Office for Health Policy & Research
Health Policy Commission
Delivery System Models Work Group

2005 Meeting Notes

April 7, 2005 10a.m.-12p.m. 600 NE Grand Ave Room 501, Portland

May 17, 2005 1-3p.m. 800 NE Oregon St Room 120B, Portland

June 21, 2005 1-3p.m. 800 NE Oregon St Room 120B, Portland

August 16, 2005 1-3p.m. 600 NE Grand Ave Room 501, Portland

October 18, 2005 1-3p.m. 800 NE Oregon St Room 140, Portland

November 15, 2005 1-3p.m. 600 NE Grand Ave Room 370A, Portland

Delivery System Models Work Group Meeting Notes
Oregon Health Policy Commission
April 7, 2005
Metro Building Room 501
600 NE Grand Ave
Portland, Oregon

Members Present: Vanetta Abdellatif, Rick Wopat, Tina Castañares, Ross Dwinell, Jackie Gaines, Craig Hostetler, Jennifer Pratt, Ken Provencher, Carlton Purvis, Peter Reagan, Dick Stenson, Karen Whitaker

Members calling in: Lisa Ladendorf

Members Absent: none

Guests: Nancy Bieber & Barry Jones, Oregon Department of Consumer & Business Services
Laura Brennan, James Oliver, & Jeanene Smith, Office for Oregon Health Policy & Research
Liz Stevenson, AFL-CIO
Joel Young, DHS Office of Public Health

Staff: Jessica van Diepen, Assistant, Oregon Health Policy Commission

Call to order 10:07a.m.

I. Welcome & Introductions

II. Review of work plan, Handout III (Tape Side A, 690), Rick Wopat

Discussion Points

- Craig Hostetler asks that we try to incorporate access issues identified in the 2004 Access work group (i.e. 100% statewide immunization) into the work of this group whenever possible; Rick Wopat replies that given the unique regions that exist within the state, this new work group will focus on regional and community-based solutions to health care delivery that best fit the needs of each region.
- Clarify fourth bullet under goal 2 in "Short Term Goals (2005)"

III. Discussion of work plan (Tape Side A, 895)

- Karen Whittaker notes that it is important to remember availability issues in rural communities when thinking of access. For example, Jordan Valley has a Physician's Assistant in town two afternoons per week, which is all the health care that is available. We should consider adding a metric for success that reads "% of Oregonians within X distance of available health care".
- Lisa Ladendorf agrees and adds that the discussion and any product we create should keep in mind the need for infrastructure development, recruiting & retention of staff, etc in rural areas.

- Question: Is there data on the level of health care availability across Oregon? Karen Whitaker: there is a map on the ohsu.edu Website that plots availability based on five variables. It is updated annually.

Tape Side B

- Jackie Gaines wants the work group to develop a good business case for hospitals & health systems to engage in 100% access efforts & collaborations. Also, we should assemble a "tool box" (what needs to be in place for implementation; how does it work.)
- Tina Castañares says useful, free tool kits exist for collaboration now. A national conference two years ago on health access solutions showcased the community building that results from collaborative access projects and shared step-by-step plans for how these collaboratives can work. Asset-based analysis of what the community has on hand is the first step. Question: What are work group members expected to contribute to reach the short-term goals outlined in the work plan? Rick Wopat: we can bring any "tool box" items that we know of individually to the work group and adapt them for our use.
- Jackie Gaines adds that the group should take these pieces of knowledge and assemble them into business cases/cost-benefit analyses for specific kinds of collaboratives (i.e. FQHC with a hospital, a public health entity with a private health system, etc)
- Carlton Purvis: metrics of success should be categorized by levels (broad vs. specific population groups)
- Chuck Kilo says the two ideals 1) doing what is best for the community from a social standpoint and 2) doing what is best for each participant's bottom line cannot be achieved simultaneously; at some point there will have to be a discussion about money: who is going to win and lose financially at the hand of any efficiencies that are implemented.
- Someone disagrees that there have to be winners and losers. He envisions a give-and-take scenario where collaborators make deals that effect compromise and by which everyone benefits.
- Craig Hostetler says we should define "worst practices" (what hasn't worked) Address mission barriers (conflicting missions of collaborators) as well as business cases. Metrics: add % of pregnant women who have a medical home and health disparities.
- Jackie Gaines notes that Safe Harbor laws are upcoming (good and bad): we need to investigate those. Ken Provencher cautions that creating business cases may not be enough to facilitate collaboration; he believes that participants must strike a balance between the bottom line and a social commitment to investing in the community. To the six-month inventory: many projects across the state are just getting underway, so the data we collect will only be a snapshot of an ever-changing and long-term process.
- Jennifer Pratt wants to develop a carrot for others to come to us (with our survey effort) and develop a mechanism for communicating with these people once we

identify them (email, etc). We should create maps of the delivery system, the finance system, & the payment system as they stand now.

