As a family medicine physician, and as board chair of your community-owned hospital, I am intensely aware of how US healthcare is changing. But the real impact is on the other side of the stethoscope—the patient’s side.

In the first six months of 2014, South Coast enrollment in the Oregon Health Plan grew to more than 21,000—up from the previous 12,000. That means 9,000 of our neighbors suddenly have health insurance. Many of them can finally afford to address medical problems they have lived with for years.

That’s huge. Equally huge is the change in how we organize and deliver healthcare and how this change can help all of us live healthier lives.

At Bay Area Hospital, we like to say that our mission is to improve our community’s health every day. Now more than ever, that mission goes far beyond taking care of you when you are sick.

This issue of Currents looks at the emerging concepts of coordinated care and population health management. This new philosophy focuses on primary care and prevention to keep people healthy. It is a far more effective and economical model than old-fashioned “sick care.”

Here on the South Coast, healthcare providers have united to create Western Oregon Advanced Health, one of 16 Coordinated Care Organizations leading Oregon’s healthcare transformation. I am proud of how our local medical community has stepped up to provide primary care access to the 9,000 new patients. In some other Oregon communities, meeting the increased demand for care has been a major problem.

I am also proud of how Bay Area Hospital has stepped up to enhance the health of the whole South Coast. Programs such as community education and chronic disease management are laying a foundation for a healthier community in the years to come.

You will be excited to learn how the transformation is already under way on the South Coast—and how it is already affecting your neighbors. I hope you will join in this transformation and seize this historic moment as an opportunity to improve your own life, perhaps by eating better, exercising a little more, or giving up tobacco.

Improving the health of our community is a big undertaking. It needs and deserves everyone’s participation.

Tom McAndrew, MD, MPH
On the Cover

Through new OHP coverage, Chris received the care he needed. Read Chris’ story on page 4.

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Like many uninsured Americans, Rebecca Garza skimped on medical care, leaving her tonsillitis untreated for years. “When you don’t have coverage,” the 29-year-old Lakeside woman says, “it’s like, Do I really need to go to the doctor for this? Do I need another bill?”

Christopher Stewart’s doctor told him the tumor on his neck probably was not cancer. Probably. Christopher needed an MRI (magnetic resonance imaging) scan to be sure. But with a wife and two children to support, the 31-year-old Coos Bay cook couldn’t afford one. “I was kind of freaking out,” he says. Today Garza and Stewart are among 200,000 Oregonians newly covered by OHP—the Oregon Health Plan, our state’s version of Medicaid. Both are getting the care they need with no out-of-pocket cost. Best of all, an MRI confirmed that Stewart’s tumor is benign and is not growing. “The whole insurance thing is awesome,” Stewart says.

This year’s expansion of OHP eligibility is a life-changing event for newly enrolled patients. It is also a challenge for Oregon’s healthcare system.
“People who have medical insurance use more services,” says Theresa Muday, MD. That puts a strain on doctors—especially primary care providers, who are squeezing more patients than ever into their hectic schedules.

Dr. Muday is medical director for WOAH (Western Oregon Advanced Health), which administers OHP in Coos County and part of Curry County. WOAH’s previous enrollment of 12,000 patients has swollen to more than 21,000 since January. Physicians in some parts of Oregon have responded to the influx by turning away OHP patients, preferring to treat patients with private insurance. Not so in Coos County, where doctors have a long tradition of treating all comers.

Dr. Muday says the philosophy here is, “We have to step up and take care of our community.”

The heaviest burden falls on primary care physicians—the internists and family practitioners who provide each patient a “medical home.” Before this year, the average primary care doctor in Coos County served 200 OHP patients in addition to patients with Medicare or private insurance. Local physicians now average 300, and some doctors have gone even further.

One standout is Dallas Carter, MD, who voluntarily increased his OHP roster to 350 patients. Dr. Muday calls him “an incredible leader.”

Dr. Carter says his new OHP patients tend to be members of the so-called working poor, struggling for financial survival in jobs that do not provide health benefits. Like Christopher Stewart, they are grateful to have coverage at last.

