Changes in Enrollment Among OHP Standard Clients with OHP2 Implementation

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In collaboration with the Office for Health Policy and Research (OHPR) and the Office of Medical Assistance Programs (OMAP)

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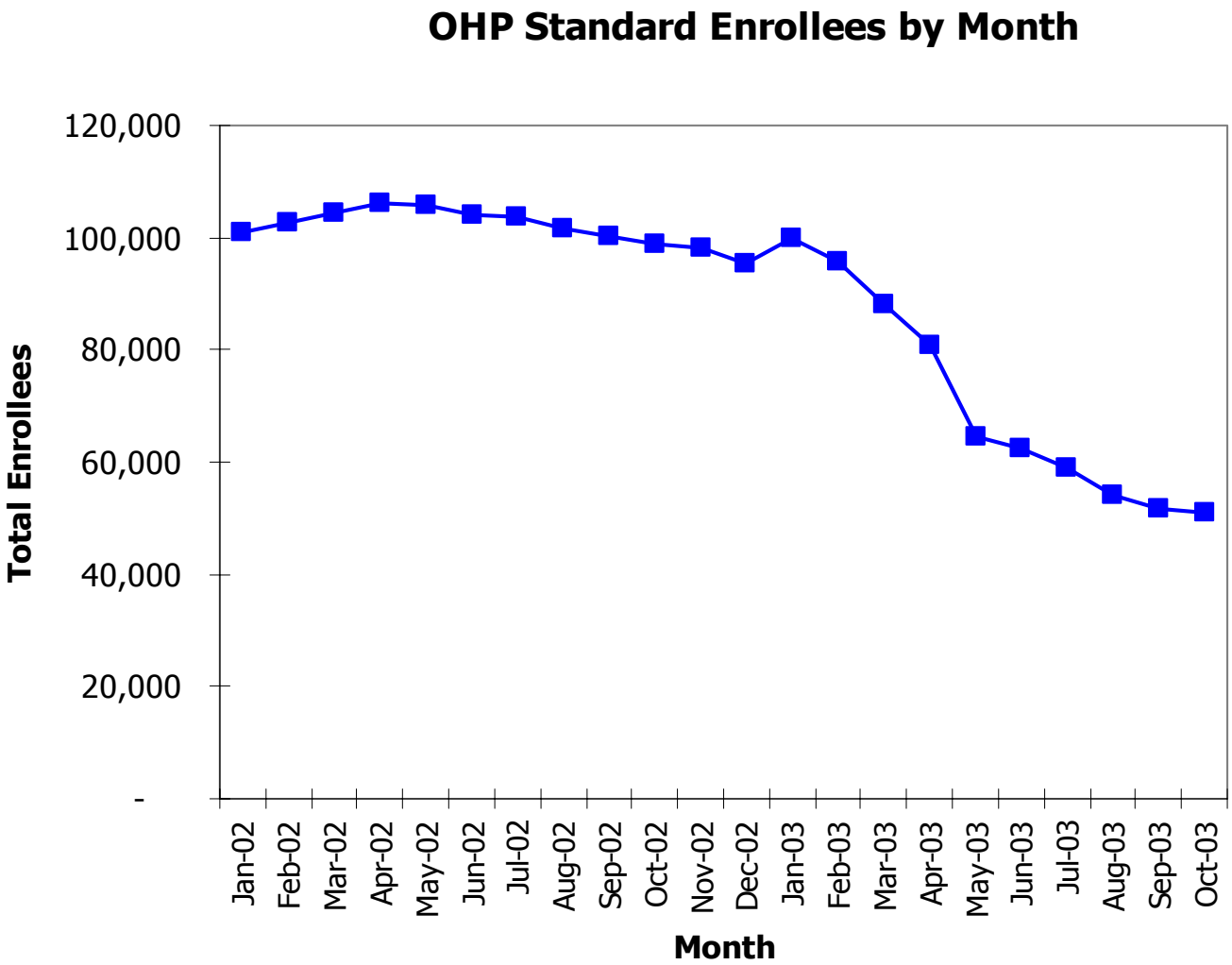
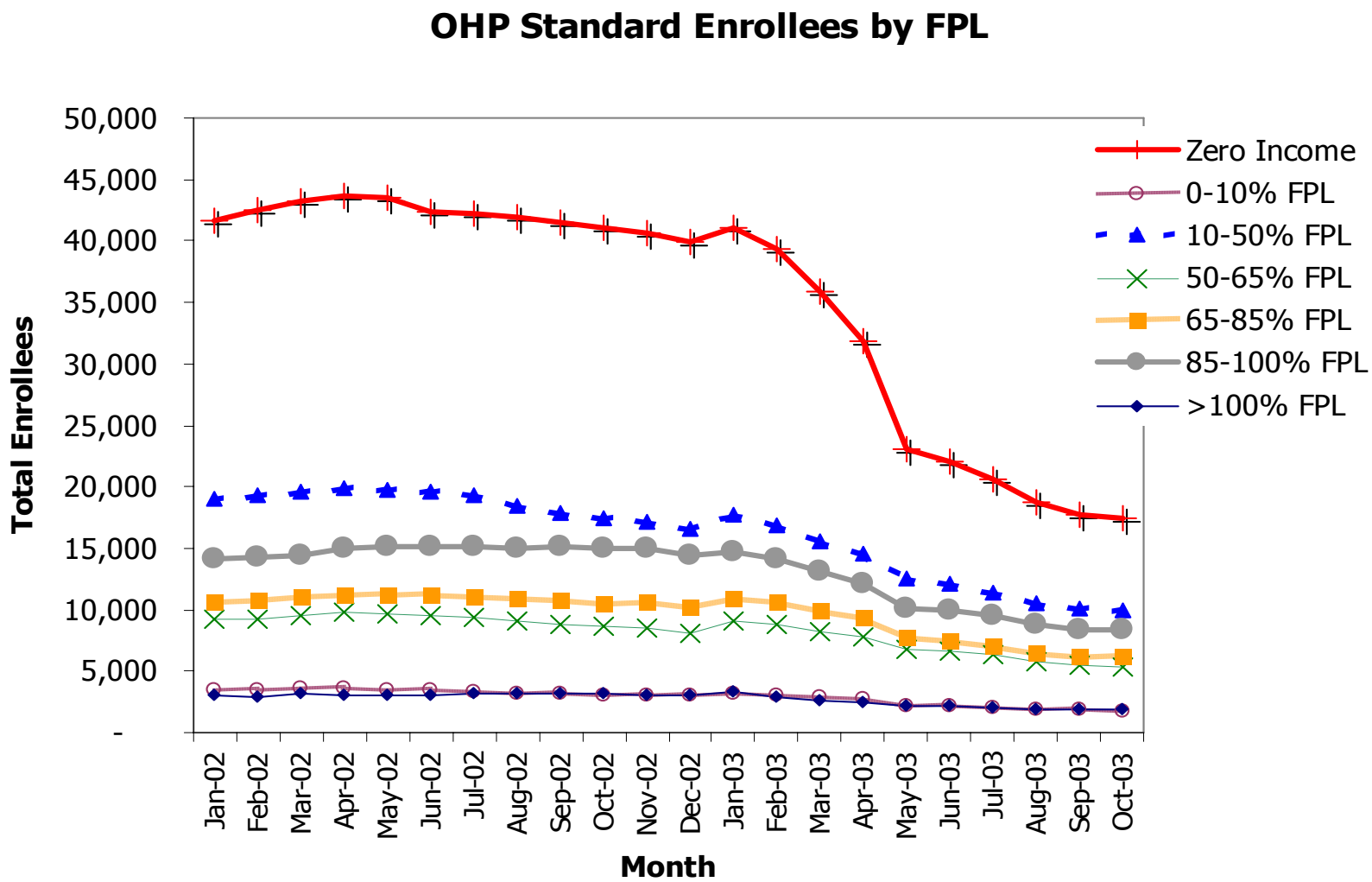


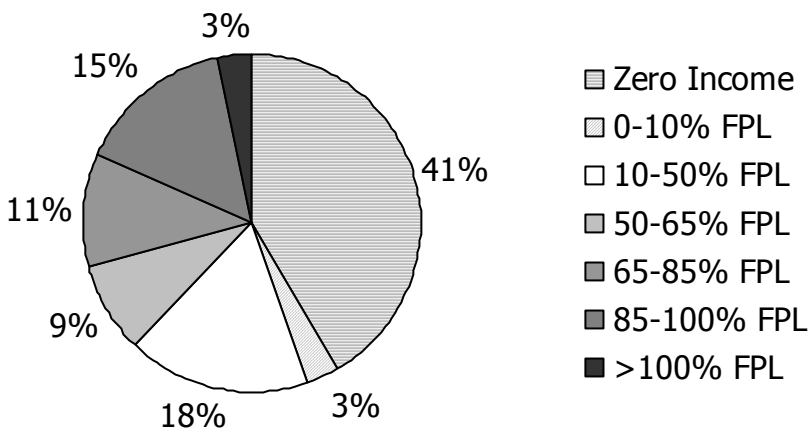
Between January 2003 and October 2003, enrollment in OHP Standard decreased from 102,000 to 51,000.



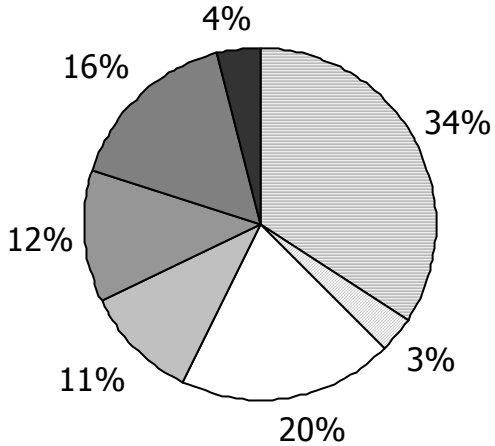
Steepest decline in enrollment experienced by those with zero income. This group experienced a 58% decline from January 2003 to October 2003.