- Lisa Ladendorf says a developmental approach is good (Understanding that different efforts are at different stages of development, knowledge, etc). "Bottom-up" approach (local, then State or larger entities) makes common interests more obvious (referenced in Handout V. Improving Healthcare Access Report).
- Tina Castañares echoes Worst Practices inventory idea (i.e. The Muskegon Michigan access model which seems to have stalled). Reiterates that the group needs to remember the vulnerable providers outside the metro area.
- Rick Wopat agrees and says that is the reason for tackling this effort county by county, so that our output is relevant to each unique region in the state.
- Carlton Purvis says we should add a federal element to our deliberations & actions on legislation.
- Let's make a statewide economic case as well that applies to state government and payors as well as the provider community.
- Ross Dwinell asks "what are community-created solutions?"

Next Steps:

- Update work plan based on this discussion & distribute before the next meeting
- Define "business case"
- Examples of community-created solutions will be disseminated via email once the group has agreed on its direction and focus; these emails will include an explanatory introductory sentence or two, and be presented in categories of "Levels of Success"
- Delineate how this group relates to the Governors's Safety Net Advisory Council (and other private initiatives, i.e. Tri-County Safety Net Enterprise); how do their charters overlap?

Adjournment 12:07p.m.

Next Meeting Agenda Items:

- Discuss expectations for workgroup members
- Discuss any clarifications to work plan and begin planning the next six months for the workgroup.

Handouts:

I. Agenda
II. Roster
III. Proposed Work Plan
IV. Proposed Meeting Dates
V. *Improving Health Care Access: Finding Solutions in a Time of Crisis,* Tina Castañares, MD, National Policy Consensus Center, Portland State University, November 2004.

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Delivery System Models Workgroup
Oregon Health Policy Commission
Portland State Office Building
800 NE Oregon St, Portland
May 17, 2005

Members present: Vanetta Abdellatif, Rick Wopat, Carlton Purvis, Craig Hostetler, Peter Reagan, Jackie Gaines, Chuck Kilo, Jennifer Pratt, Ken Provencher, Ross Dwinell

Members calling in: Tina Castañares

Members excused: Karen Whitaker, Lisa Ladendorf, Dick Stenson

Staff: Gretchen Morley, Director, Oregon Health Policy Commission
Jessica van Diepen, Assistant, Oregon Health Policy Commission

Guests: Lupita Salazar (Yakima Valley Farm Workers), Beryl Fletcher (Oregon Dental Association), Tina Edlund, Fred Steele, Laura Brennan (Office for Oregon Health Policy & Research), Diane Lund (Oregon Health Forum), Varner Seaman (SEIU), Joel Young (Department of Human Services)

Call to order 1:09p.m.

I. Welcome & Introductions
II. Update on Health Policy Commission Activities

- SB 541 (Electronic health records taskforce) – passed out of Senate; currently in the House Health & Human Services Committee
- 3 workgroups in 2005: Healthy Oregon, Quality & Transparency, & Delivery System Models

III. Updates from last work group meeting

A. Roles of the Safety Net Advisory Council (SNAC) vs. Delivery System Models workgroup (See handout diagram)
    - SNAC exists to provide a voice for the healthcare safety net in statewide policy dialogue
    - Delivery System Models workgroup will identify ways that the state can support local delivery system models to improve health care access.

Discussion (Tape Side A, 290)

- Key terminology should be clearly defined in order to maintain consistency across these two groups (i.e. “access”)
- Is there a statewide “head-count” of who is lacking access, what communities they are in, and what is that community’s safety net capacity. There is, but the numbers are continually changing due to the many variables involved. James Oliver will address the group in June on the Health Care Indicator Project.

- Rather than spend time and effort on an access inventory, *this* group should identify and disseminate innovations in delivery systems
- Laura will continue to update the workgroup on the SNAC

IV. Reaching group consensus on a manageable work plan – see handout (Tape Side A, 622)

Discussion

- Inventory should be not be limited to Oregon; conversation recognized that the inventory should however be focused to best use the workgroup's time.
- Establish definitions for clarity of communication, i.e. "innovation", "improved access"
- Decide on a methodology for communicating the information that is collected/produced
- *Assembly of toolkit*: discussion about how this cannot be done with two staff people; useful tool kits already exist if one knows where to look; creating a toolkit specific to each community is beyond the scope of what this group should focus on producing. The same is true for "identifying methods for facilitation": this is something that already exists. The role of this group should be to point people in the direction of these existing resources when they ask for them. Barriers to innovation are fragmentation & lack of leadership, not lack of a ready-made tool kit.
- Grant opportunities for pilot projects: this group can lay the groundwork for communities to be able to apply for grants with very targeted and well-planned proposals.

Tape Side B

- Currently, community leaders have difficulty finding someone at the state-level to contact for knowledge and resources in this area
- Discussion on the FQHC model and what can be learned from the successes and challenges of that model. (Tape Side B, 207)
- In doing an inventory we should ask "is this a fix to the old system, or is this a new model?"
- Legislation: there is consensus that we are not prepared to submit any bills this Session; there will be opportunities to work with interim committees to lay the groundwork for the 2007 session.
- Defining metrics: suggestion that we move this from long-term to short-term goal list (within the next year). They need not be perfect, but establishing something would be valuable
- (640) The group needs to define shared goals/targets for the purposes of measuring future progress

Adjourned 3:00p.m.