As a group, Dr. Carter says, they tend to be relatively healthy, and they seem to be absorbing fewer medical resources than expected. But going years without health insurance means many arrive with long-untreated problems, such as ailing gallbladders, bad knees, and diabetes.

Kent Sharman, MD, recently saw a patient who had not been to a doctor in 10 years. A simple blood pressure check revealed hypertension, which is easily treated with a daily pill. That patient illustrates a key goal of expanding coverage, Dr. Sharman says. With his blood pressure under control, the man remains a healthy, employable community member. Untreated, he would be at risk of a disabling stroke, potentially burdening his family and taxpayers. “It’s a snowball effect if he gets sick,” Dr. Sharman says.

The same principle guides Oregon’s healthcare initiative: spend money on preventive medicine now and avoid costly illnesses later. “That’s the grand plan,” Dr. Muday says. “Our end product really is supposed to be a healthy community.”

Will it work?

“The jury, I think, is still out,” says Paul Janke, chief executive officer of Bay Area Hospital. “Just because people have health coverage, does that mean they’ll have better health?”

Other unanswered questions are: How much of the current increase in patient volume is temporary? Will demand for care subside as doctors whittle down the backlog of untreated ailments? Dr. Muday says that no one knows.

The South Coast, with statistically high levels of both poverty and chronic illness, may be an ideal laboratory for studying such questions. Rebecca Garza, however, already knows her own answer: “I’m just happy to have treatment,” she says.
Knee-Deep in Gratitude for Joint Surgery

Patti Sommer’s bad knees ended her teenage dream of swimming in the Olympics. Later they kept her from being as active a mom as she would have liked. "My kids were used to having a mom who didn’t do much with them when they were growing up," she says.

That’s going to change. Sommer, 53, has a new left knee and plans for a right one. The surgeries are possible because of this year’s expansion of OHP (Oregon Health Plan) eligibility.

Sommer works part-time as a circuit coach at a health club. She also designs jewelry and helps in her husband’s construction business. But despite those efforts, the Sommers could not afford health insurance. A couple of years ago, they were quoted a rate of $800 per month just for Patti.

Her left knee went from bad to worse in 2013 on Easter. At a church potluck, a little boy collided with her while running to an egg hunt. After that, she says, “It was excruciating to walk.”

Sommer is typical of many patients newly covered by the expanded OHP. Doctors say many of the new patients arrive with long-untreated health problems such as diabetes and worn-out joints.

Orthopedic surgeon Jason Bell, MD, performed Sommer’s surgery in July. Physical therapy followed. Now Sommer is preparing to lead an October campout with her church’s troop of American Heritage Girls. And someday, when grandchildren eventually arrive, she plans to be a mobile, active part of their lives.

“That’s one of the things that’s going to please me,” she says.

HEALTHCARE COVERAGE

Staying Informed

What Is Changing

As of January 2014, new rules brought more low-income adults into the OHP (Oregon Health Plan). Coverage is now available to people who earn up to 138 percent of the federal poverty level—that’s about $16,100 per year for a single person or $32,900 for a family of four.

In the first six months of this year, 200,000 Oregonians signed up for state-funded coverage through CCOs (Coordinated Care Organizations).
What It Means

The upside? More low-income Oregonians now have better access to care, more financial stability, and less debt to healthcare providers. The downside? An influx of newly insured patients is straining healthcare providers, especially primary care physicians.

Glossary

Understanding the changes in Oregon healthcare is easier if you know the lingo. The following are some commonly used terms and abbreviations.

Population Health Management
Healthcare in the United States has begun to emphasize improving the health of an entire human population. These efforts address social, cultural, economic, and physical factors that may affect people’s health. On the South Coast, these factors show up in high levels of tobacco addiction, diabetes, obesity, cancer, and other chronic conditions.

OHP The Oregon Health Plan is Oregon’s version of Medicaid, which provides medical coverage to low-income Americans. (Medicaid is not to be confused with Medicare, which covers senior citizens.)