FPL Case Mix Changes with OHP2

Case Mix, October 2002

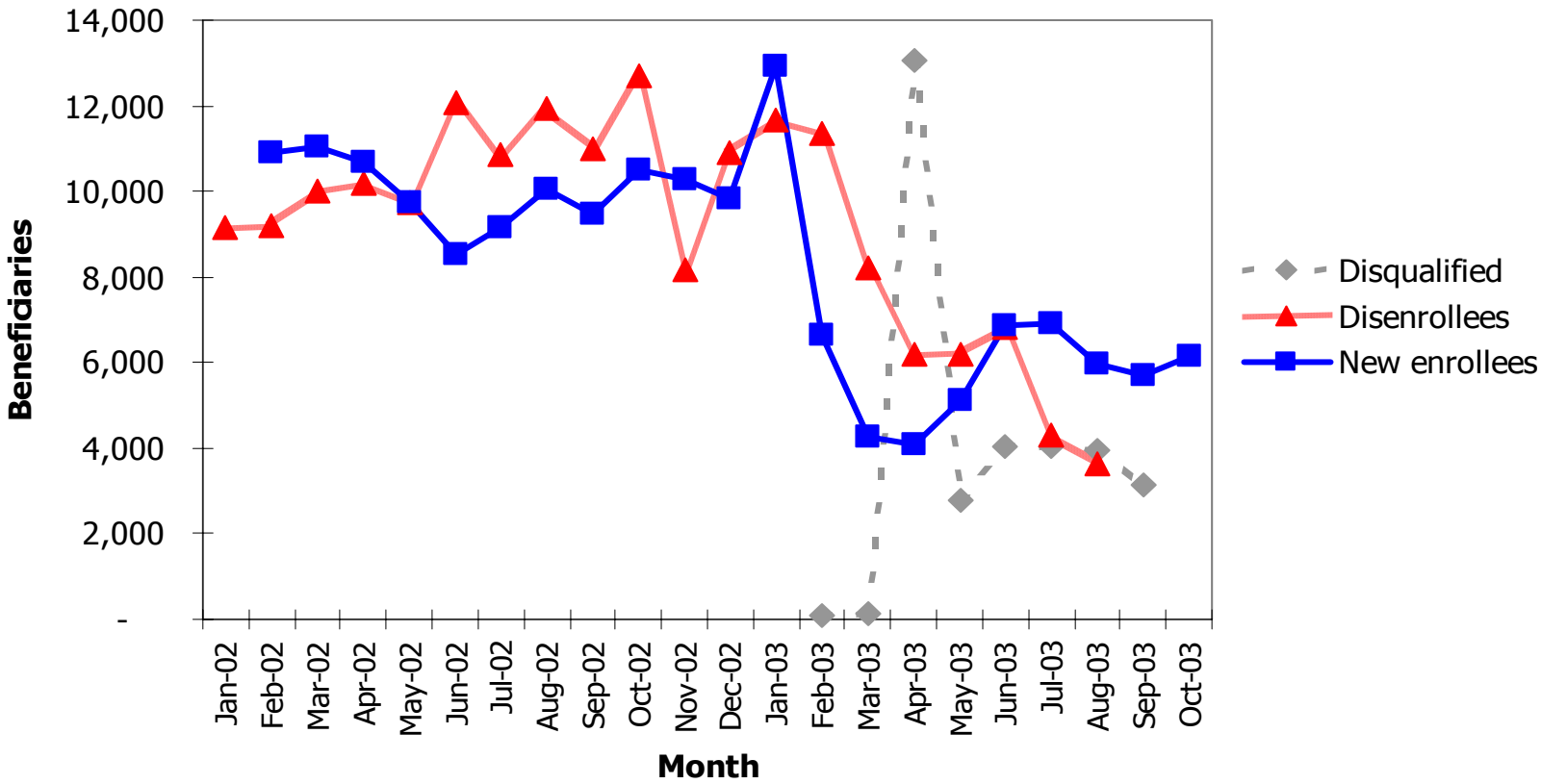


Case Mix, October 2003

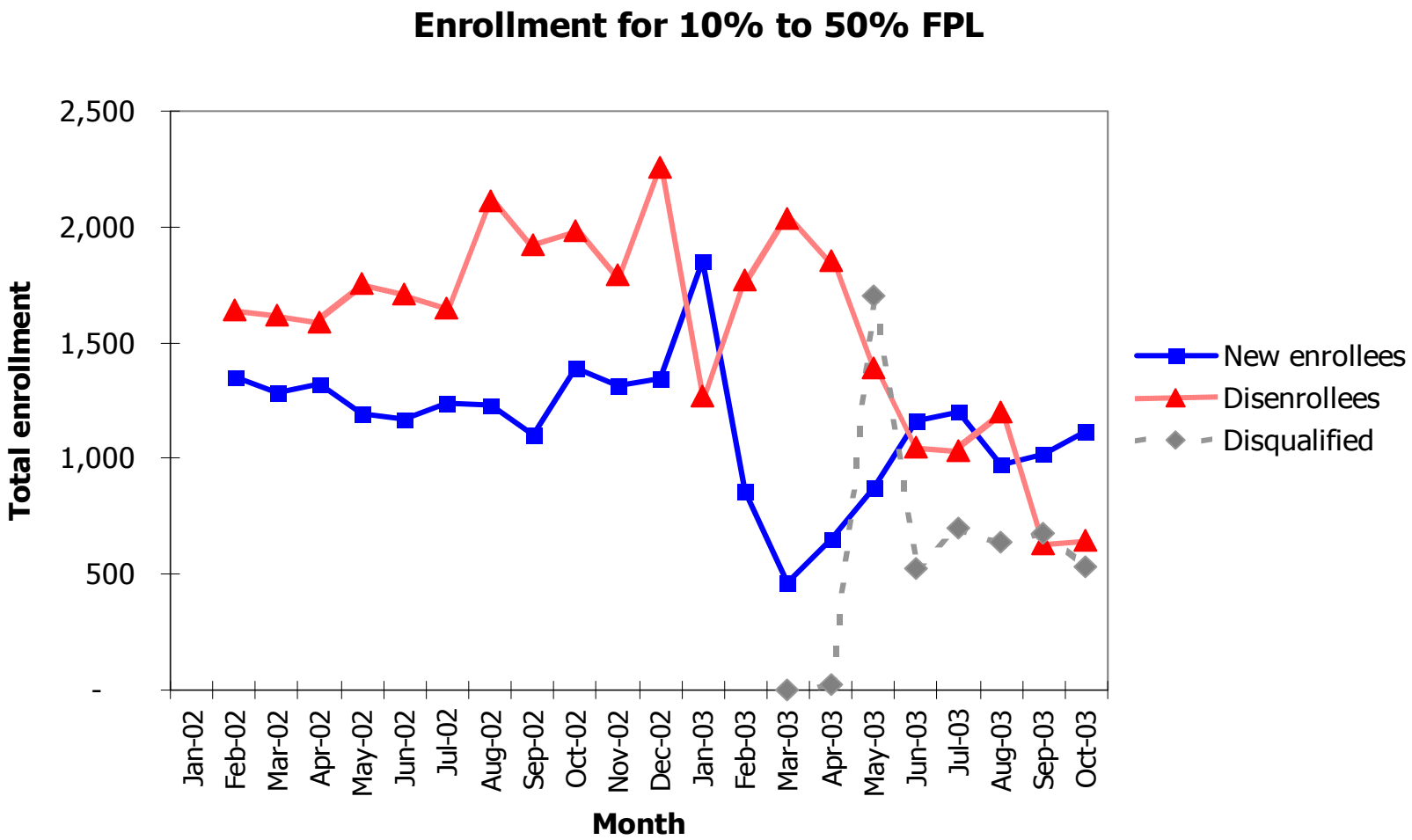


The "case mix" for OHP shifted as a result. The zero income category accounted for 41% of the OHP cases in October 2002. By October 2003 they accounted for 34% of the cases.

New enrollments, disenrollments, and disqualifications: All OHP Standard



After the initial implementation of cost sharing and benefit changes, new enrollment for the zero income category declines sharply and never returns to pre-OHP2 monthly levels.



Other income categories almost return to pre-OHP2 monthly levels.

Limitations of the Data

- Premium was not the only change
  - Increased co-pays implemented (February 2003)
  - Outpatient mental health and chemical dependency benefits eliminated (March 2003)
- Utilization data not part of this analysis
  - Will be important to understand who stayed in terms of utilization (e.g., did healthier people leave?)
  - Without utilization data, impossible to understand the influence of co-pays

Additional Findings

- Individuals enrolled for more than 7 months are more likely to continue with enrollment
  - Utilization or other effect?
- Older individuals more likely to stay enrolled
- After implementation of rule disqualifying individuals for non-payment of premiums:
  - 85% to 100% FPL most likely to stay enrolled
  - 0 income least likely to stay enrolled
  - Non-English speakers more likely to stay enrolled

This study was funded by the Office for Health Policy and Research (OHPR) in collaboration with the Office of Medical Assistance Programs (OMAP) through the Oregon Health Research and Evaluation Collaborative (OHREC) using funds from the Robert Wood Johnson Foundation's (RWJF) State Coverage Initiatives Grant.

Further study with analysis of utilization changes is planned and recently submitted for consideration of grant funding to the RWJF Changes in Health Care Financing and Organization (HCFO) Program.

Individual Characteristics of Patients in the OHSU Emergency Department (ED)

Survey Results Presented by
Tina Edlund, MS
Evaluation Research Director
Office for Oregon Health Policy and Research

February 2004

Study Background

- Descriptive study designed to complement earlier analysis of OHSU ED administrative data conducted by Dr. Robert Lowe.
- Dr. Lowe's study showed 17% increase in uninsured ED visits from March-May 2003 when compared to same time period in 2002.

Research Questions

- Did patients attempt to obtain care in other primary care settings before visiting the ED?
- What were the barriers to access in other settings?
- What is the insurance history of uninsured patients in the OHSU ED?

Survey Administration

- OHSU ED patients between October 12, 2003 and November 3, 2003.
- Interviewers present in the ED 16 hours a day, 7 days a week.
- Interviewers were volunteer undergraduate research assistants in the Clinical Research Investigative Studies Program (CRISP) at OHSU.

The Sample Frame

- Patients meeting the inclusion criteria randomly selected into the study with a coin toss
- 2,669 ED admissions during the study period: 647 surveys completed.
- Exclusions
  - Transfers from Skilled Nursing Facilities (SNF)/Nursing homes
  - Non-English speakers (except Spanish)
  - Trauma patients
  - Sexual assault victims
  - Patients on psychiatric holds
  - Patients in police custody

The Survey

- 33 questions, administered by face-to-face interviews
- Questions included:
  - Patient experience of care prior to ED visit, if any
  - Prior 12-month ED utilization
  - Prior 12-month health care utilization
  - Usual source of care
  - Unmet need (didn't get needed care, delayed care)
  - Current and previous health insurance status
  - Source of health insurance
  - Reasons for insurance loss
  - Demographics

Demographics: Age

Age

Age Categories	Sample Frame		Respondents	
	n	%	n	%
0 to 18	595	22%	115	18%
19 to 29	596	22%	148	24%
30 to 39	467	17%	114	18%
40 to 49	408	15%	93	15%
50 to 59	299	11%	85	14%
60 to 69	146	5%	47	8%
70 and over	158	6%	24	4%
Total	2669	100%	626	100%

Demographics: Gender

Gender

	Sample Frame		Respondents	
	n	**%**	**n**	**%**
Male	1317	49%	293	45%
Female	1352	51%	353	55%
Total	2669	100%	646	100%

Demographics: Insurance Status

Insurance Status

Insurance Status	Sample Frame		Respondents	
	n	%	n	%
Uninsured	721	27%	164	25%
OHP	665	25%	226	35%
Medicare	342	13%	71	11%
Commercial	649	24%	153	24%
TRICARE	25	1%	16	2%
Other	78	3%	10	2%
Unknown/Missing	189	7%	7	1%
Total	2669	100%	647	100%

Symptom Onset

- Symptom onset fairly evenly distributed across time.

Time since onset	Percent
0 to 4 hours	14.8%
5 to 8 hours	11.4%
9 to 24 hours	16.1%
1 to 2 days	13.4%
3 to 6 days	15.6%
1 to 4 weeks	15.8%
1 to 6 months	8.5%
More than 6 months	4.2%

Medical Advice-Seeking Behavior

- 45% of the study participants came to the ED on medical advice from a provider
  - Of those, 55% phoned and 45% visited
- 55% came to the ED without seeking medical advice

Of the 45% who sought medical advice, reasons for coming to the ED included:

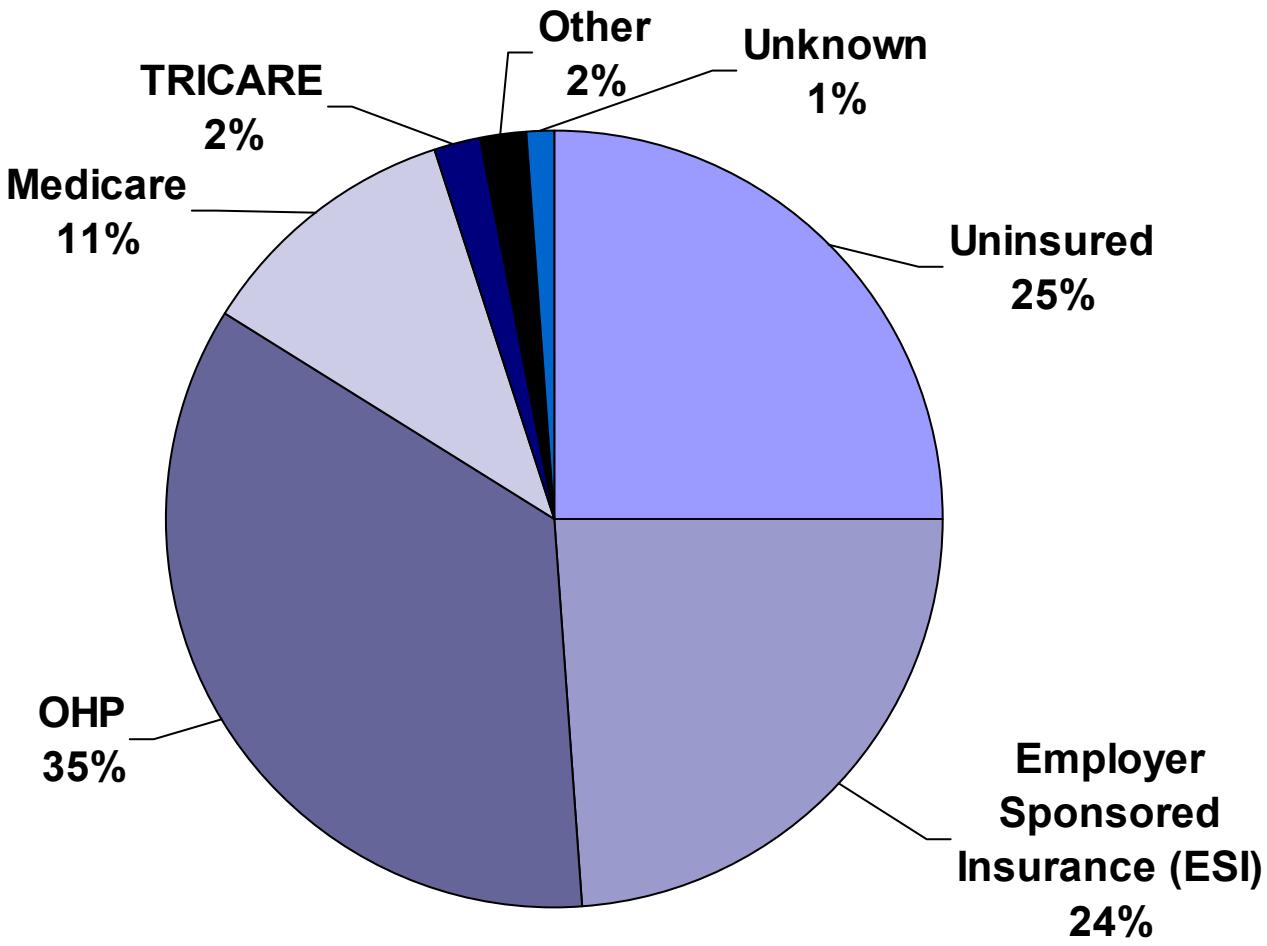
- 93% were referred to the ED by their provider

- 28% reported their regular clinic was not open
- 23% reported that there were no appointments available when they could get to their regular source of care
- 22% reported no urgent appointments available