Next Steps:

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- **Develop inventory template via email**
- **Define shared goals/targets for the purposes of measuring future progress**
- **Finalize the work plan**
- **Develop joint definition page with the Safety Net Advisory Council and the Health Indicator Project for key terms (This will be a living document, subject to change)**
- **Recruit intern to assist with the inventory and investigate local ROI/business plan models**

Assignments:

- **Workgroup chairs, Jennifer Pratt, Gretchen Morley, and Laura Brennan will work together via telephone between meetings to tighten the language of the work plan and draft proposed goals for vetting with larger workgroup.**
- **Workgroup email dialogue between now and next meeting:**
    - **Gretchen Morley will email inventory template draft to workgroup members for comment and revision**
    - **Gretchen Morley will route proposed work plan and proposed goals for discussion**
    - **Gretchen Morley and Laura Brennan will work with workgroup members between meetings to create a vocabulary list of terminology with definitions**
    - **Carlton Purvis & Laura Brennan will work together to define projects/programs/innovations to bring to the June 21 meeting. This will assist in defining the scope of the workgroup and inventory process.**
- **Gretchen Morley will be working to secure an intern for the summer to assist the group**
- **Members are encouraged to provide feedback to the co-chairs on meeting management & effectiveness**

Next Meeting Agenda:

- **Approve goals and work plan**
- **Inventory template - Identify the kinds of models that we may want to consider and establish the parameters for those**
- **Health Care Indicator Project: Measuring and assessing primary care service delivery in Oregon – James Oliver (Urban), Karen Whitaker or staff (Rural)**
- **Safe harbor report - Fred Steele**

Next Meeting: June 21, 2005

Potential agenda items for July meeting:

- **Discussion and approval of definitions**

Delivery System Models Workgroup
Oregon Health Policy Commission
Portland State Office Building Room 120B
800 NE Oregon St, Portland
June 21, 2005 1-3p.m.

Members present: Vanetta Abdellatif, Rick Wopat, Craig Hostetler, Jennifer Pratt, Ken Provencher, Carlton Purvis, Peter Reagan, Karen Whitaker

Members calling in: Tina Castañares

Members excused: Ross Dwinell**,** Jackie Gaines, Chuck Kilo, Lisa Ladendorf, Dick Stenson

Staff: Gretchen Morley, Director, Oregon Health Policy Commission
Jessica van Diepen, Assistant, Oregon Health Policy Commission
Marian Blankenship, Intern, Oregon Health Policy Commission

Guests: Beryl Fletcher (Oregon Dental Association), Jeanene Smith, Laura Brennan, & Tina Edlund (Office for Oregon Health Policy & Research)

Call to order 1:07p.m.

I. Welcome & Introductions
II. James Oliver – Health Indicators Project (Handout #2)
Discussion
- James will keep the workgroup updated as his project progresses

III. Fred Steele – Legal Parameters Regulating Community Collaborations (Handout #3)
Discussion
- We will add a disclaimer that this document does not constitute a legal opinion, and then distribute it in electronic form for workgroup members to use

IV. Reaching group consensus on a manageable work plan – (Handout #4)
Discussion
- Vickie Gates and Jonathan Ater will bring this draft to the Commission for approval

Adjourned 2:30p.m.

Next Steps:

- **Marian Blankenship will contact members individually and continue to develop inventory template**
- **Define shared goals/targets for the purposes of measuring future progress**
- **Develop joint definition page with the Safety Net Advisory Council and the Health Indicator Project for key terms (This will be a living document, subject to change)**

Next Meeting Agenda:

- **Inventory template - Identify the kinds of models that we may want to consider and establish the parameters for those**

Next Meeting Date: August 16, 1-3p.m.

Potential agenda items for next meeting:

- **Discussion and approval of definitions**

Handouts:
#1 Agenda
#2 Health Indicator Project update
#3 Safe Harbor issues primer
#4 Proposed work plan

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Oregon Health Policy Commission
Delivery System Models Workgroup
August 16, 2005
Metro Room 501, 600 NE Grand Ave
Portland, Oregon

Members Present: Vanetta Abdellatif, Jackie Gaines, Craig Hostetler, Lisa Ladendorf, Ken Provencher, Carlton Purvis, Peter Reagan, Dick Stenson

Members Excused: Rick Wopat, Tina Castañares, Ross Dwinell, Chuck Kilo, Jennifer Pratt, Karen Whitaker

Staff: Jessica van Diepen, Assistant, Oregon Health Policy Commission
Marian Blankenship, Intern, Oregon Health Policy Commission

Guests: Kevin Earls, Briar Ertz-Berger, Beryl Fletcher, Tom Fronk, Cathy Loftus, Robert Lowe, Carole Romm

Call to order 1:13pm

I. Oregon Health Policy Commission's review of the work plan

- Commission approved the work plan at its July meeting

II. Update on Safety Net Advisory Council

- met in July and approved refined safety net definition
- no August meeting, but will meet in September
- Laura Brennan will email this group a complete summary of the July meeting when she returns from vacation

III. Update of Local Delivery Systems Inventory Project

- Marian Blankenship has begun the inventory by contacting key people within the Lane County 100% Access Project

Discussion

- Make sure to capture these elements in the course of an interview:
  - ♦ What are they doing differently than other projects around the state and the nation?
  - ♦ What tools are they using for collecting data and bringing people together and are they willing to share them?
  - ♦ What is the key factor for determining/measuring success?
  - ♦ What factors are in play which make the timing right at this juncture?
  - ♦ What is the expected impact on access in the community? (culture or language specific services, etc versus simply the total number of people served)