OHA The Oregon Health Authority is the state agency in charge of OHP and other healthcare programs.

CCO Coordinated Care Organizations manage the OHP at the local level. Each CCO serves a different geographical area, coordinating healthcare providers to serve patients receiving Medicaid coverage under OHP. CCOs focus on prevention and helping people manage chronic conditions such as diabetes. Each CCO is accountable for the health outcomes of the population it serves, with scores posted publicly four times per year. CCOs were created as part of Oregon’s implementation of the federal Patient Protection and Affordable Care Act, also known as Obamacare.

WOAH Western Oregon Advanced Health, previously known as Doctors of the Oregon Coast South (DOCS), is the CCO for Coos County and part of Curry County. It serves about 21,000 South Coast residents.

Triple Aim The federal government’s Centers for Medicare & Medicaid Services dictates three goals for healthcare improvement: better care, better health, and lower costs.

To Learn More

Oregon’s healthcare transformation initiative: www.oregon.gov/oha

Quality scores: www.oregon.gov/oha/Metrics/Pages/ccos.aspx
When state authorities deliver a child to foster care, they deliver mysteries as well: Has the child been immunized? Does the child have a chronic medical condition or any drug allergies?

Children taken into state custody rarely bring along their medical records, and the resulting riddles hamper attempts to care for them. In Coos County an innovative project provides some answers. Two mornings a month, Carla McKelvey, MD, takes over an exam room at Waterfall Community Health Center. She conducts a quick exam and reviews whatever records are available.

The program is called FEARsome, short for Foster Education and Resources. Although it does not directly provide healthcare to kids, it delivers information to foster parents and organizes future care.

While Dr. McKelvey reviews the kids’ physical health, a Waterfall counselor evaluates them for developmental, psychological, and behavioral issues. And before each child leaves, an assistant makes an appointment for the child with a primary care physician.

Down the hall Dane Smith, DDS, works in Waterfall’s dental exam room. It is purely painless dentistry: Dr. Smith looks at teeth, reviews records, and refers each child to a private practice that will provide treatment.

Providing prompt health assessments for foster children is one of 17 incentive measures the state requires Coordinated Care Organizations to meet. Each measure requires choreographing the efforts of independent healthcare providers and institutions, with the overall goal of a healthier community.
Oregon grades its CCOs (Coordinated Care Organizations) on 17 incentive measures that track improvements in patient care. State payments to CCOs are based partly on these measures:

- Adolescent well-care visits
- Substance abuse screening
- Emergency department visits
- Colorectal cancer screening
- Controlling high blood pressure
- Developmental screening before age three
- Diabetes control
- Early elective delivery
- Electronic health record adoption
- Follow-up after hospitalization for mental illness
- Follow-up care for children prescribed ADHD (attention-deficit/hyperactivity disorder) medication
- Mental and physical health assessments for children in state custody
- Patients with primary care “medical homes”
- Timeliness of prenatal care
- Patient satisfaction with access
- Screening and follow-up plan for depression
- Patient satisfaction with care

Full-term pregnancies produce healthier newborns

No one is too young to participate in Oregon's healthcare transformation. You don’t even have to be born yet!

One statistic monitored by the Oregon Health Authority is “early elective delivery.” It counts the number of babies born early because of induced labor. Once commonplace, early elective delivery has virtually disappeared at Bay Area Hospital.

“It’s probably one of the best things we have done for our clientele in the past decade,” says Susan Chaney, RN, CNM, who manages the hospital’s Family Birth Center. “I think it improves outcomes for babies.”

Pregnancies used to be considered “term” if they lasted anywhere from 37 to 42 weeks, but obstetricians nationwide have changed their definitions. Now a baby born between 37 weeks and 38 weeks, six days is considered “early term.”

To be classified as “full term,” a baby needs a full 39 weeks.

Chaney welcomes the change. She says babies born in the 37-to-38-week range are more likely to have trouble feeding, and their blood sugar may be unstable. They may even have immature lungs. “That’s rare, but if it’s your baby who ends up in the NICU [Neonatal Intensive Care Unit], that matters.”