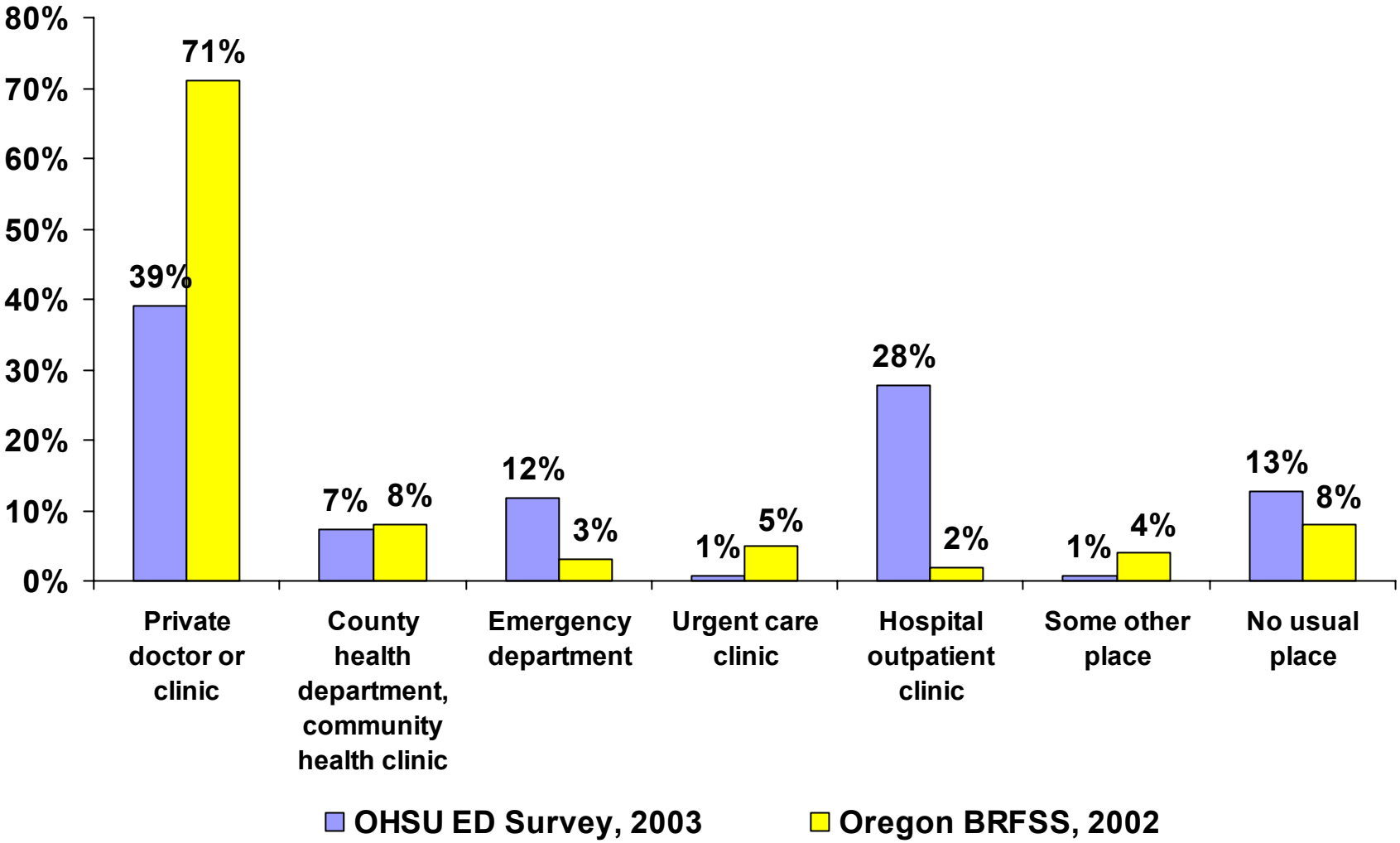
For the 55% not seeking medical advice, reasons cited were:

- 81% believed they had a medical emergency
- 56% reported their condition was worsening or pain increasing
- 43% reported that OHSU was convenient
- 38% reported that they have no regular health provider
- 35% reported that OHSU is their regular source of care
- 30% reported that they have no health insurance

Insurance Status and Source

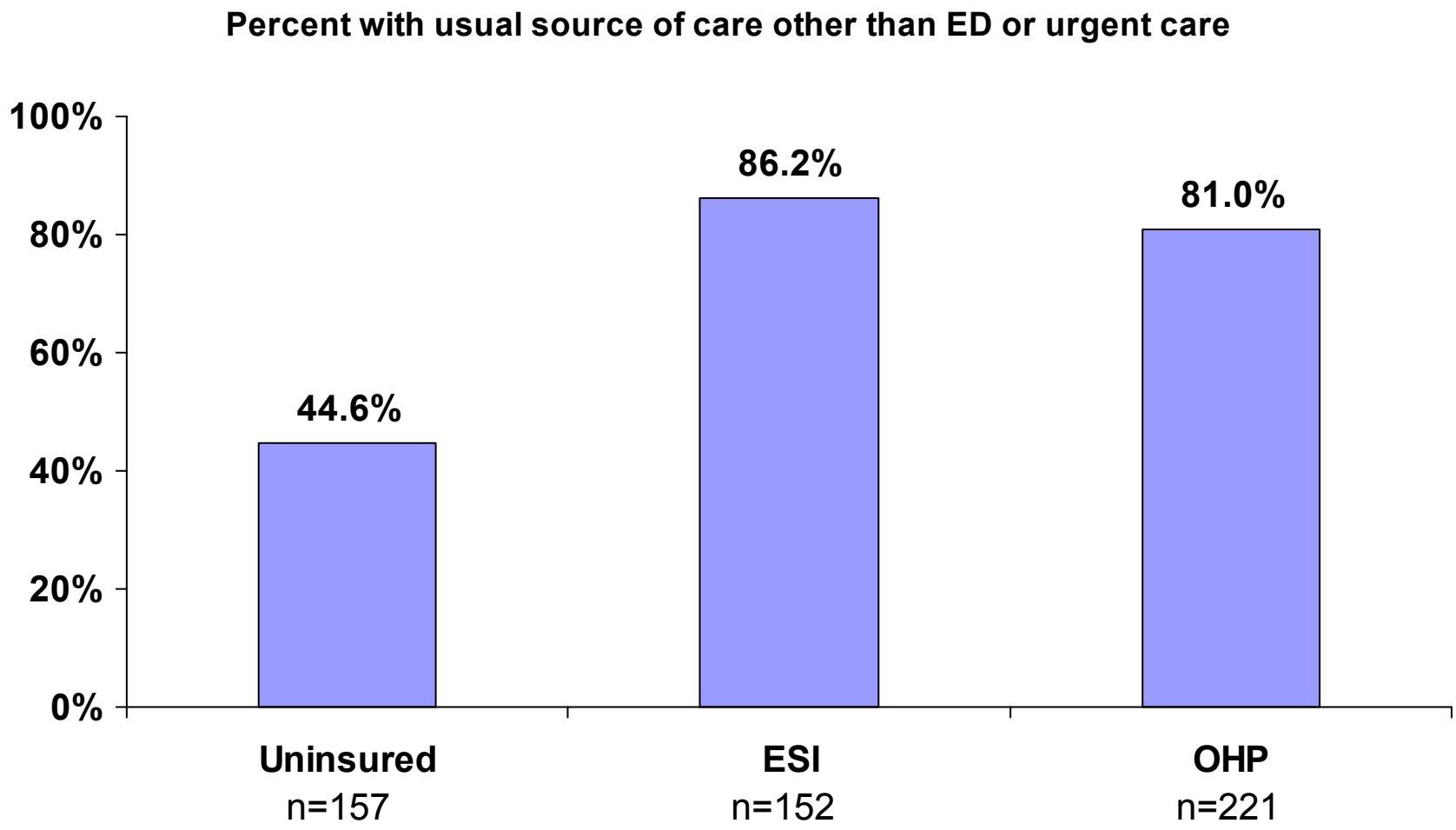


Usual Source of Care



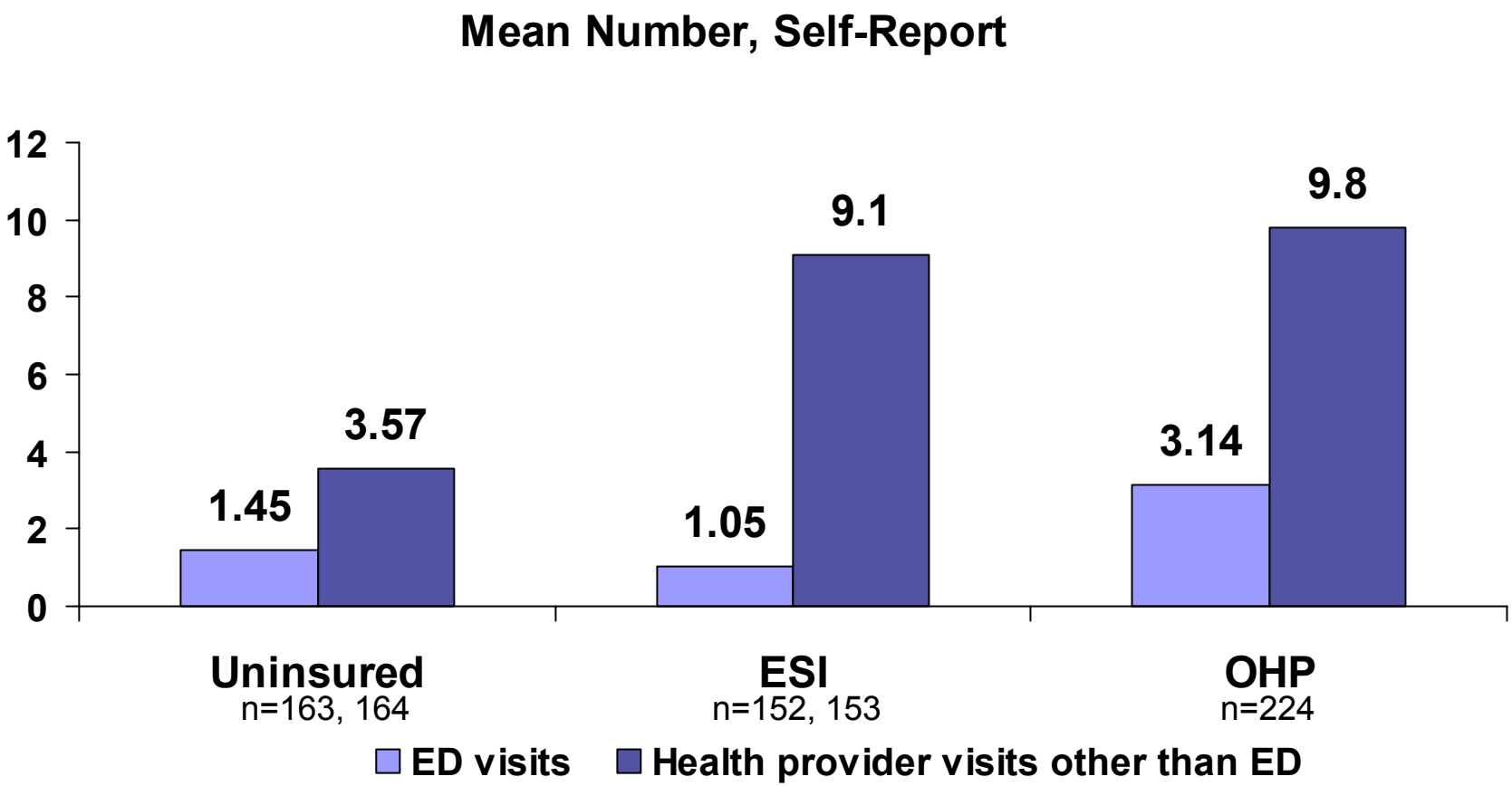
Data age and sex adjusted.

Usual Source of Care



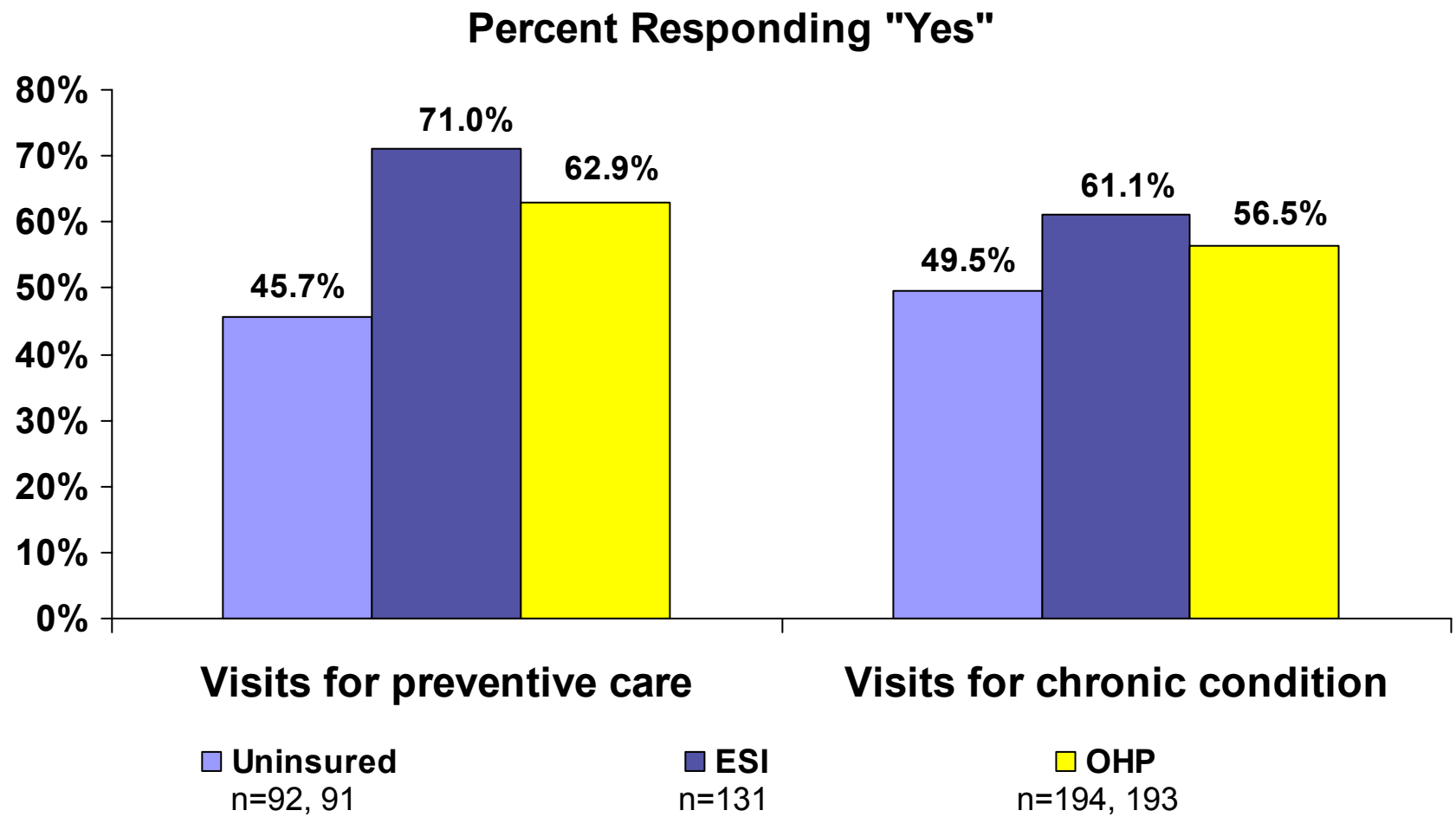
Sig. .000 (Chi-Square)