- ♦ Ask specifically about successes and failures rather than generically about "lessons learned"
- ♦ Developmental phases they have experienced and the goals for each?
- ♦ What specific local or state health policies help or hinder the development of the project? (Break the barriers question into finance, administration, legislation)
- ♦ More important than what they achieved is to capture HOW they went about achieving it

- Marian should use personal or telephone interviews rather than mailings to collect these data
- Marian will compile a short inventory of projects elsewhere in the nation
- Do the projects currently on the list meet the requirements for inclusion that are laid out in the work plan? South Coast integrated provider team may not fit our criteria for inclusion in the inventory; check on that
- Washington County Division Action Network, contact Sia Lindstrom
- Talk to NW Health Foundation about their experiences with projects past and present
- Prioritizing the list of projects for survey: consult with Laura Brennan and the workgroup

Adjourned 2:03pm

Next meeting: TBA. We may not meet in September.

Potential agenda items for next meeting:

- Define shared goals/targets for the purpose of measuring progress
- Discuss and approve definitions in partnership with the Safety Net Advisory Council and the Health Indicator Project
- Update from James Oliver on Health Indicator Project?

Handouts:

1. Agenda
2. Work plan through December 2005
3. Local access model inventory tool
4. Proposed list of communities to include in survey
5. List of stakeholders/constituencies who should be interviewed in each community

Oregon Health Policy Commission
Delivery System Models Workgroup
October 18, 2005
800 NE Oregon St, Room 140
Portland, Oregon

Members Present: Vanetta Abdellatif, Rick Wopat, Tina Castañares, Ross Dwinell, Jennifer Pratt, Carlton Purvis, Peter Reagan, Dick Stenson, Karen Whitaker

Members Excused: Jackie Gaines, Craig Hostetler, Chuck Kilo, Lisa Ladendorf, Ken Provencher

Staff: Gretchen Morley, Director, Oregon Health Policy Commission
Jessica van Diepen, Assistant, Oregon Health Policy Commission
Marian Blankenship, Intern, Oregon Health Policy Commission

Guests: Bruce Goldberg, Bob DiPrete, Laura Brennan, David Rosenfeld, Briar Ertz-Berger, Beryl Fletcher, Tom Fronk, Valerie Katagiri, Laura Sisulak (for Craig Hostetler)

Call to order 1:07pm

I. Update of Local Delivery Systems Innovations Inventory Project (Laura Brennan)

- Marian has completed key informant interviews for Lane County, for Deschutes County and central Oregon, and for the Northeast Oregon Network (Wallowa, Union & Baker Counties); she will try to include Linn-Benton/Lincoln Counties and Clackamas-Washington-Multnomah Counties. Her timeline is to finish interviews by Thanksgiving and have her report to the group in mid-December.

II. Safety Net Advisory Council Update (Laura Brennan)

- Sept 20 was the most recent meeting; its agenda was to review and discuss an outline of the different funding streams that run through the Department of Human Services (DHS) and out to the health care safety net as well as a discussion of extant and potential funding streams outside of DHS. The purpose of this discussion was to ultimately assemble a business case (cost/benefit analysis) for the health care safety net to be presented to the Governor and to the Legislature.

III. Current Environment around the Oregon Health Plan Waiver (Rick Wopat)

History of the Plan

- original Oregon Health Plan legislation: SB27 created Oregon Medicaid, SB534 created the high-risk pool (a third bill that would have created an employer mandate was left out of the final package).
- The sustainability of the collaborative model the framers envisioned was built on three assumptions that have not held – there could be flexibility depending on the amount of funding available at a given time, providers

would be paid at least at cost ('03 session, hospitals agreed on a reimbursement reduction to 72% of cost; physicians have not received cost of living increases and the reimbursement rate now lags behind cost. Measure 30 took hundreds of millions of dollars out of healthcare.)
- Enrollment in OHP Standard has been cut from 120,000 to 27,000. Statewide uninsurance has risen from 10% to 17%. OHP enrollment is frozen and enrollee benefits continue to be reduced

Today
- Recently considered waiver amendments: reduction in hospital reimbursement rates, reduction in maximum in-hospital days per year to 18, elimination of consumer price index increases to fee-for-service physician payments, eliminating graduate medical education funding (resident training), elimination of coverage for over-the-counter drugs and reduced coverage of adult dental services, eliminating non-emergency transportation
- This had led to an environment in which collaboration is being forsaken and many providers are declining to accept Medicaid patients
- This group is well-positioned to take a fresh look at delivery system models and facilitate the integration of systems innovation with the next OHP waiver application to CMS

IV. Delivery Systems & Demonstration Waivers (Bob DiPrete), Exhibit II

Discussion
- Rather than approach CMS and ask what they will and will not allow and building a project around that, history has shown that it is best to establish state policy on delivery systems, outline the framework and strategies, lay out what needs to be fixed and how the given framework will fix it, and give that whole package to CMS for approval. In other words, build the best model you can come up with and then go to CMS for any changes you need to the federal component of that.
- What do you mean by "single medical chart"? CMS wants a single place to go to verify that there is proper case management for a given patient; in a fully-capitated plan, CMS expects one consolidated record. For primary care case management, they want to see what referrals were made and that there was follow-up on those.

