Draft

Quality Work Group Meeting Notes
Public Meeting
August 30, 2004
Room 120-C
800 NE Oregon Street, Portland, Oregon

Members in attendance: Vickie Gates, Jonathan Ater, Ron Potts, Chuck Kilo, Karen Burke, Glenn Rodriguez, Robert Wheeler

Members Excused: Joel Ario, Michael Leahy, Gil Munoz

Staff in Attendance: Mike Bonetto, Elizabeth Kurtz, Shelley Bain

I. Overall Meeting Desired Outcome:
Discuss EMR subcommittee, review Health Policy Commission activities, edit the Quality Work Group outline and finalize legislative concepts.

Minnesota's EMR program is distributed as an example of a system two months ahead of us, currently in place and could serve as the basis for Oregon's.

II. Discussion on Electronic Medical Records Subcommittee
Desired Outcome: Identify potential subcommittee members.

As names for this subcommittee are submitted, the overlaps include Jodi Pettit on each list of names. Names are mentioned and discussed to represent statewide users of such a system.

III. Update of Commission Activities
Desired Outcome: Understand Commission's upcoming work-plan and review other work group summaries.

Mike shared other work group's potential strategies in terms of tiers. Short-term, Intermediate-term, and Long Term. Identified significant overlaps between cost and quality. Access and Health Status Work Groups.

V. Edit Quality Work Group Outline
Desired Outcome: Edit Quality Work Group outline – problem statement, goal, preamble and potential strategies.

Problem Statement: include a piece about work force issues, staffing, and training. Identify the link between quality and cost, health status, and access. "Quality makes sense for fiscal reasons". Duplication of efforts does not assume quality, rather it is clearly not cost-effective.

Reference policymakers. Improve results achieved by Oregon's health care system. Improve gathering and reporting of health care information. Improve the health of the population. Support evidence-based medicine.

Is a mandated strategy too strong; too politically charged? Encourage development, improvement; support systems, using currently existing data and information. Performance measurement. Supporting purchasers. Connectivity.

Encourage participation rather than mandating.

Looked over handouts about the Minnesota Health Care Reform Bill. http://www.minnesotahealthinfo.org

DHS, SAIF, PEBB, OHPR, and DCBS Insurance – separate pockets. Siloing. No connectivity across departments who are all involved in this, among other, projects. Will require the consolidation of all of them to bring stronger, more provocative lobbying to the Legislature. Lack of coordination. Not sure what the best solution is, but we will ask for longer term to deal with it.

IV. Discussion on Drafting Legislative Concepts
Desired Outcome: Assist Legislative Council in identifying recommended legislative concepts to be drafted.

Holly Robinson, Legislative Council from the Governor's Office, instructs on appropriate methods of writing, and effective language for writing a legislative bill.

Community Forums – public input charge from the HPC. From all stakeholders. Broad-based information

This is the new commission – what's on your mind, what solutions do you have for us to consider? Small businesses, advocates and public, private. Bring back in October, prepare for November.

PowerPoint presentation from Liz Baxter.

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Quality Work Group Meeting Notes
August 9, 2004
Room 140
800 NE Oregon Street, Portland, Oregon
1:00 – 4:00 p.m.

Members in attendance: Vickie Gates, Jonathan Ater, David Lansky, Keith Marton, Ron Potts, Glenn Rodriguez, Michael Leahy, Chuck Kilo, Robert Wheeler (by phone), Joel Ario

Members Excused:
Staff in Attendance: Mike Bonetto, Elizabeth Kurtz

I. Call to Order/Introductions
Jonathan Ater and Vickie Gates, Co-Chairs

II. Review Legislative Concepts of Mandated Reporting Requirements
- **David Lansky**

See attached handouts.

III. Electronic Prescribing
- **Dave Widen, Safeway**
- **Representative from the Oregon Medical Association**

Group discussion regarding the pros and cons of electronic prescribing. Examples of electronic prescribing are email, fax and palm pilots. Electronic prescribing is a substitute for a phone call or a written prescription.

IV. Discussion of Pay for Performance

V. Update from Patient Safety Commission
- **Dr. George Miller, Chair**
- **Jim Dameron, Director**

VI. Adjournment

4:00 p.m.

Next Meeting: Monday, August 30th 1:00—4:00 p.m.