Number of ED and health provider visits in last 12 months



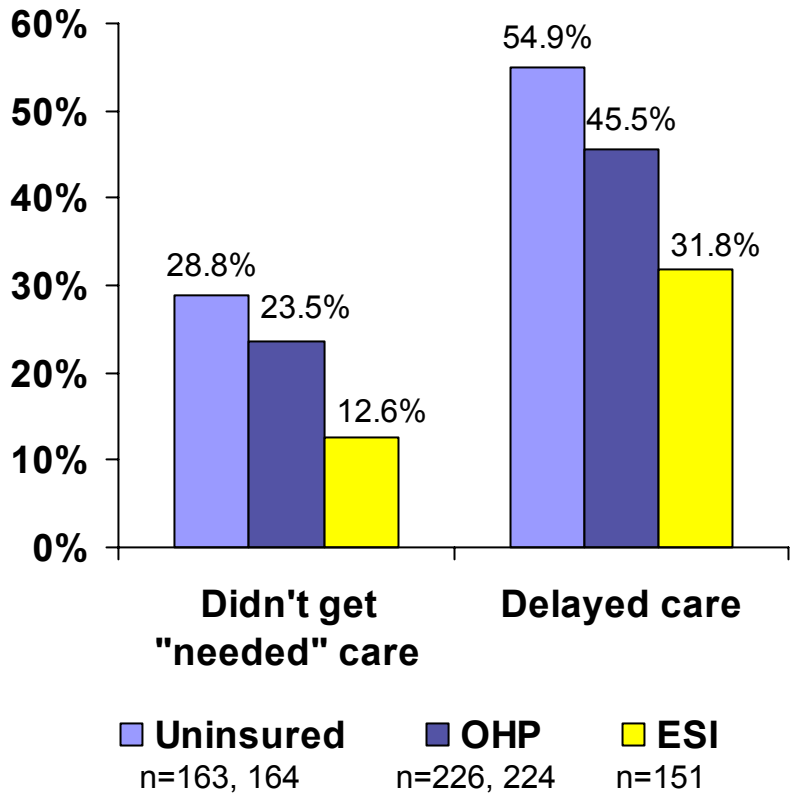
*Asymp. Sig. .000, Kruskal-Wallis Test for both visit types.

For those with visits in prior 12 months, any visits for preventive care or chronic condition?



Unmet Need

- 21.7% of population in Portland PMSA below 200% federal poverty level report not getting “needed” care (NHIS, 1999/2000)
- Higher levels of unmet need associated with higher ED utilization for survey respondents
  - 3.9 vs. 1.5 ED visits in last 12 months for those not getting needed care
  - 2.9 vs. 1.4 ED visits in last 12 months for those reporting delaying care



*Asymp. Sig. .000, Pearson Chi Square for both measures.

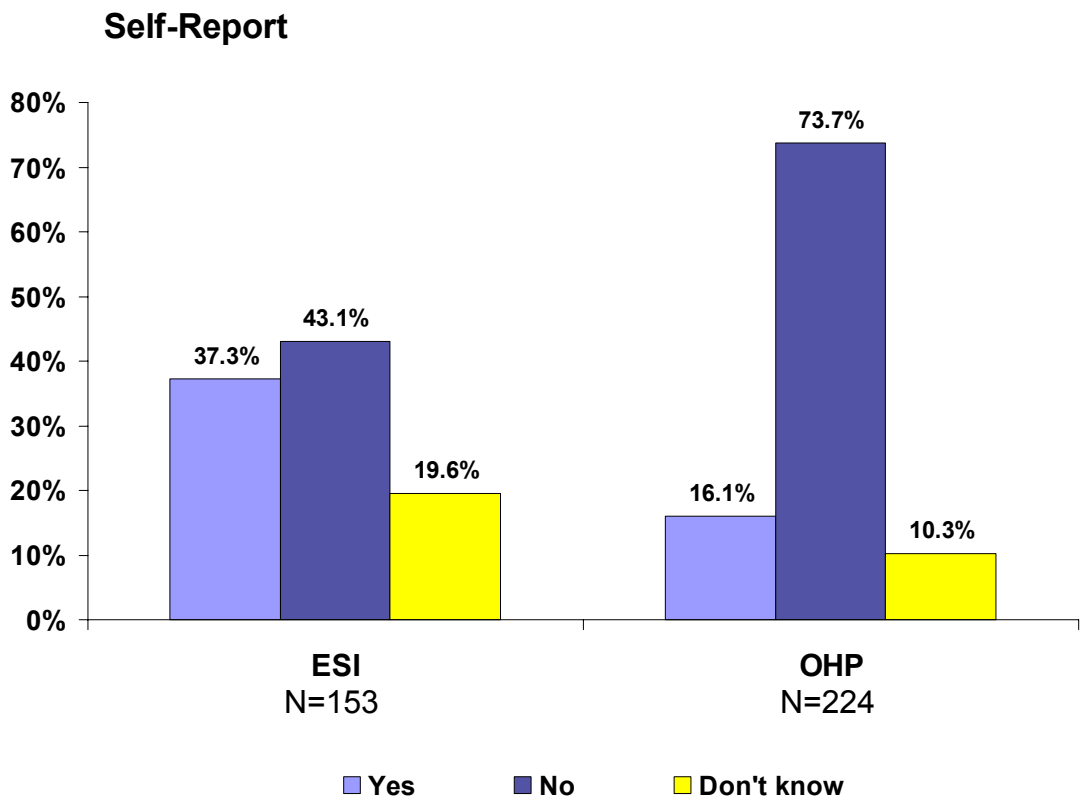
For those not getting needed care or delaying, 5 top reasons cited were*…

- 47.2% reported they were worried about cost
- 43.8% didn't have health insurance at the time
- 35.2% didn't have a regular healthcare provider
- 33.8% couldn't get an appointment as soon as they wanted
- 20.7% owed money to a doctor, clinic or hospital

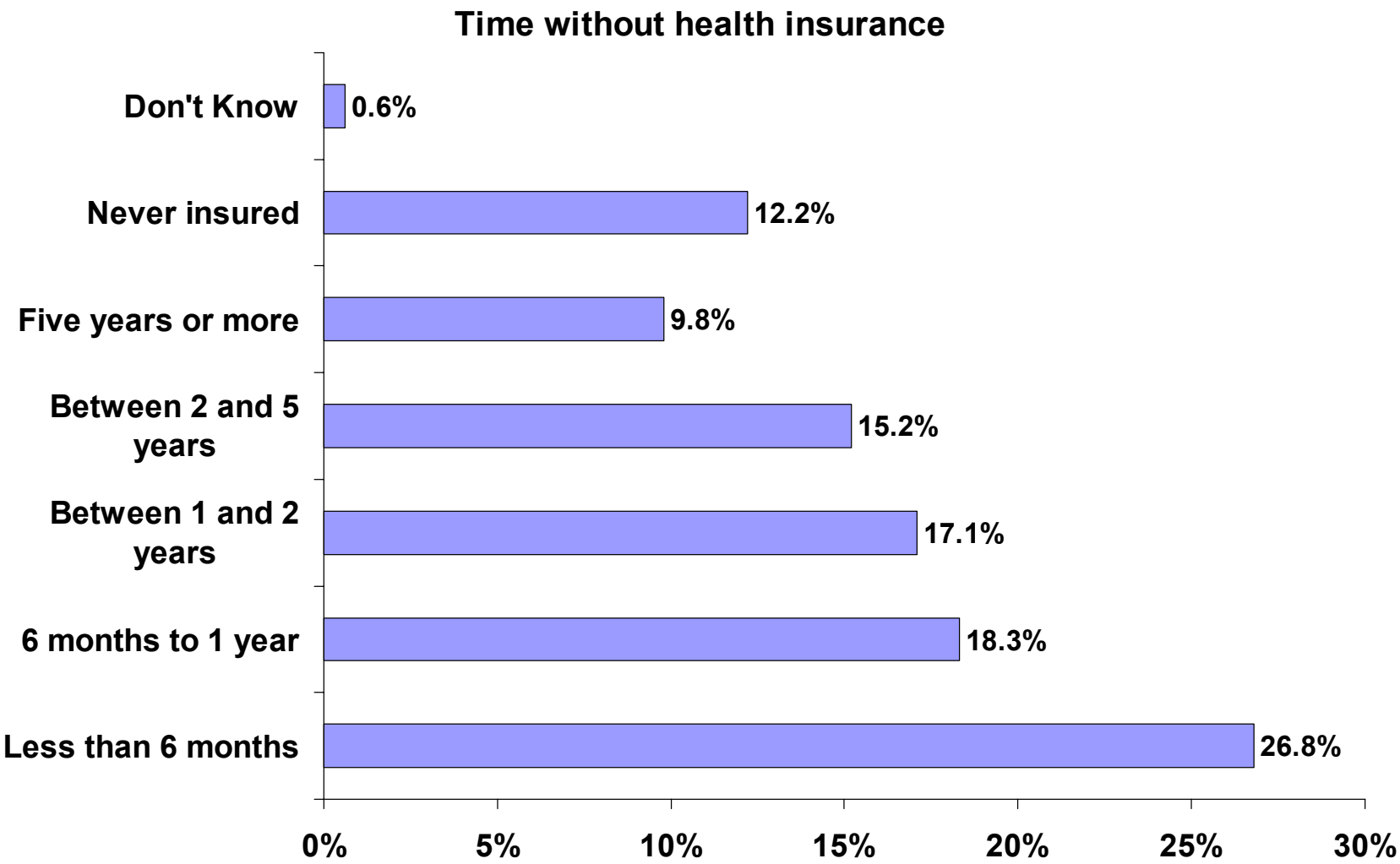
*n=269. Multiple responses allowed. Will not sum to 100%.

Co-Pay Required for ED Visit

- 3 respondents reported a percentage (10% to 15%) as their co-pay requirement
- Most commonly reported amount was $50 (34%)

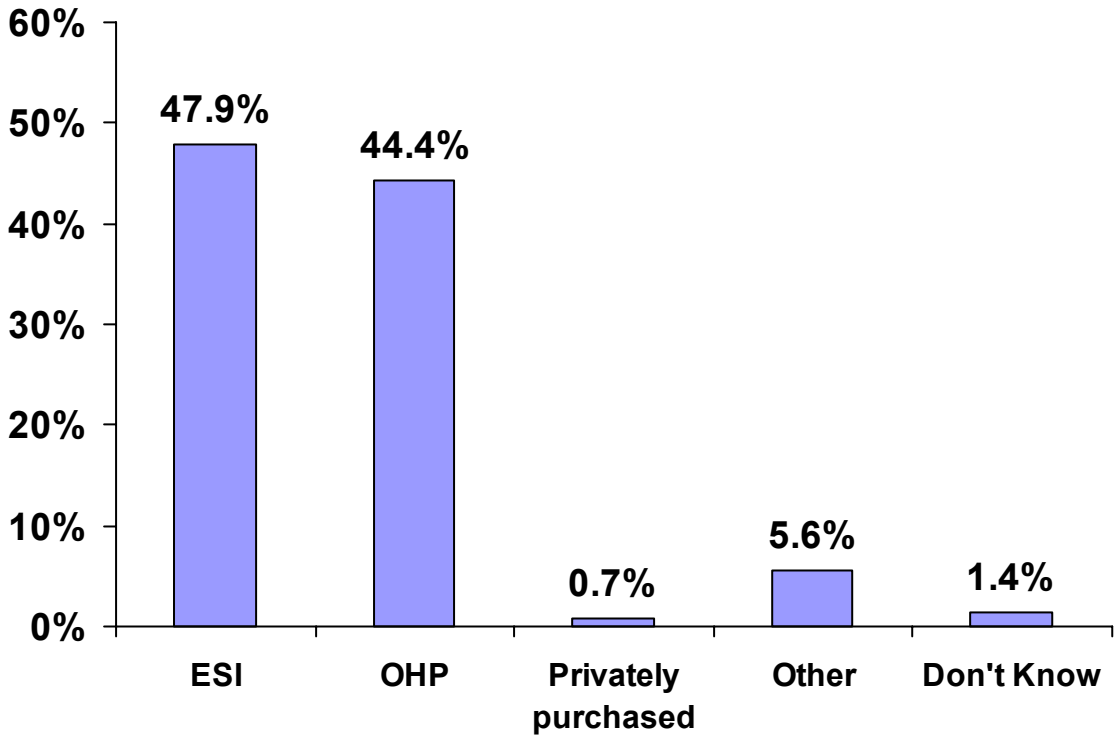


Uninsureds' Insurance History



Uninsured: Most Recent Health Insurance

- Shorter span of uninsurance (6 months or less) more likely to have come from OHP 63.6% vs. 31.8% from ESI
- Uninsurance spans of greater than 1 year, 65% came from ESI and 33% from OHP



Reasons cited for losing ESI*…

- 62% lost job
- 13% aged out of parents' ESI or quit school
- 7% changed jobs and do not yet qualify for new ESI
- 6% reported ESI premiums became too expensive
- 4% reported employer quit offering dependent insurance
- 6% reported that they retired or moved

*Multiple responses allowed. Will not sum to 100%.

Reasons cited for leaving/losing OHP*…

- 49% reported premiums not affordable or locked out due to premiums
- 29% reported income too high to qualify
- 13% forgot or didn't reapply in time
- 11% reported they couldn't afford the co-pays
- 5% reported that it was too much paperwork
- 2% reported that their assets were too high

*Multiple responses allowed. Will not sum to 100%.