V. Discussion: what is needed for successful community-based access models? Exhibit III (Flip-chart notes)

Group 1
- 3 models for improving health:
    - virtual FQHC which identifies a community or region as a patient population, with a defined set of benefits for which they are eligible and delivered by anyone willing to play by the rules.
    - public education model ala Governor Kitzhaber

        - community-based system: who has to be at the table to make sure everyone is invested?
- Vaccines for Children (VFC) is a model in which everyone is guaranteed service. Can this serve as an across-the-board model for prevention? (Equitable, defined benefit program) How did the VFC model develop and become universally accepted as good and necessary? Federal government invested a lot of money in the 70's and a shared ideology that public health and communicable disease prevention was important and that it worked. Also, school enrollment requirement. If prevention is the basic service available to everyone, what is the consumers responsibility that gets them to the next level of service?
- Challenges: creating a balance between the needs of patients and sustainability for providers, building respect and partnership among stakeholders.
- Medicare is an entitlement that creates problems/barriers to looking at broad solutions. Where is the bridge for someone between private employer sponsored insurance and Medicare when they retire before they are eligible?

Group 2

- Necessary elements:
    - capitation
    - disease management
    - case management using a managed care model; there is responsibility built into it for individual people at risk (case manager or PCP) and for establishing relationships with people in need of chronic disease management.
    - should incentivize electronic health records, billing, coordination between systems to eliminate paper
    - formularies should be required and strict, and generics used whenever appropriate.
    - transportation should be tied to capitation rates and be reimbursed (including arranging and supporting the use of it for continuity of care).
    - enabling services: case management, interpretation services including languages and/or health care literacy.
    - malpractice reform for systems including Medicaid/Medicare: we need to make sure that in the process of making it easier for providers to afford to treat safety net patients that we do not inadvertently institute an underclass of healthcare consumer.
    - increased use of off-shore providers. (X-rays are being read in New Zealand at night already for some Oregon hospitals)
- FHIAP model: localities have a premium purchasing product for employers to increase private insurance locally
- Multi-share model: employee, employer, and local foundation share cost
- Incentivize healthy behaviors and habits: tax incentives to businesses or individuals who support healthy behaviors,

- Use of Kaiser-style model: the parts that make delivery of care more rational (e.g., more integrated services), reducing likelihood of skimming or creation of "centers of excellence for billing/reimbursement"
- Community-based plan created around the communities needs and desires in which everyone shares in the benefits. Components:
    - Change the expectations of citizens (a realistic understanding of available resources and an understanding of the long-term nature of the timeline for change)
    - Have more citizen involvement beyond the typical community forum model (perhaps an ongoing board including citizen members)
    - Lifetime caps on benefits of (i.e.) $1M for Medicaid expansion population (an expectation that there are limited resources for this population, allowing participating plans to underwrite it with more confidence, to see a stop-loss thereby incenting continued participation). We will worry about outliers once we've gotten further down the road
- Incentivize providers who take on a larger share of the uninsured in their community
- Insurance companies should not be allowed to sell insurance to public employees/entities without serving a minimum number of Medicaid/Medicare recipients

Next Steps:

- Timeline for CMS waiver application: the group would need to put forward a solid delivery system model with a community that is ready and willing to implement it
- Clear articulated plan for what services will be provided, what population it will serve, and how the dollars will be spent (ala a grant application)
- Offline work: find out what other groups in the state are doing to make sure we are not duplicating efforts

Adjourned 3:00pm

Next meeting: November 15, 2005

Exhibits:

I. Agenda
II. Delivery Systems & Demonstration Waivers
III. Flip chart notes

Delivery System and Demonstration Waivers

The federal government tends to be concerned with the same set of delivery systems issues every year, but its willingness to be flexible on those concerns in a given year depends on who is in charge and what kinds of systems problems crop up elsewhere in the country. CMS will consider previous experience in Oregon and other states as well as the overall health reform design (eligibility, benefits, payment levels and types, research and evaluation questions, etc.) in making its decision on the proposed delivery system(s).
CMS has consistently taken the view that states can delegate authority to delivery system plans/providers, but not responsibility. The feds will always hold the state accountable for fulfilling the terms and conditions of the waivers granted to the state, no matter what delivery system models they have agreed to.

CMS typically requires that a state operating a waivered demonstration assure the following:

- Adequate provider network and capacity
- Timely access to appropriate care
- Case management, probably including
    - Single medical chart
    - Referral and follow-up protocols
    - Continuity of care planning and monitoring
- Quality assurance, e.g.
    - Complaint and grievance process
    - QA committee with written minutes
    - Review/audit of a sample of medical charts
- Utilization review
- Availability of covered services when medically necessary
- Integrity of claims submittal and payment
- Sound financial management and accountability
- Effective patient orientation and education
- Accurate and appropriate marketing

States (including Oregon) typically identify health plan/provider performance requirements (with standards specified in contract) that reflect what CMS requires of the state as well as the state's own policy objectives, such as

- Adequate provider network and capacity
- Maximum waiting periods for appointment scheduling and at appointment
- Case management responsibility and procedures
- Quality assurance
- Utilization review