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Quality Work Group Meeting Notes
Organizational Meeting
July 26, 2004
Room 140
800 NE Oregon Street, Portland, Oregon

Members in attendance: Vickie Gates, Jonathan Ater, David Lansky, Keith Marton, Ron Potts, Glenn Rodriguez, Michael Leahy, Chuck Kilo, Robert Wheeler (by phone), Joel Ario

Members Excused:
Staff in Attendance: Mike Bonetto, Elizabeth Kurtz, Liz Baxter

I. Call to Order/Introductions
Jonathan Ater and Vickie Gates, Co-Chairs

II. Overview of Hospital Discharge Data
Bruce Goldberg, Office for Health Policy and Research

This presentation has been postponed due to technical difficulties that prevented its availability for this meeting.

III. Discussion of Quality Matrix – (Performance Measurement & Pay for Performance) – Addition of new action items, Prioritization of action items

Vickie urges members to look over the matrix and submit recommendations and suggestions prior to the next meeting, for inclusion in the agenda.

Systemic, long-term improvement to current health care policy, rather than putting a bandaid on things. Short term goals should lead to longer-term goals, and be part of the process.

Provide the legislature with strategies and recommendations for them to consider prior to the November Session.

Pay for performance as one idea. OHP is a separate issue, even though it reflects the commonality of the health care system. Private sector market place. Employer-based insurance. Are we looking at a one year or five year plan?

Small steps, but firm and solid steps toward the long-term goal. Incremental change toward the whole goal.

Transparency, infrastructure, and purchasing – non-partisan areas toward a concise pitch to the legislature. The matrix fits into these three labeled as a framework to develop the process. Identify appropriate principles for the legislature to address, and those that do not belong to the legislature. The

legislature can request assistance and ask for comment without requiring a change or additional law. Advisory. Collective leadership to identify strategies.

Legislative action versus market action – separate and connected. Transformation will require a step-by-step process. Linking with existing initiatives.

Registries and databases to track conditions and effect improved or appropriate treatment or intervention. Clinic registries. Benchmarking with the data.

Spread out over more areas as opposed to focusing on one piece for the benefit of presenting to the legislature.

Support the PEBB model?

Mandatory reporting as a beginning? Reporting standardized data. Support identified mandate requests with proof of success from other states who have already done it, or with existing data that qualifies these requests to the legislature. Specific reporting. OMA model.

HEDIS as an example of existing registries. LEAPFROG

Integrated reporting and simplification process.

Bruce and Mike draft a legislative concept around reporting for the next meeting. Rhode Island legislation.

Evaluate reporting. Maintain the standard. Every two years.

Motivate purchasers to buy-into this project. Consensus of major players to adopt a common standard.

Provider tax to pay for infrastructure (EMR and establishment of the data)?

IV. Discussion of Quality Matrix and Prioritization of Issues

V. Discussion of Next Meeting Agenda and Date

Bruce and Mike draft a legislative concept around reporting, for the next meeting. Information from Joel and David will assist in creating this draft.

Mike and Bruce talk to Board of Pharmacy to gather information to share with this group to determine the efficacy of electronic scripts. Computerized Rx orders.

Patient Safety Commission – ask Glenn Rodriguez

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VI. Adjournment

4:00 p.m.

Quality Work Group Meeting Notes
Organizational Meeting
July 6, 2004
800 NE Oregon Street, Portland, Oregon

Members in attendance: Vickie Gates, Jonathan Ater, David Lansky, Keith Marton, Ron Potts, Glenn Rodriguez, Michael Leahy, Chuck Kilo, Robert Wheeler, Joel Ario, Nancy Clarke, Rick Wopat-ex-officio

Members Excused: Karen Burke

Staff in Attendance: Mike Bonetto, Elizabeth Kurtz, Liz Baxter, Jeanene Smith, Shelly Bain

I. Call to Order/Introductions

Jonathan Ater and Vickie Gates, Co-Chairs

Jonathan and Vickie report on the Governor's meeting last week outlining an OHP plan. History of OHP. Beginning look at financial realities. Report back to HPC. Applying OHP founding principals to today's financial and statutory environment. Sustainability of health care given current resources. Health care inflation. Profit margins.

Mike highlights issues of sustainability the Governor discussed last week.

II. Overview of Commission's Public Input Process – Review Health Value's Survey – Liz Baxter, Office for Health Policy and Research

Mike introduces this presentation as the Commission's charge of each work group to make recommendations specific to their area. Liz Baxter is making rounds to each work group to give her ideas and input together to compile a survey that will cover each area of concern or priority.

1.) what will you do with the info -

2.) who are the key stakeholders -

3.) what are the issues –

Prior survey's consisted of focus groups. Repeat the 2001 Health Values Survey. Telephone surveys. Community meetings. HSC recommended communities. Feedback during fiscal constraints. What cautionaries do you prefer?