Key Findings

- Coverage and usual source of care did not translate into fewer ED visits for OHP
  - OHP similar to commercially-insured in terms of having a usual source of care (81%), but still have significantly higher rates of ED visits than any other group.
  - OHP reported higher overall utilization than any other group.
  - And even with the high self-reported utilization numbers, OHP also reports higher unmet need than a commercially-insured population

Key Findings

- Lack of access not completely explanatory. For those not consulting a physician before the ED visit,
  - Less than one-third of the respondents reported that their clinics were closed when they came to the ED.
  - Less than 25% cited lack of available or timely appointments at their usual source of care as the reason for coming to the ED.

Key Findings

- On a self-report basis, OHP clients in OHSU ED much higher utilizers than OHP clients overall.
  - Not directly comparable because of different time frames in the questions, but previous surveys of the OHP population indicate much lower rates of ED and primary care utilization than this population reports.
- Seem to have much higher absolute need.

Key Findings

- Uninsured visiting OHSU largely short-term uninsured: 45% uninsured less than 1 year; 27% less than 6 months; and 12% never insured.

- OHP disenrollment (44%) and loss of employer-sponsored insurance (48%) -- largely due to job loss -- contributed equally to uninsured visits to the OHSU ED during the study period.

Data Limitations

- Pilot study
- No generalizability beyond the OHSU ED.
  - OHP patients at OHSU ED different than overall OHP patients
  - Patients visiting OHSU ED different than other EDs as well as population overall
- No severity adjustments in the data
- Next Steps: If funding is available, broader survey of statewide EDs. Add administrative data.

Special thanks…

OHSU Center for Policy and Research in Emergency Medicine (CPR-EM)

- Heather Brooks, Sr. Research Assistant
- Robert A. Lowe, MD, MPH, Director, CPR-EM
- Robert Cloutier, MD, Assistant Professor
- CRISP Students

Satisfaction with Provider Communication Among Spanish-Speaking Medicaid Enrollees

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Background

- Satisfaction with provider communication is an important indicator of quality of care
- Little research comparing satisfaction with provider communication among English and Spanish speakers
- Few providers can effectively communicate in Spanish
- Language barriers compromise information transfer and reduce the effectiveness of health related messages

Study Objectives

Among Parents of Children Enrolled Enrolled in a managed Medicaid Health Plan

- Determine whether satisfaction with provider communication differs among Spanish vs. English Speakers
- Determine if differences between these groups can be explained by need for interpretive services

Study Design

- Cross-sectional study design of parental assessments of pediatric provider satisfaction for 570 children enrolled in Oregon's largest Medicaid managed health plan
- Data Source: Consumer Assessment of Health Plan Survey (CAHPS)-Version 2.0:
- Surveys conducted over two time periods
  - 10/1998 through 3/1999
  - 11/2000 through 3/2001
- Data were collected by telephone and mail and administered in English and Spanish

Sample Selection

- Random sample of 1,125 parents of children between ages 0-17:
  - 570 responded for a response rate of 50.7%
- Enrollment Criteria:
  - ≥ 6 months of continuous health plan coverage prior to the survey date
  - Children had to be at least 6 months old at the time of the survey

Dependent Variables

- Parents were asked how often (never, sometimes, usually, always) physicians or health care professionals:
  - ***Listened carefully to their concerns***
  - ***Explained things in a way that could be understood***
  - ***Showed respect for what the parent had to say***
  - ***Spent enough time with their child***
- Each of the four measures was dichotomized:
  - 1=always
  - 0=never, sometimes, or usually

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Primary Independent Variables

- Language and Need for Interpretive Services
  - English-Speaking
  - Spanish-Speaking: No Need for Interpretive Services
  - Spanish-Speaking: Need for Interpretive Services

Description of Interpretive Services Question

- Respondents that needed interpretive services in the previous six months were further asked, “In the last 6 months when you needed an interpreter to help you speak with doctors or other health providers, how often did you get one?”
  - Respondents that answered “always” were considered to have needed and received interpretive services
  - “Never/Sometimes/Usually” were considered to have needed, but not received interpretive services

Other Independent Variables

- Socio-demographic Measures:
  - Child's age
  - Parent's gender
  - Child's gender
  - Parent's educational attainment
- Reported health status of child by parent
  - Good/Very Good/Excellent vs. Poor/Fair
- Year of Survey Administration
  - 1998/1999 vs. 2000/2001

Statistical Methods

- Descriptive Statistics
- Bi-variate associations between language with outcome variables
- Significant bi-variate relationships followed by logistic regression models
- Adjusting for age, gender, clinic location, category, and length of health plan coverage, two models constructed:
  - Model 1- Primary Language
  - Model 2 - Primary Language and Need for Interpretive Services

Descriptive Statistics

Characteristic	N	(%)
Language and Interpreter Services		
Parent's Language		
English	358	(63%)
Spanish	212	(37%)
Spanish Speakers:		
Did not Need Interpreter Services	91	(43%)
Needed Interpreter Services	121	(57%)
Unmet Need for Interpreter Services		
Needed and received services	95	(82%)
Needed and did not receive services	21	(18%)

Descriptive Statistics

Characteristic	N	(%)
Case Mix Adjustors		
Child's Race/Ethnicity		
White (Non-Hispanic)	238	(42%)
African-American	33	(6%)
Hispanic	260	(46%)
Other[1]	39	(7%)
Child's Age (years)		
0-5	328	(58%)
6-11	169	(30%)
12-17	73	(13%)
Child's Gender		
Male	295	(52%)
Parent's Gender		
Female	508	(89%)
Parent's Education		
Less than High School	205	(36%)
High School Graduate	190	(33%)
Some College or Greater	153	(27%)
Health Status		
Good/Very Good/Excellent	529	(93%)
Poor/Fair	36	(6%)
Survey Year		
1998-1999	299	(53%)
2000-2001	271	(47%)

[1]Includes Asian American and American-Indian Ethnicities

Bi-variate associations of Language with Satisfaction with Provider Communication

Respondent Language	Listened Carefully[a] N=251	Explained Things Well[b] N=251	Respected Comments and Concerns[c] N=259	Spent Enough Time[d] N=183
Language				
Spanish	78 (66.7%)	71 (61.7%)	83 (70.9%)	37 (32.5%)
English	173 (70.0%)	180 (73.5%)	176 (70.7%)	146 (58.6%)
p-value	p=0.50	P=0.03	p=0.98	p=0.0001

Respondents who answered "always" to specified satisfaction questions

Only respondents who utilized outpatient care 6 months were eligible to answer these questions assessing provider satisfaction: Includes respondents who always said that:

[a] Doctors or health professionals listened carefully to their child
[b] Doctors or health professionals explained things in a way that could be understood
[c] Doctors or health professionals showed respect to what was said by the parent
[d] Doctors or health professionals spent enough time with their child

Logistic Results: Association of Language and Need for Interpreter Services with Parent's Report of Provider Time Spent with Child

Variable in Model	Model 1[a] O.R.	95% C.I.
Language		
English-Speaking (Reference Group)	1.00	NA
Spanish-Speaking	0.38	0.21-0.71
Variables in Model	**Model 2[a] O.R.**	**95% C.I.**
Language and need for interpreter services		
English-Speaking (Reference Group)	1.00	NA
Spanish-Speaking		
No need for translator services	0.47	0.20-1.11
Need for translator services	0.34	0.17-0.68

[a] Models adjusted for the following case-mix adjustors: child's age, child's gender, parent's gender, parent's educational level, child's health status, and survey year

Limitations

- Small overall sample size
- Lack of data on several important factors that may impact provider satisfaction:
  - acculturation
  - language proficiency
  - provider language concordance
  - quality of interpretive services received
- Limited power to detect differences among:
  - those that needed and received interpretive services compared to those that needed and DID NOT receive interpretive services

Conclusions

- Spanish-speaking Parents reported significantly lower ratings on provider time spent with child
  - Parents that needed interpretive services reported lower satisfaction compared to English-speaking Parents
  - No difference in ratings of provider time spent with child among Spanish-speaking parents that needed interpretive services compared to English-speaking parents
- No other differences found

Implications for Policy and Practice

- Efforts are needed to ensure that Spanish-speaking patients have access to medical staff with Spanish proficiency
- It is important that sufficient time be spent with Spanish-Speakers that need interpretive services during pediatric medical encounters
- Further research is needed to understand:
  - To what extent do Spanish-speaking patients in need of interpretive services receive such services from professionally trained staff
  - Understand how variation in the quality of interpretive services impacts satisfaction with provider communication

Acknowledgements

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The Impact of Program Changes on Health Care for the OHP Standard Population: Early Results from a Prospective Cohort Study

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Bill Wright, PhD
Providence Health System
Center for Outcomes Research and Education

Charles Gallia
Oregon Office of Medical Assistance Programs

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- This study would not have been possible without the assistance of the Oregon Health Research and Evaluation Collaborative, Oregon State Office of Medical Assistance Programs and the Office for Oregon Health Policy and Research.

Background

- In February - March 2003 OHP benefits changed for ~89,000 Oregon Health Plan (OHP) Standard members.
- Added premiums - $6-$20 per month based on income.
- Expanded co-pays - office visits, labs, ED, prescriptions, hospitalization.
- Non-payment of premium results in 6 month “lock-out” from OHP.
- Eliminated coverage for dental, vision, outpatient mental health, substance abuse, durable medical equipment.
- Temporarily (two weeks) eliminated prescription benefits.

Study Objectives

- The purpose of this study is to assess the impact of benefit changes on the OHP Standard Population across three domains:
  - Enrollment
  - Access to care
  - Utilization

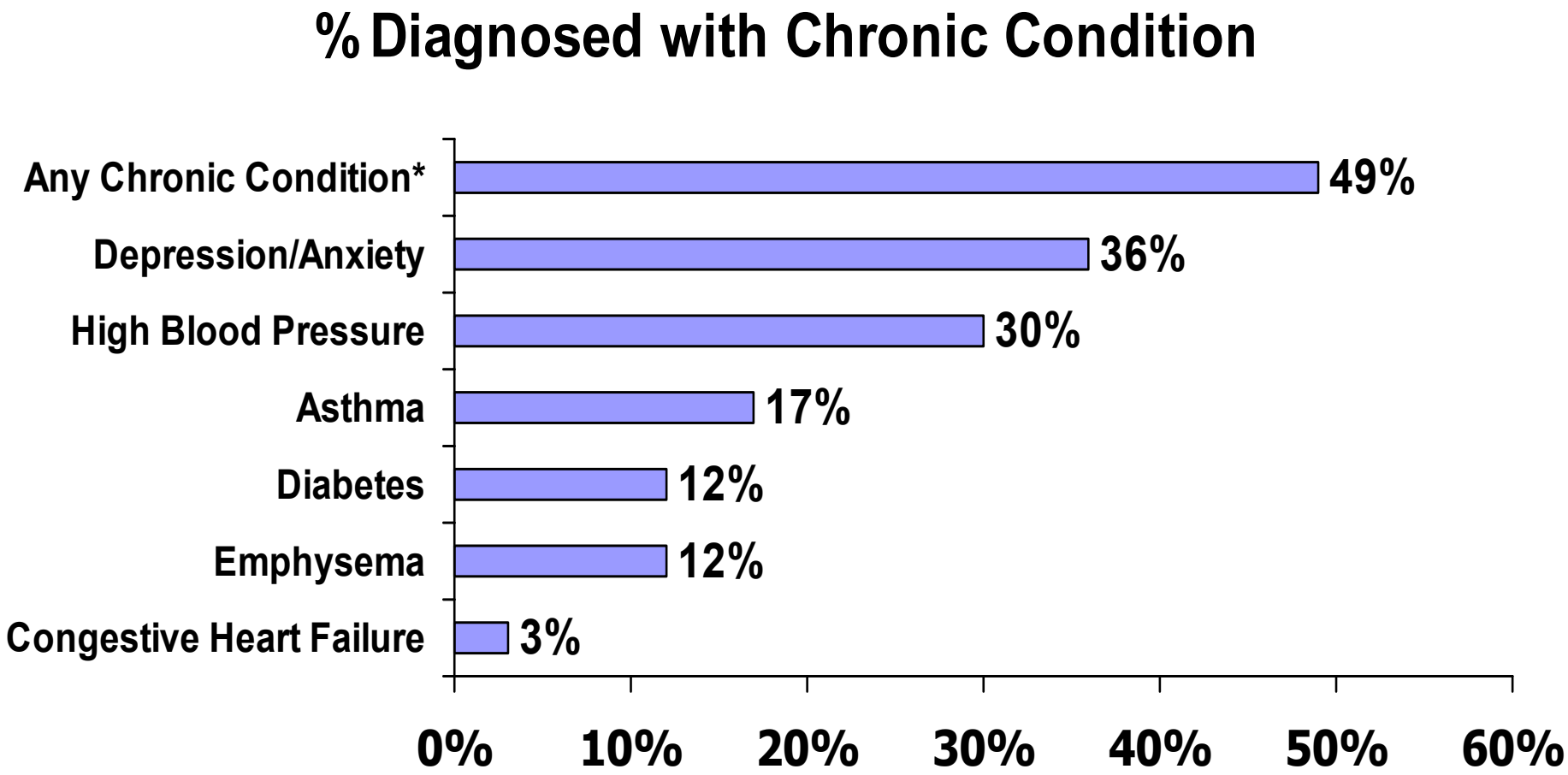
Methods

- Mail-return survey of a stratified probability sample of 10,597 OHP Plus and OHP Standard members enrolled in February 2003.
- Over-sample of 1,500 African Americans, Native Americans, and Hispanics.
- Preliminary survey results based on 2,195 English-speaking individuals.
- Preliminary response rate = 32%. Final disposition not yet available.
- Longitudinal cohort design: If funded, OHP Standard members will be compared over time with OHP Plus members, whose benefits did not change.