- Financial management processes and procedures
- Patient orientation and education
- Approved marketing materials

Since the early 90's, Oregon has included the following delivery system models under OHP demonstration waivers:

1) Physician care organization (PCO), e.g. inpatient hospital
    a. Partial capitation
    b. Limited risk (physician and outpatient care, with exclusions such as Rx)
    c. Based on provider organizations at the community level in less populous areas of the state
2) Fully capitated health plans (FCHPs)
    a. Full capitation
    b. Full risk
    c. Based on provider organization at the community level in all areas of the state initially, but FCHPs pulled back from some areas after a few years of operation

3) Primary Care Case Managers (PCCMs)
    a. Capitation only for case management responsibilities (currently $6 pmpm), not for treatments provided
    b. No financial risk
    c. Found in most communities in Oregon

In general, delivery system models which emphasize accountability are likely to get a favorable federal review as long as they support the overall objectives of the demonstration and are clear in how they address the issues of importance to CMS:

- accessibility and availability of care,
- financial integrity and sustainability
- performance standards in quality assurance and utilization of services
- enrollee orientation and education
- integrity and availability of records (medical and administrative)

Group 1

Issues in General

1. Respect for providers as well as patients
   ➔adequate payment
   ➔current "adversarial" environment
   ➔need to strengthen provider network

2. Disintegration of delivery system
   ➔certain services are available only at certain locations (family planning)

3. Role of insurance companies

1

What is the Goal?

1. increased access or universal access
2. increased health for all?

2

Potential Models

1. FQHC model for
   ➔community/region
   ➔primary care model
   ➔FQHC "without walls"
   ➔Canadian/entitlement

   Barriers
   Lack of secondary care

   Issues
   ➔How to define benefits to be covered?

➔"Penetration Rate" for qualifying individuals
➔Blanket entitlement leads to decreased individual accountability

3

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2. Public Education Model
   ➔How is this different from FQHC?

4

Benefit Package Issues
➔Prevention would be investment

5

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3. Community Model

local politicians
government
labor
education
faith base
payers:
- ➔business
- ➔insurance companies

providers:
- ➔hospital
- ➔physicians

public at large:
- ➔uninsured
- ➔Medicare recipients

6

Group 2

Delivery Systems that May Work

- ◆ Capitated, including disease management & managed care model
  - responsibility for individual people at risk (e.g. case manager/PCP)
  - relationship established with chronic disease case manager

- ◆ Incentivize eectronic records, billings & coordination between systems (hospitals, etc)

- ◆ Formularies – make it strict, use lots of generics

1

- ◆ Transportation, tied to capitation – arrange & support for coordination of care
  e.g. enabling services – case management
  - interpretation services (language and healthcare literacy)

- ◆ Malpractice reform for this system
  - find data to validate how/if costs adversely affect costs
    - o determine qualitative behavioral costs of fear
    - o defensive medicine – heroic efforts from provider standpoint
  - reasonable level of liability

- ◆ Increase use of offshore providers, e.g., reading X-rays in India

- ◆ "FHIAP" or way to finance 3-share/multi-care model at local/community level premium purchasing

2

- ◆ Incentivizing healthy behaviors, habits, tax incentives to businesses and/or individuals

- ◆ Use of "Kaiser-style model": more integrated services at community level

- ◆ State concept (Community Health Plan)

- change expectation of citizens (by fostering more citizen involvement, and not necessarily what has been done in the past)
- supports health care consumers to get or access needed services, e.g., transportation, right services, right time.
- capitation as the financing model

◆ Incorporate timeline that recognizes long-term nature of human behavior changes

◆ Should limit lifetime care for expansion population (stop-loss, needs data) and be capped at $1million for instance (allows plans to underwrite with more confidence)

3

◆ Incentivize providers who take on larger share of uninsured (compared with others in their community)

◆ Can't sell health insurance to any government groups if insurance companies don't take their fair share of Medicaid/Medicare people

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DRAFT

Delivery System Models Work Group Meeting Notes
Oregon Health Policy Commission
November 15, 2005
600 NE Grand Ave, Room 370A
Portland, Oregon

Members Present: Vanetta Abdellatif, Rick Wopat, Tina Castañares, Ross Dwinell, Lisa Ladendorf, Jennifer Pratt, Ken Provencher, Carlton Purvis, Peter Reagan, Dick Stenson

Members Excused: Craig Hostetler, Chuck Kilo, Karen Whitaker

Guests: Laura Sisulak, Briar Ertz-Berger

Staff: Marian Blankenship, MPH Intern, Oregon Health Policy Commission (OHPC)
Laura Brennan,
Gretchen Morley, Director, Oregon Health Policy Commission
Jessica van Diepen, Assistant, Oregon Health Policy Commission

Call to order: 1:10p.m.

I. Safety Net Advisory Council Update (recap of this morning's meeting)

- Ken Provencher elected chair
- Discussion of what components should be included in the Council's report on safety financing streams and attendant state policy recommendations
- Discussion of DHS-furnished numbers describing the Medicaid portion of safety net financing

II. Revisiting the workplan

- Timeline: Marian will submit the first draft of her report to OHPC staff on November 23. Staff will distribute the draft report to workgroup members via email the second week in December; workgroup members will reply with edits in time for staff to distribute the second draft at the December 20. We will discuss policy recommendations to the OHPC at the December meeting as well as recommendations on the future of the workgroup
- To address return-on-investment (ROI)/"business case" for community involvement in systems innovation, Dr. Wopat suggests we look at the methodology described at the Communities Joined in Action conference in Columbus, OH. We should also gather ED utilization data (trends, types of visits, etc) to support an ROI case.

