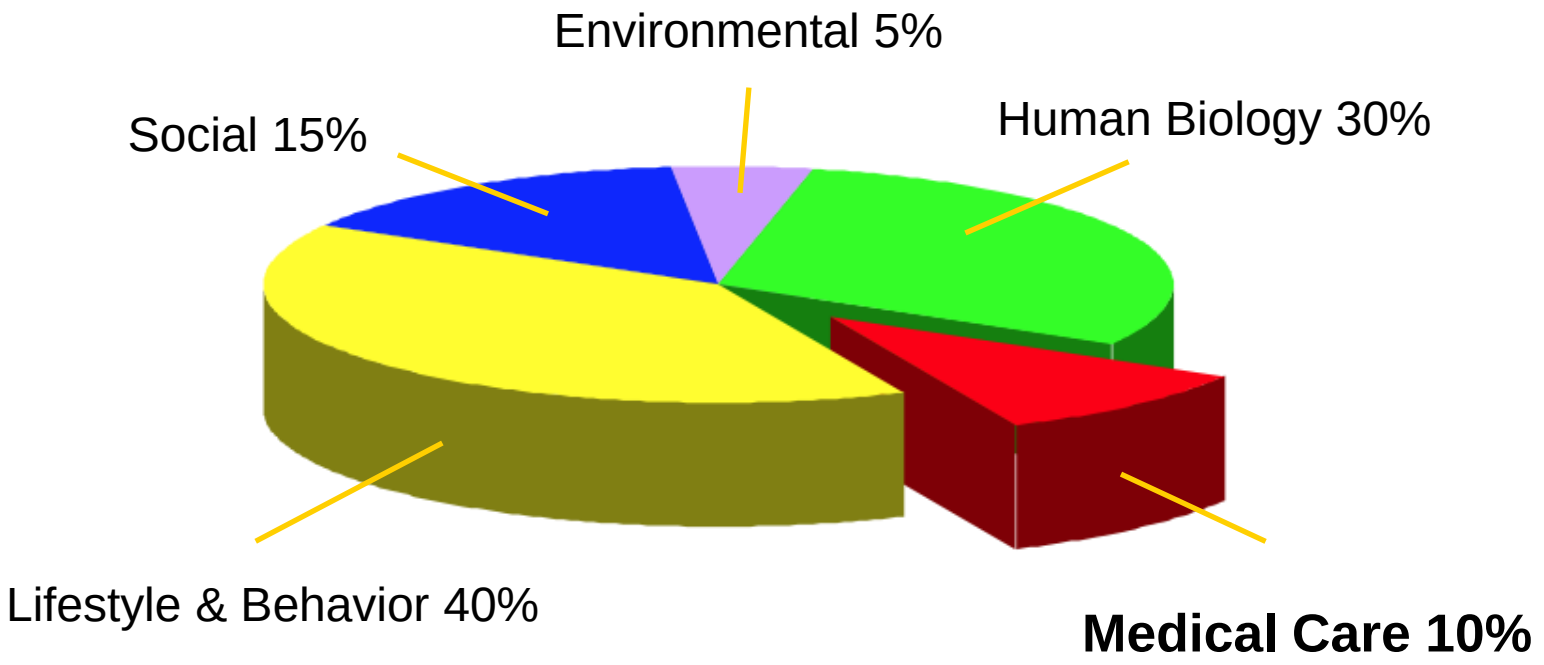

Source: McGinnis J.M., Williams-Russo, P., Knickman, J.R. (2002). Health Affairs, 21(2), 83

Challenges:

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- Funding silos and billing rules
- Parallel payment models
- “Pig in the Python”
- Provider shortages
- Moving metrics
- Data depth

- **Focus on health care, rather than health**

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Discussion and Q & A