Demographic Characteristics

Gender	Eligible Sample (n=8,487)	Respondents (n=2,741)
Male	39.4%	32.8%
Female	60.6%	67.2%
Race/Ethnicity		
Asian	3.5%	2.1%
African-Am	10.0%	8.1%
Hispanic	14.1%	11.6%
NA/AN	9.5%	9.1%
White	62.8%	69.1%
Language		
English	87.9.7%	92.0%
Spanish	7.6%	6.0%
Russian	1.4%	0.6%
Vietnamese	1.3%	.8%
Other	1.7%	0.6%
Population		
OHP Plus	51.6%	50.7%
OHP Standard	48.4%	49.3%

% Reporting Chronic Conditions in OHP Standard Population

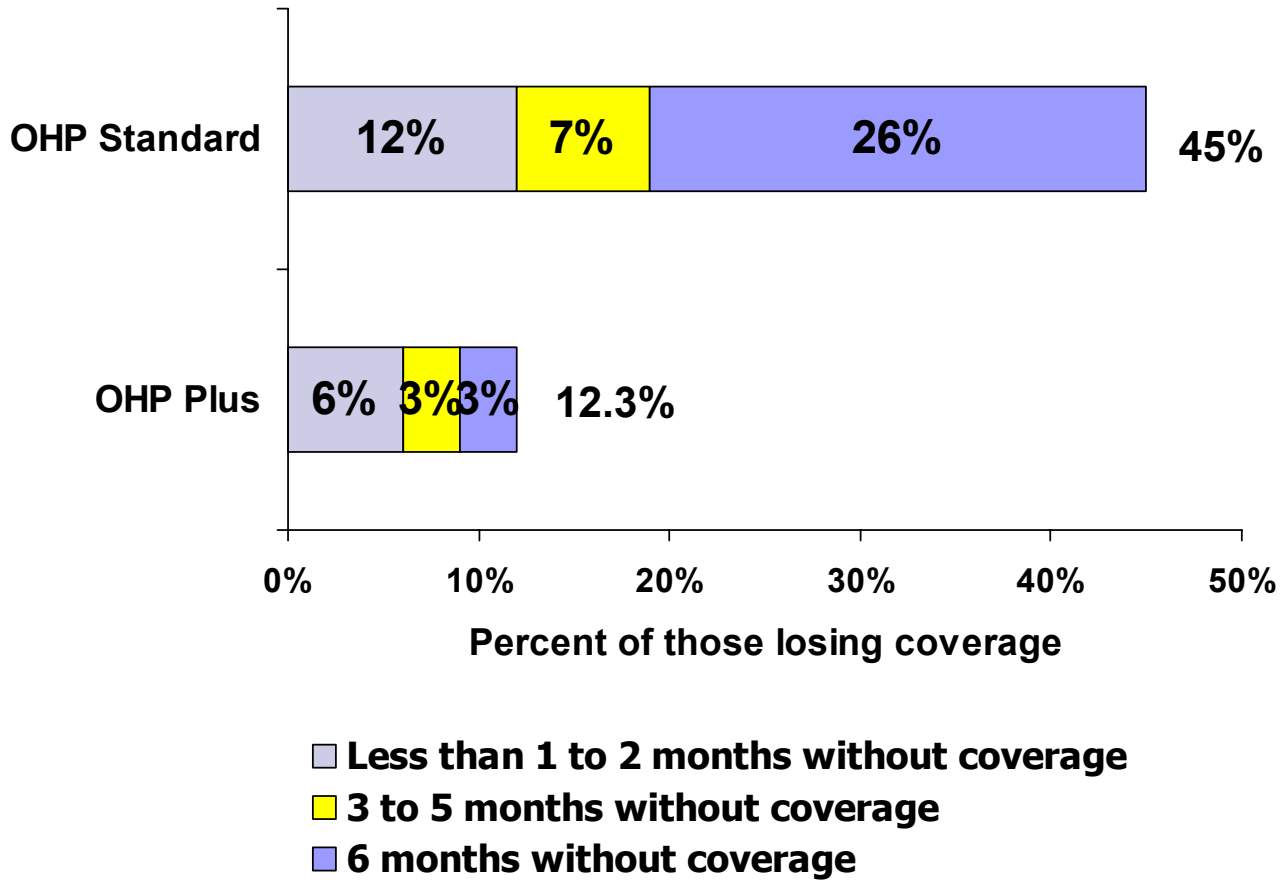


* Excluding depression/anxiety

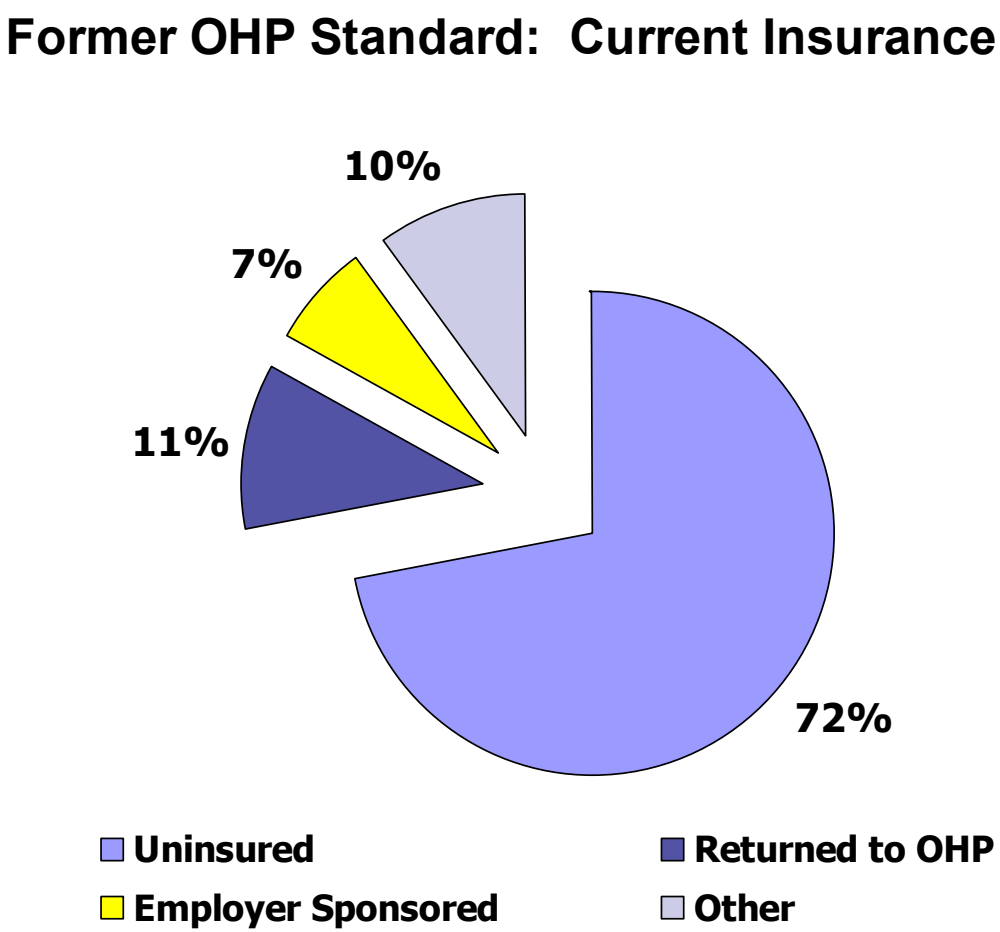
Section I

Impacts on Enrollment and Insurance Status : OHP Standard

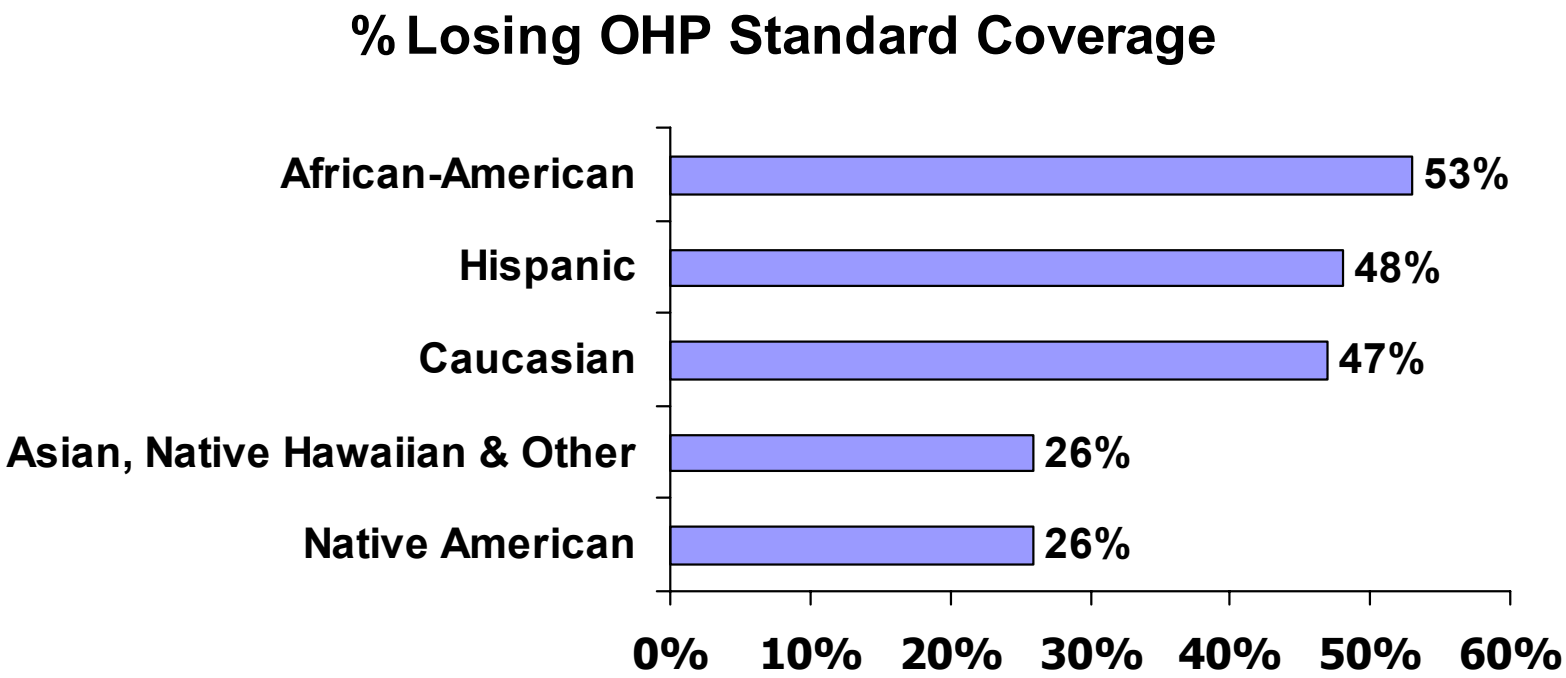
OHP Standard members were more likely to lose OHP coverage. Those who lost OHP were asked how many of the last 6 months had they been without coverage…



Most OHP Standard clients who left do not currently have health insurance coverage.



African Americans were more likely to lose OHP Standard coverage…



p<.05

OHP Standard clients with chronic conditions are more likely to stay continuously enrolled…

- 61.2% of those reporting a diagnosis of one or more chronic conditions** maintained continuous enrollment

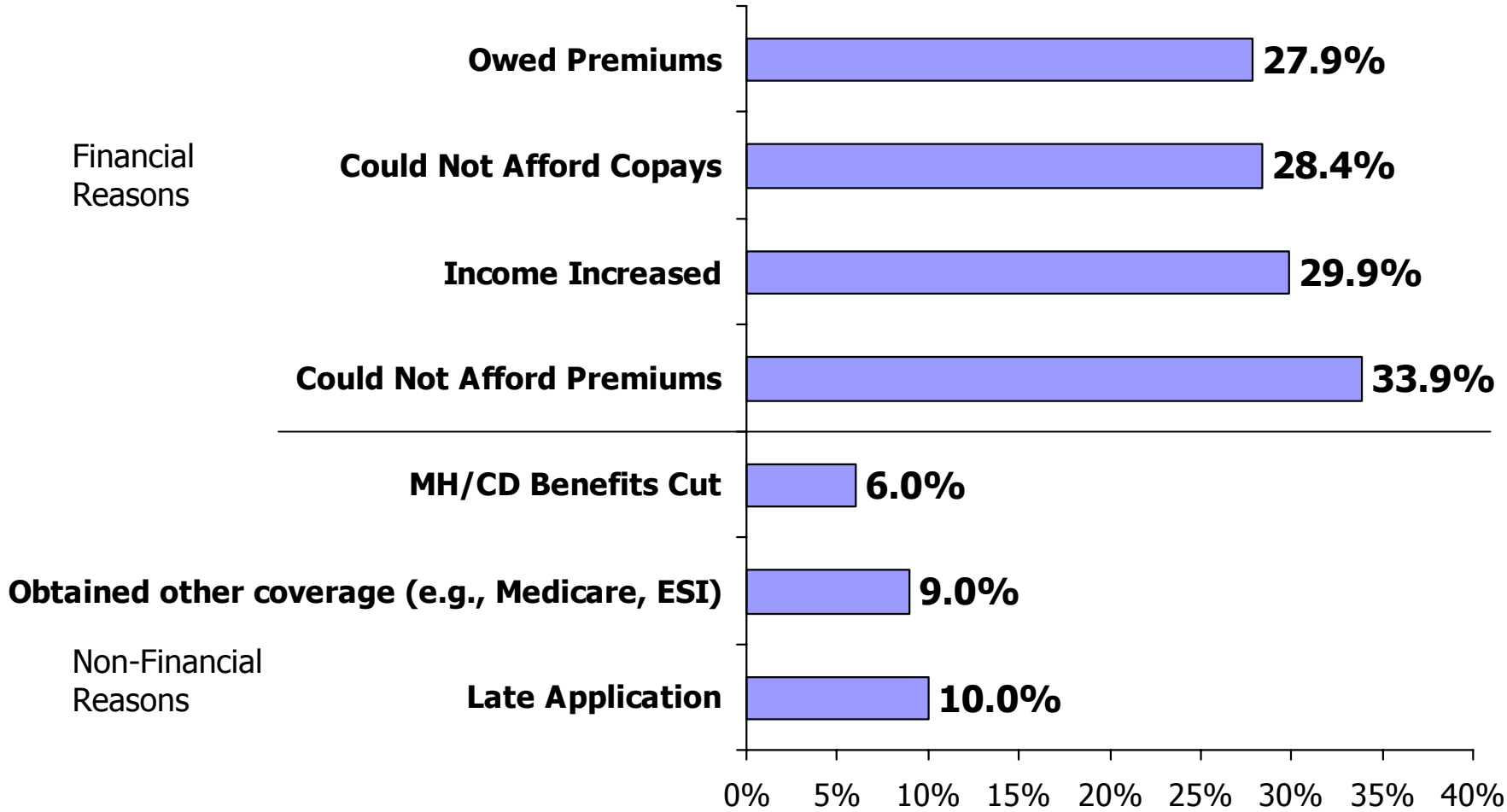
vs.