III. Community Inventory Update and Overview of Findings (Marian Blankenship), Exhibit IV

- Five communities interviewed
    i. Deschutes County – in initial planning phase – a concept paper, authored by Christine Winters, Mike Bonetto, Dan Pettycord, and a local safety net representative, is being circulated to pull in stakeholders to convene a "leaders panel" to start a dialogue on local health issues
    ii. Lane County 100% Access Coalition (Ken Provencher) – began last winter – after a United Way assessment identified access to care as a primary issue (it found far greater need in that assessment compared to previous ones). Its coalition of partners is very broad, including local business, providers and faith groups; these stakeholders completely revamped the original proposed workplan. The Coalition was recently awarded a Healthy Communities Access Program (HCAP) grant to continue its efforts. It has several workgroup in progress: the pharmacy workgroup has worked the fastest so far on a number of initiatives; the primary care/medical home workgroup has been slower going by virtue of the more sensitive issues it is addressing in cooperation with the Oregon Primary

Care Association. The Coalition is unique thus far in its outreach to insurance companies

iii. Northeast Oregon Network (Lisa Ladendorf) – Union, Baker, & Wallowa Counties, combined population 35,000-40,000. Began in August 2004 with a meeting of interested providers including area public health, mental health, area Agencies on Aging and Services for Seniors & People with Physical Disabilities, and the Commission on Children and Families to discuss healthcare access issues. Over the last year it has continued to meet to define Network parameters, build the membership, define work processes, etc. It was recently awarded a Health Resources & Services Administration rural health development planning grant. The Network now includes two hospitals and two rural safety net clinics. It has hired a consultant from CHOICE and there is an upcoming strategic planning day scheduled for January to bring all partners to the table at the same time. A possible future project is a feasibility study for a tri-county FQHC; also focusing on using existing relationships to continue to fund outreach efforts for OHP, SCHIP, and FHIAP programs, and on submitting grants to pay for a couple of bi-lingual community health outreach workers to serve all three counties.

iv. Tri-County Safety Net Enterprise – early operations stage – born of a Robert Wood Johnson Foundation grant in 1999 which resulted in the "Blue Ribbon Panel" of founders. The Enterprise is an intergovernmental agreement between Washington, Multnomah, and Clackamas Counties which is now about a year old. Legal issues and slow relationship building led to a drawn out development process. It serves as a convenor of community-focused attention to health care issues between the three counties and supporting/facilitating of existing, non-Enterprise projects. Has been active in developing a coordinated healthcare system for women (focus on prenatal and maternal health care). There is consensus around what the access issues are. The board is currently wrestling with what projects it will take on. Membership consists of FQHC's, hospitals, county commissioners and county health department directors. Three goals: develop community created solutions which are supportive of the safety net, ensure access, and build a supportive infrastructure for the safety net.

v. Samaritan Health Services (Rick Wopat), Linn, Benton & Lincoln Counties – fully operational – late 80's, early 90's: formation of physician/hospital organization, three hospitals joined in the creation of a Medicaid health plan, and agreement on a payment structure in which hospitals and physicians take on patients regardless of their insurance status or ability to pay. They are paid on a flat, per-service rate (Money from all patients is pooled.) Collaborative, community-based, not-for-profit organization serving 230,000 people (80% of care provided in the three counties). 5 community non-profit hospitals, 200 physicians (primary care, neurosurgery, cardiac surgery, cardiology, orthopedics, general surgery; employ 75% of primary care physicians in the area, 30% of specialists), 35 clinics, senior care facilities, & health plans. Work with county health departments and local governments; Oregon State University, Lynn-Benton Community College, & Oregon Health & Science University. Built heart center and mental health hospital in Corvallis. 10% annual profits are reinvested in the community in the form of grants. Member physicians volunteer at safety net clinics and hospitals provide lab services at no charge for those patients. Maternity care coordination plan. Health career center training local health care workers. Guesthouse in Corvallis for patients' families. Contract with Public Employee's Benefit Board for private insurance in January. Next steps for collaboration is working more closely with county health departments and building relationships with local employers.

Discussion

- *Note for further investigation*: who, if anyone, is working to address access to care for seniors?

- Final report will profile each of the communities interviewed with nuts & bolts specificity to questions like the structure of the collaborative and how it was assembled.

IV. Discussion of a plan to communicate findings

- Held over to December 20 meeting agenda

V. What's next

- December meeting agenda: discuss report findings, identify delivery system models not represented in Oregon, formulate recommendations to the State, make recommendation to Commission on next steps for the workgroup

Adjourned: 2:55p.m.