Doctors often felt pressured by their patients to induce early labor for a variety of reasons: a rural family living far from the hospital, a dad being deployed with the military, or a mom desperate for relief from the increasing discomfort of pregnancy. But almost two years ago, spurred by a recommendation from the state hospital association, Bay Area Hospital banned the practice. Now it is allowed only when medically necessary.

“I think overall our physicians feel like this is an extremely positive change,” Chaney says.
A nurse embarks on an unusual quest to help her patients.

The boxes were stacked higher than Linda Mill’s head. UPS had delivered 324 bathroom scales, each destined to help a heart failure patient follow a treatment plan. But first Mill had to find storage space.

Heart failure is a chronic condition in which the heart pumps too little blood to meet the body’s needs. It is serious and usually incurable, but its symptoms can be managed. Mill, a registered nurse who leads Bay Area Hospital’s Strong Heart program, helps heart failure patients make lifestyle changes that will keep them feeling good—and out of the hospital.

“My job is to give them a choice,” she says.

Mill’s work is part of an increasing emphasis in US healthcare. Healthcare leaders hope that managing chronic diseases outside the hospital will result in a healthier population and lower costs for everyone. The scale project illustrates the creative spirit driving the trend.

Strong Heart teaches chronic heart failure patients about diet, medications, physical activity, and how to keep a daily log of their health. Tracking their weight each day is part of the routine.

Mill was surprised to learn that obtaining a bathroom scale was difficult for many of her patients. Some had limited incomes; others lacked energy for shopping. For a heart failure patient, walking just a few steps can trigger chest pain and shortness of breath, so Mill and her co-workers started raising money for scales. A local motorcycle group helped raise $2,000 this year with a poker run, and Mill stretched the money by finding digital scales online for just $6.15 each. Ordering two at a time qualified for free shipping, which meant 162 separate credit card transactions.

The result is worth Mill’s effort. The scales arrived in July, and Mill found room for them in two supply closets. Now she is sharing the bounty with other local hospitals to help their patients, as well.
Be Healthy, Live Longer

LIFESTYLE CHANGE IS ONE OF THE KEYS TO A HEALTHIER POPULATION AND LOWER MEDICAL COSTS FOR EVERYONE

Pills? Cocaine? Meth? Maryann McKay says they all were easier to kick than cigarettes. After failing five times, she is now determined to beat her tobacco addiction. Being diagnosed with COPD (chronic obstructive pulmonary disease) is one reason why. Her four-year-old grandson is the other. “I’d like to see him grow up,” she says.

McKay, 50, was a pack-a-day smoker for 37 years. She quit this summer with the help of Bay Area Hospital’s smoking-cessation class. Her willpower was backed up by a three-month prescription of the nicotine blocker Chantix, paid for by Western Oregon Advanced Health. “I feel so much better already,” says Maryann.

Encouraging positive lifestyle change is a big part of population health management. In addition to tobacco cessation, the hospital offers classes that help with diabetes, depression, chronic pain, anxiety, and more.

One of the newest programs is called The Fire Within. Presented in partnership with Oregon State University Extension, it teaches about chronic inflammation, a condition that plays a role in diseases as diverse as Alzheimer’s, diabetes, asthma, and even some cancers. The Fire Within teaches ways to combat inflammation, such as with diet, exercise, and proper sleep.

Will these efforts actually lead to a healthier population in Coos County? Terri Camp, RN, chief quality officer at Bay Area Hospital, says a definite answer may be 20 years away—when people who change their lifestyles today reap the long-term benefits.

Maryann’s grandson will be in his twenties by then. With luck he will still be enjoying his grandma’s company.
Smooth Transitions

Most businesses work hard to keep their customers coming back. A hospital wants the opposite: when you leave Bay Area Hospital, we want you ready for the next phase of your recovery, with ongoing care and support to prevent a return trip.