- 52.4% of those with no chronic conditions maintained continuous coverage.

**Diabetes, Asthma, Hypertension, CHF, Emphysema

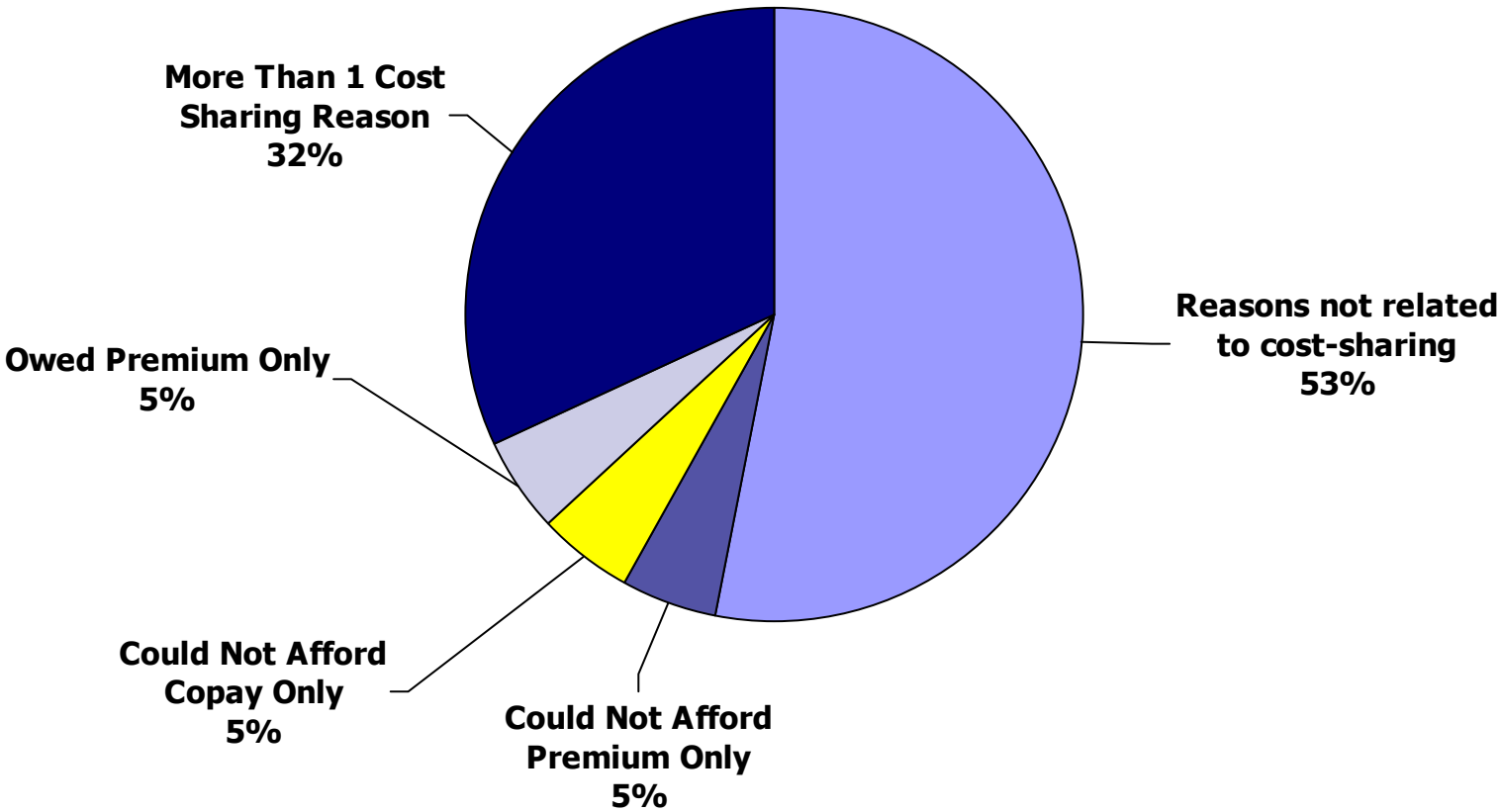
Significant, $p<.05$ (chi square)

Cost-sharing was a major driver of loss of coverage…

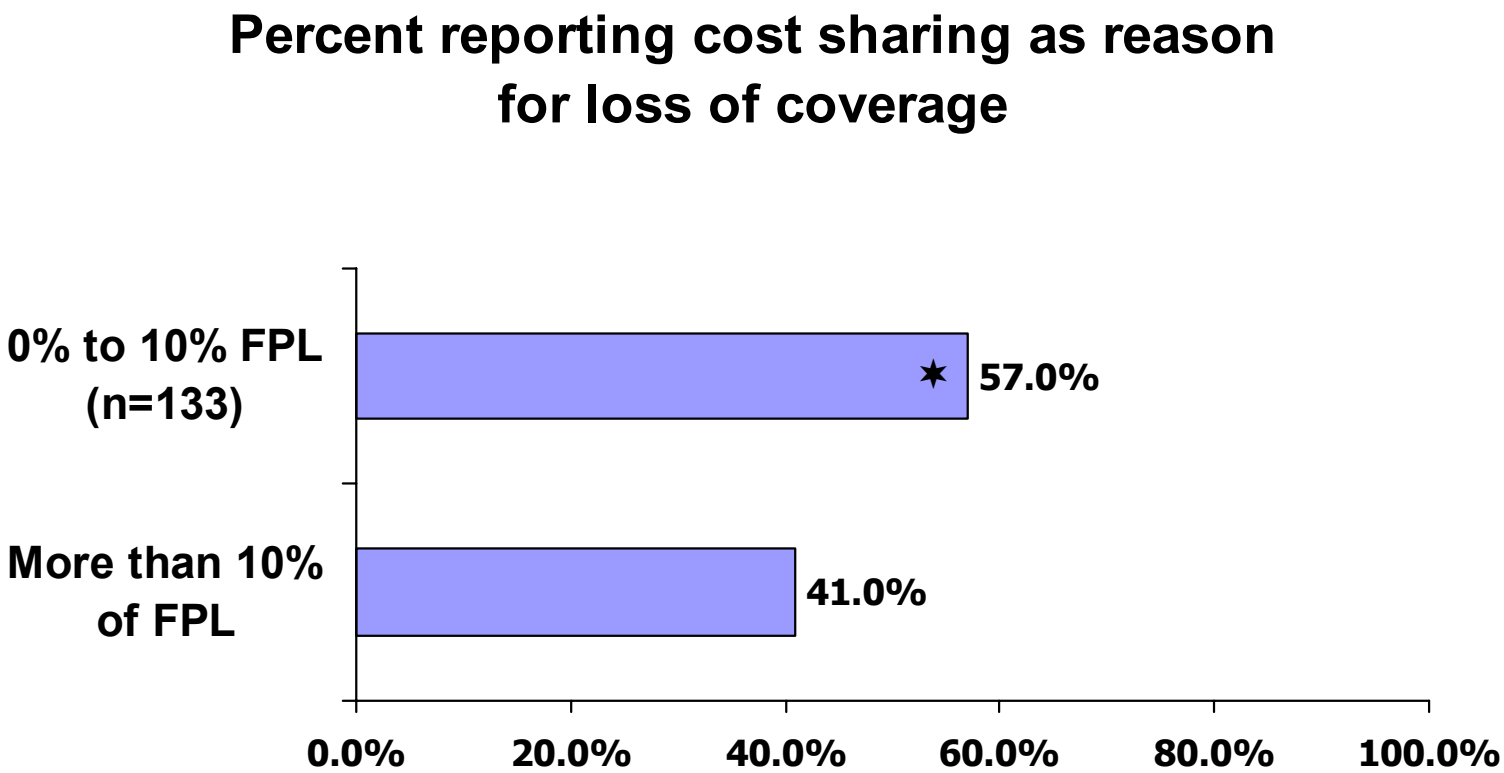


Note: Categories are not mutually exclusive. Will not sum to 100%.

Among those stating financial reasons for loss of coverage, most cited both premiums and copays as factors…



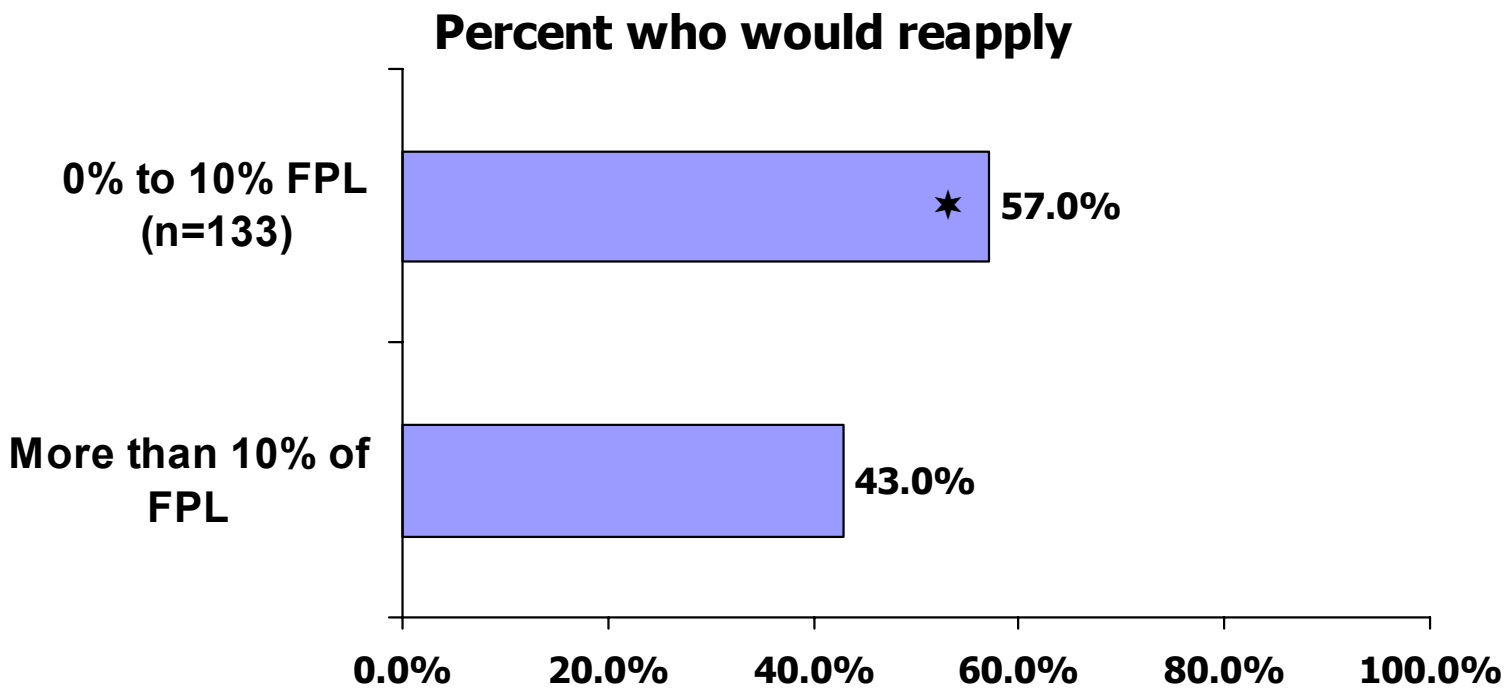
Cost sharing disproportionately affected lowest income group…



* p<.01

Respondents state a willingness to pay with small decreases in premiums…

If Premiums were lowered by $3 per month would you continue without coverage or reapply for OHP?