Assignments:

- **<u>OHPC staff</u> will make initial edits to Marian's first draft and email it to workgroup members ahead of the December 20 meeting**
- **<u>Workgroup members</u>: read critically over draft report, making note of needed changes and additions, and send back to OHPC staff for compilation before the December 20 meeting**

Next Meeting: December 20, 2005

<u>Exhibits:</u>
I. Agenda
II. October 18 meeting notes draft
III. Current work plan
IV. Marian's initial survey results, overview

Survey Summary (all five communities combined)

Question 1: Innovation of project (Do you see anything about this project that you would identify as innovative and if so, what do you think it is?)

Range of Responses:	*Incidence:*
Collaboration (the breadth and/or depth of skill, key players/diversity)	(9)
Structure of collaborative	(5)
Scope of the project	(4)
Tenacity of core leaders	(4)
Over-arching shared sense of purpose among leadership and staff	(3)

Question 2: Timing of project (What contributed to this project being undertaken now?)

Range of Responses:	*Incidence:*
Consensus around health care crisis	(11)
Vision shared by key leaders	(3)
Financial imperative	(3)
"Stars aligned"	(2)
Collaborative efforts provided credibility by earlier successes	(1)

Question 3: Project goals

Range of Responses:	*Incidence:*
Achieve 100% Access	(6)
Increase access for un/underinsured	(6)
Relationship build	(5)
Shore up existing safety net clinics	(5)
Integrate system/include schools, social service etc.	(5)
Achieving fairness/equity	(4)
Increase efficiency/decrease cost	(4)
Improve measurement tools/capacity	(4)
Provide education/added value to community	(4)
Influence policy	(3)
Project should be replicable	(2)

Question 4: Methods/strategies to reach goals

Range of Responses:	*Incidence:*
Relationship building	(10)
Begin with winnable tasks ("low hanging fruit")	(7)
Recruit key people	(5)
Network/info-share with others around state/country	(5)
Get provider "buy-in"	(4)
Cultivate ability to share health information	(4)
Partners need to commit tangible resources	(4)
Use of workgroups for targeted issues	(4)
Focus on prevention	(3)
Use of professional facilitation	(2)
Reduce # of medical errors	(1)
Position project to influence funders	(1)
Reduce unnecessary medical care	(1)

Question 5: Sources of project funding and/or projected funding issues

Range of Responses:	*Incidence:*
Will need FTE designated to project (to maintain)	(6)
Have or will apply for grant funding	(6)
Have utilized donated resources	(3)
Need seed money in order to move project forward	(3)
Need to stabilize funding of project	(1)

LESSONS LEARNED AND SIGNIFICANT CHALLENGES

Question 6: Desired/achieved outcomes (How will you know if you've impacted access, how will service delivery be different?)

Range of Responses:	*Incidence:*
Track statistical data (E.D. use, immunization rates, surveys etc)	(12)
Improved trust among partners	(6)
Evidence of increased access	(5)
Improved/increased community dialogue	(5)
Increased visibility of project	(3)
Achieve 100% Access	(2)
Improved efficiency/decreased costs	(2)
Better understanding of how to measure projects developmentally	(2)
Sustainability	(1)
Project expands	(1)

Question 7: Significant challenges and/or barriers facing project

Range of Responses:	*Incidence:*
Politics/turf issues	(16)
Fairness/equity issues	(8)
Busy schedules	(7)
Getting provider community on board	(7)
Distance between communities (geographically and/or culturally)	(6)
Project concept hard to grasp/too vague-what are the "products"	(6)
Project too overwhelming/maintaining momentum	(5)
Insufficient data-especially r.e. un or underserved	(5)
Path unclear for undertaking a project of this type	(5)
Scarce number of doctors/recruiting challenges	(4)
Burden of mental health needs	(4)
Risk of becoming a "beacon city"	(4)
Lack of consumer or broader community voice	(4)
Instability of state funding	(3)
Managing inclusiveness	(3)
Lack of ability to share health information across systems	(3)
Cost of medications	(3)
Burden of dental needs	(2)

Question 8: Strategies considered or implemented to attempt to address challenges and/or barriers

Range of Responses:	*Incidence:*
Honest communication	(8)
Individualize strategies to meet needs of specific community/population	(7)
Recruit/maintain those participants who are dedicated and optimistic	(5)
Focus on the development process of building the collaborative	(5)
Include a diversity of participants	(4)
Focus on building relationships	(4)
Use outside consultants	(3)
Must be willing to give something up	(2)
Invest in electronic health records system	(2)
Use of mediation	(2)
Use of professional facilitators	(2)

Question 9: Lessons learned that might be helpful to other communities

Range of Responses:	*Incidence:*
Investing in the *process* is key	(14)
Be inclusive	(7)
Get the provider community on board	(4)
Build a winning team of principle players	(4)
Do what is best for patients and communities	(3)
A non-profit is a good convener	(2)
Marketing of the concept is very important	(2)
Use of targeted workgroups is beneficial	(2)
Build in the public health system	(2)
Organizations must be willing to stretch beyond their core missions	(1)

Question 10: What can the state do to assist this project (In the form of policy, technical or agency assistance?)

Range of Responses:	*Incidence:*
Provide technical assistance (consultation r.e. data, grant writing etc.).	(14)
Provide "connective tissue" between communities and other models.	(11)
Value that communities have an important role and that each is different.	(9)
Provide seed $ for project start up/fund promising pilots/programs	(7)

Specific policy and/or support suggestions can be found in Appendix I