CASE MANAGEMENT TEAM WORKS TO SEND YOU HOME SAFELY—AND PREVENT UNNECESSARY RETURN VISITS.
“The goal is to have good plans for people so they don’t fail,” says Angie Andersen, RN.

Andersen heads a team of registered nurses and other skilled workers who specialize in coordinating patient care and recovery planning. Whether you plan to recuperate at home, undergo continuing outpatient treatment, or a stay in a skilled-nursing facility, Andersen’s crew wants you to thrive.

Their work starts as soon as you check in. Each patient receives a welcome visit from one of the half dozen registered nurses who work as “case managers.” Andersen says the first step is an assessment: Does the patient belong in the hospital, or could effective care be provided less expensively elsewhere? Is the patient receiving the right care? Does the patient understand the reason for the hospitalization?

The next step focuses on care after discharge: What is the patient’s home situation? Will the patient return to running water, electricity, and healthy food? Does the patient have a primary care doctor for follow-ups? The case manager coordinates with the patient’s doctor to plan future outpatient services. Insurance coverage, medications, home medical equipment, even transportation—all are considered.

The red tape can be daunting. For a complicated case, the case manager calls in a discharge planner, a person with a background in social work. The discharge planner works the phone to line up services, such as securing the patient a bed in a skilled-nursing facility.

“There are days when it’s very difficult,” says Discharge Planner Sam Ghattas. “But it’s rewarding when you can get things done for people who are in desperate need.”

The job does not end when the patient leaves the hospital. A team of registered nurses makes follow-up phone calls to discharged patients, making sure they take their medications and get to doctor appointments.

The case management program is not unique. Hospitals across the country are working to ensure that discharged patients do not wind up back in the hospital.

Chief Quality Officer Terri Camp, RN, says a hospital’s responsibility used to end when the patient rode down the elevator and out the front door. But now the federal government and insurers are pushing all healthcare providers to coordinate their efforts.

“One thing we're doing has to reach out beyond the walls,” Camp says. And for good reason: Last year the Robert Wood Johnson Foundation reported on what it calls “the revolving-door syndrome” at US hospitals. It cites federal statistics showing one in five elderly patients returning to the hospital within 30 days of discharge. Many of those readmissions “can and should” be prevented, the foundation concluded. The government estimates that unnecessary readmissions cost taxpayers more than $17 billion per year.

Not surprisingly, hospitals face financial pressure to improve. Medicare penalizes hospitals for excessive readmissions of patients with certain chronic illnesses. But internist Wendy Haack, DO, who chairs Bay Area Hospital’s Readmissions Committee, says patient welfare, not money, is the biggest reason to reduce preventable readmissions. A patient who returns to the hospital is often sicker the second time around, she says.

Bay Area Hospital has undertaken multiple initiatives to reduce readmissions, such as coordinating with home health agencies and helping patients manage diabetes, pneumonia, and other chronic diseases. A program called BOOST (Better Outcomes by Optimizing Safe Transitions) focuses on specific factors that indicate a patient’s increased risk of readmission; for example: Does the patient lack a caregiver at home? Does the patient take five or more medications each day? Case managers tailor the patient’s discharge plan in response to each factor.

Unfortunately, readmissions are not a onetime problem for hospitals to solve. “It’s going to be something you’re always going to be working on,” Dr. Haack says.
Can you explain in layman’s terms why Oregon’s healthcare transformation is so important to our citizens?

Over the past few decades, Americans have spent more and more on healthcare and received low-rated health outcomes in return. We decided to take a different path in Oregon. Not only does our work focus on improving health but it’s also key to Oregonians’ financial security. One benefit of health insurance is that the incidence of healthcare-related bankruptcy goes down. When people don’t have to choose between paying the rent and going to the doctor, it’s better for our economy.
Oregon clearly has made a huge change by insuring so many previously uninsured patients. What are the long-term implications for Oregonians in general?

A key component of Oregon’s coordinated care model is learning from and building on what is working—taking those innovations that one community finds success with and then tailoring them for other patient populations.

Another key piece is flexibility. CCOs (Coordinated Care Organizations) have flexibility on how they meet benchmarks and respond with creative and effective programs. CCOs meet regularly to talk about what is working and what needs improvement.