It can be used as an opportunity. Can be used to get on those issues. Begin building collaborations, and opportunities to bridge. Target audiences. More diverse audiences. Small employers, commercial insurance providers,

Ask who cares. Find out whether State has the responsibility, or the private sector – identify if some areas should be shared, by whom, and how much.

Identify values we should support. Minimal volumes in a cost-effective environment. Educate communities on key issues. Assess needs and current resources. How much, how many – health resource utilization. Framing questions appropriately to fit the needs of the survey. Qualitative research. What permission do we have from the public to change health care?

Quality = access and convenience. Supply does not equal quality. Educating the public to a specific mindset. Are we a leader or responder, and should we change that? Visible quality. Identify how the system is broken. Where does health care fall in line against such things as safety, education, etc.

Cultural perception of quality. Incentives, attractors to change in an effort to improve the quality of sustainable, affordable, health care.

III. Discussion of Quality Work Group's Goal Statement

Mike distributes a handout of a sample mission and goal statement. Each work group is responsible for their own missions and goal statements. These will be presented to the Health Policy Commission. This work group recommends, it is not an enforcer or creator.

IV. Discussion of Quality Matrix and Prioritization of Issues

Mike distributes environmental levers and matrix. Members consolidated pieces of the two that work well together. Combining strategies and interventions.

Prioritizing strategies. Rank them for Jonathan and Vickie to present to the Legislature in September.

Begin with Tort Reform (perhaps by establishing a medical court or board) from the identified environmental levers, to organize priorities for this work group.

Priority conditions – identify conditions and offer recommendations across the health care delivery system. Distinguish between public health issues and quality of medical care as the charge to this work group.

Work Group recommendations for improvement or changes in health care cannot include additional or continued funding by the State.

Vickie suggests the HPC act as a convener or conveyor to provide information of existing systems or programs that currently work, or not. It is agreed that these

systems exist – HPC could identify them and report to this work group in an effort to provide direction.

Supply vs demand , short and long-term identifications.

V. Discussion of Next Meeting Agenda and Date

Vickie suggests members email their ideas and information prior to the next meeting, flush them out,

VI. Adjournment

4:00 p.m.

Quality Work Group
Draft Meeting Minutes
June 10, 2004

I. Call to order

II. Review IOM Quality Chasm Report

III. Discussion of Hypothesis for Quality Reform (Goals and Objectives)

System reform. Fit within our scope. Define new form and new model. Achieve desired results. Results count. Health Care across populations.

How do we get there? What reforms are necessary to get there? 6 goals Encourage helpful factors; improve undesirable factors.

What are major driver's to quality? Two – competition and equity of distributions. Information – need data driven information, rather than rhetoric and opinion. Have's and Have-not's. Identify short and long term approaches to quality. Legislature would like short-term recommendations on the way to long-term goals.

One of the system failures is the lack of attention to the broader population. Doesn't have the ability to disseminate information. Influencing consumers. Irresponsible spending.

The torte system has an important influence on health care. Restructure the legislative system that creates a win-win for the legislature, population and providers. Create a positive structure.

What environmental drivers exist? Accreditation and licensing, training, financial incentives, information resources. To what end to we manipulate these levers? Evidence-based practice, patient-centered practice, chronic care management, stewardship. What problems can we solve using these goals? Develop a strategic model.

Business-plan suggestions. Enable people to create ownership.

Our current system is not sustainable. We need to think about something completely different.

OCHIN collaborative database is tracking Medicaid and uninsured currently being served. Use of electronic medical records will reduce cost. Efficiency. Hospital ERs.
Primary-care access instead. Is there a relationship between low cost=low quality. Concrete recommendations. Tinker smartly.

Single-payor system? Primary care option? Transformed vision – principles and dimensions of such.

Illustrate a visual model.

1. Information
    - Benchmarking/Assessment
    - Transparency/Decision support
        - Clinicians
        - Public
        - Policy

2. Tort System

3. Educational/Professional/Lay
    - Health library

4. Regulatory Process/environmental

5. Financial

Identify State roles and Federal roles

Include equity and disparity to the list of drivers.

	Environmental Levers					
	Information		Tort	Educ	Reg	Finan
	Transparency	Assessment				
Evidence Based						
Patient Centered						
Chronic Care Mgt.						
Stewardship						
Cultural Sensitivity						

Benchmarks, evidence-based measures.

"Perfection is impossible, but improvement is perpetual"

Don't change the system, rather require information and participation within the existing system. Carrot and sick approach.

Performance of the system. Facilitate delivery of care.

IV. Review Other Healthcare Groups' Work on Quality

V. List Top 10 Positive and Successful Quality Protocols in Oregon

1. Chronic care – discovered asthma care had room for improvement in Lane County. Performed a research study resulting in lower hospitalization. Patients did better. The study education to providers.
2. End-of-Life – Physician-assisted suicide study for outcomes as it relates to extended and costly hospitalizations and treatments. Interventions and case-study to this issue. Geography and culture.
3. Institute for Health Care – bringing practices together – learning collaboratives.

VI. Identify Necessary Levers that should Be Pursued at the State Level

This topic was covered in discussion around topics II, III.

VII. Discussion of Next Meeting Agenda

Strategize the pieces to the grid, and rank/prioritize next time. Fill in the boxes, and within each issue, use low, medium high to prioritize.

Short-term urgency.

Anecdotal illustrations. Explore examples of system integration that are proving successful.

Next meeting will be July 6, PSOB, 1-4.

VIII. Adjournment

4.00 p.m.

Quality Work Group Meeting Notes
Organizational Meeting
May 17, 2004
222 SW Columbia, Suite 1800, Portland, Oregon
1-4 p.m.

Members in attendance: Vickie Gates, Jonathan Ater, David Lansky, Keith Marton, Ron Potts, Glenn Rodriguez, Michael Leahy, Chuck Kilo, Robert Wheeler, Karen Burke, Joel Ario

Members Excused: Gil Munoz

Staff in Attendance: Mike Bonetto, Elizabeth Kurtz, and Randy Gale – Office for Health Policy and Research; Shelley D Bain -Oregon Insurance Division

I. Call to Order/Introductions

Jonathan Ater and Vickie Gates, Co-Chairs

Calls the first organizational meeting of the Quality Work Group to order. Explains this group as one of four that stem from the Oregon Health Policy Commission – the other three being Cost, Access, and Health Status.

II. Overview of Group's Charge and Work Plan

Mike distributes an organizational structure of the Health Policy Commission and Work Groups. Short and long-term goals, task forces, and groups are defined. Mike distributes overviews of national examples to assist this group in defining itself. What can states do as 1) purchasers, 2) providers, 3) regulators, 4) educators and 5) collaborators. Roadmap of how this work group can proceed.

Distributes Florida's 2001 report to illustrate its successful presentation to their legislature. Doesn't think it is necessary to 'reinvent the wheel'.

Distributes Maine's 2003 report as an example of performance indicators around cost, participation, and quality. Build upon this report; adapt for use in Oregon.

(1) Acute Care (2) Chronic Care (3) Routine Care

III. Discussion on Quality

Discussion on IOM definition of quality health care. (safe, effective, patient-centered, timely and equitable).

If funding is sufficient, does the issue become how/where/when/how much/for whom health care is provided?

How do we make the health care system operate more efficiently?

Pragmatic versus visionary approach.

Service-infrastructural approach.

Determine the needs. Feedback systems. Pay for services or results?

Health care financing versus health care delivery.

Illness care versus health care.

Clarifying multiple goals.

Does everything need to be 'medicalized'; thereby costing more than necessary.

Dissect the Quality Chasm Report, from a health policy standpoint.

What are the levers the state has? (1) Information (2) Payment (3) Culture.

Pitfalls of the current HSA Program

Dr. Kilo states his interest in having members clarify their hypothesis of what a reform proposal should look like. Dr. Kilo illustrates his point by drawing his idea:

Specialists		
	Primary Care	Social Services
Hospital		Mental Health

The premise around the model is that everything revolves around the primary care system and that the patient/family/providers and multiple specific functions make up this system. The idea is that this model is adaptable to different environmental demands (i.e. rural vs. urban needs).

Discussion around Dr. Kilo's model. Members agree that current terminology is too loaded and should be changed.

Members discuss the importance of shifting away from acute care to preventive care

IV. Discussion of Next Meeting Agenda

1) Review/analyze IOM Quality Chasm report – review goals around quality (Ron Potts)

2) Hypotheses for Quality reform – 2-3 sentences highlighting the basic premise of what is wrong and how the group proposes to fix it (Chuck Kilo)
3) Identify the necessary levers that should be pursued to enact change at the state level (David Lansky)
4) List the top 10 positive and successful protocols that have been done around quality in Oregon (Glenn Rodriguez)
5) Review what other health care groups are doing around quality (all members)

V. Adjournment

4:00 p.m.