We should all expect better health from our healthcare system. Health is a fundamental component of our success as a state.

How satisfied are you with Oregon’s progress and momentum on this initiative?

The results so far are encouraging. Emergency department (ED) visits decreased by 9 percent. Hospitalizations for congestive heart failure dropped by 29 percent. Meanwhile, primary care visits for Oregonians served by CCOs increased 18 percent. And reported spending for ED use is decreasing as spending for primary care is increasing—all indicators that show a shift toward more-preventive, patient-centered primary care.

WOAH (Western Oregon Advanced Health) serves one of Oregon’s neediest areas, both economically and medically. What observations can you make about the direction WOAH is taking us?

WOAH works toward improving the health and the healthcare of the community by taking into consideration the needs of its population. It developed the FEARsome clinic that enables new foster families to address all of their child’s health needs in the same place. To serve patients with multiple chronic conditions, WOAH’s registered nurse care manager creatively works with physicians, hospital staff, and other stakeholders to proactively engage members and address social issues.

WOAH created an after-hours clinic to reduce ED use. It saw the rate of ED visits drop by 10 percent in 2013 from a 2011 baseline. One of the most important priorities is for WOAH to continue working alongside providers, community groups, and Oregon Health Plan members to find solutions that work for members and the community.

Are there any other insights you would like to share with readers of Currents?

The personal stories from our CCOs are just as compelling as the raw data. I’ve heard about a community health worker who helped a patient avoid the ED by taking her Gatorade during a bad bout with stomach flu. I’ve also learned about the team helping patients with mental health issues improve treatment of physical conditions that affect patients’ well-being.

There are nontraditional approaches, such as a worker who helped a patient replace old shoes and buy a sleeping bag and eventually helped the patient qualify for housing assistance so that he no longer had to live in his car. Other programs include smoking cessation for pregnant moms and home-based management strategies to prevent strokes and reduce asthma attacks.

It’s amazing to see this community-minded approach to improving health in action. There is so much to be gained by focusing on wellness and prevention. The healthcare professionals who are making it happen are really part of history.
Celebrating Service

Louisiana girl grew into an Oregon political dynamo

Some people slow down in their seventh decade of life. Joanne Verger was just getting warmed up. The retired state senator’s 22-year community and political career earned her Bay Area Hospital Community Foundation’s 2014 John Whitty Award for Excellence. This award recognizes her work improving the health and well-being of the community through her steadfast support of healthcare as well as her service as a city councilor, mayor, and state legislator.

“Joanne was always a leader in healthcare because she had a touch for the common person,” says State Senator Alan Bates of Medford, a physician. “She knew they are the ones suffering without proper health insurance and good healthcare, especially in rural parts of Oregon, where it’s difficult to recruit physicians, nurse practitioners, and nurses. She always strongly supported her local healthcare network.”

“If she said she was going to do something, she followed through and did it, and people could take that to the bank.”

—State Senator Arnie Roblan

First elected to public office at age 60, Senator Verger served two years on the Coos Bay City Council before becoming the city’s first female mayor. Elected to the Oregon House of Representatives at age 70, she became an advocate for rural Oregon and a leading member of the bipartisan Coastal Caucus.

Senator Verger is known for supporting expanded access to affordable healthcare, including Oregon’s healthcare transformation bill. She also championed healthcare access for seniors and for low-income women diagnosed with cervical and breast cancer. She had notable success in securing state funding for projects in her district. She takes special pride in her “bully bill,” which aims to protect children from coercion and harassment. It passed in 2012 during her final legislative session.

Senator Verger grew up in the Louisiana town of Amite. She moved to Oregon in 1969, when she and her husband, Lawton, bought a Coos Bay auto dealership. They were married for 55 years and raised four children: Kathy Verger Muscus, Jim Verger, John Verger, and Anne Johnson.

Since leaving office, Senator Verger has undertaken multiple writing projects, including a memoir of her Louisiana upbringing.