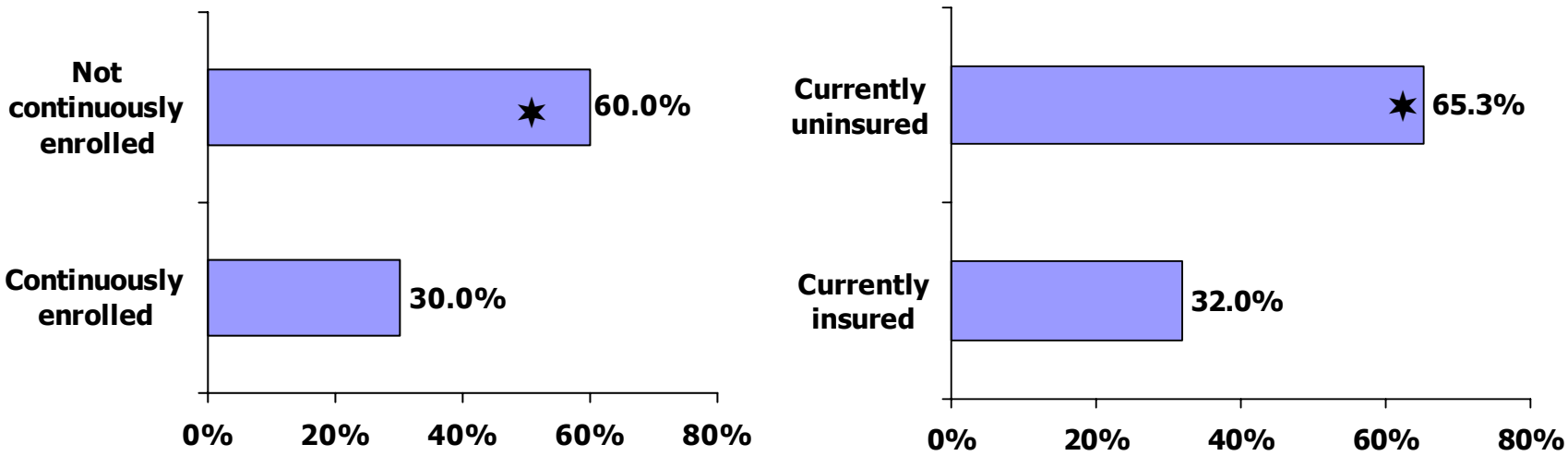


* p<.05

Section II
Impacts of Program Changes on Access to Health Care: OHP Standard

Loss of OHP and lack of current insurance lead to higher unmet need

Was there ever a time in the past 6 months when you needed care but did not get it?

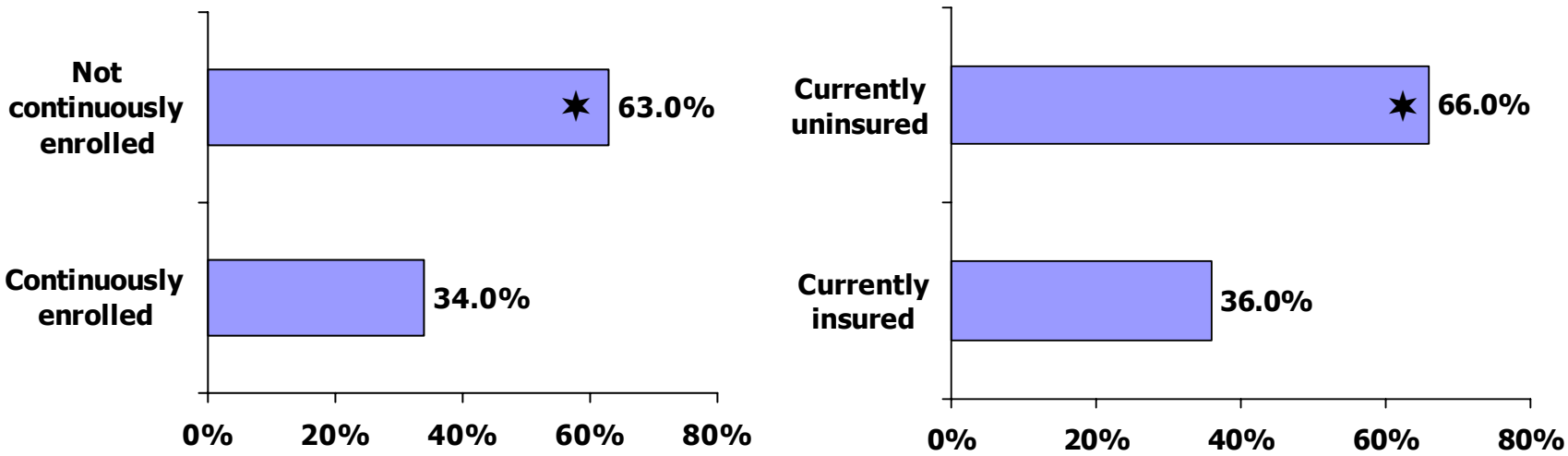


Percent Responding "YES" to Unmet Health Care Need.

✶Significantly different, p<.01.

Loss of OHP and lack of current insurance lead to higher unmet need, even for urgent care…

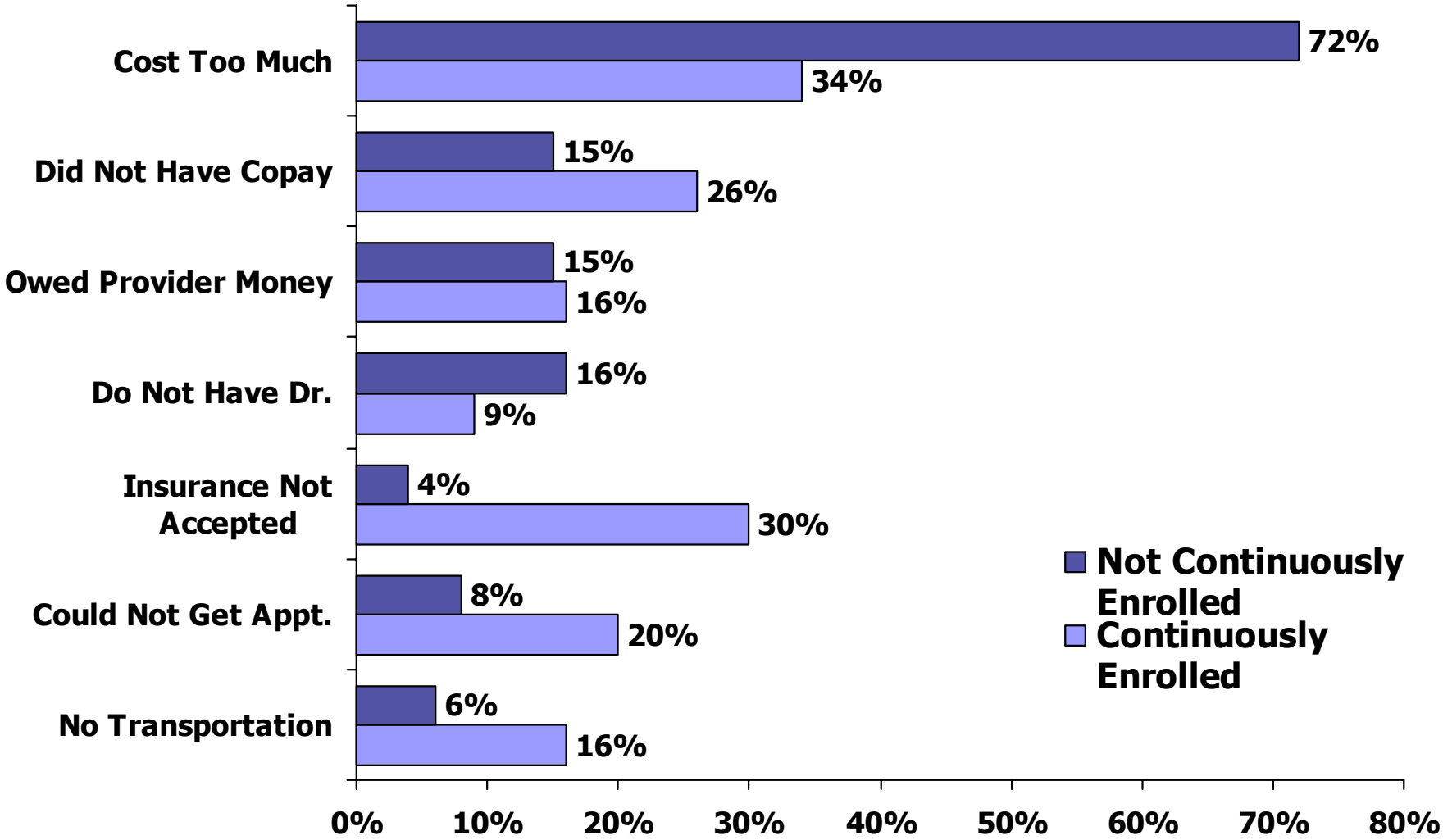
When you needed care right away for an illness or injury, how often did you get care as soon as you wanted?



Percent Responding "Never/Sometimes"

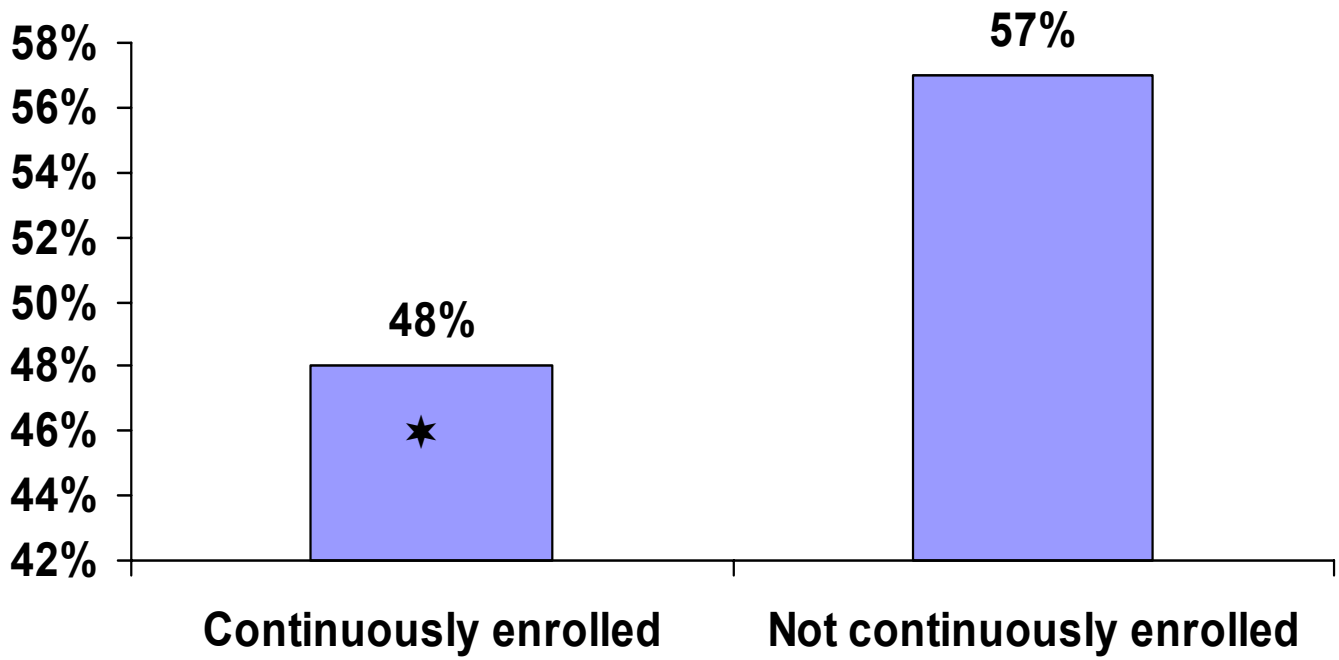
✶Significantly different, p<.01.

Cost was a major reason for not getting needed care…



Note: Categories Are Not Mutually Exclusive. Will not sum to 100%.

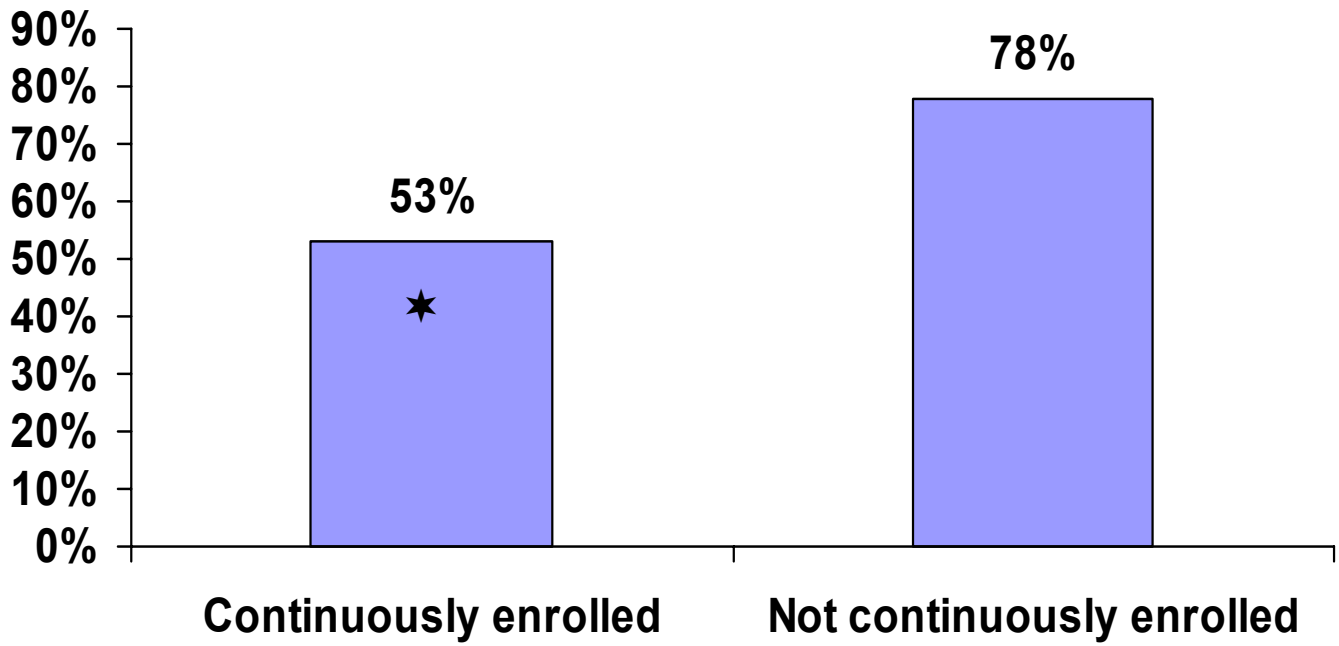
Former OHP Standard clients report there have been occasions when they have not purchased prescription medications due to cost…



Percent reporting could not afford prescription medications.

★ Significantly different, p<.05.

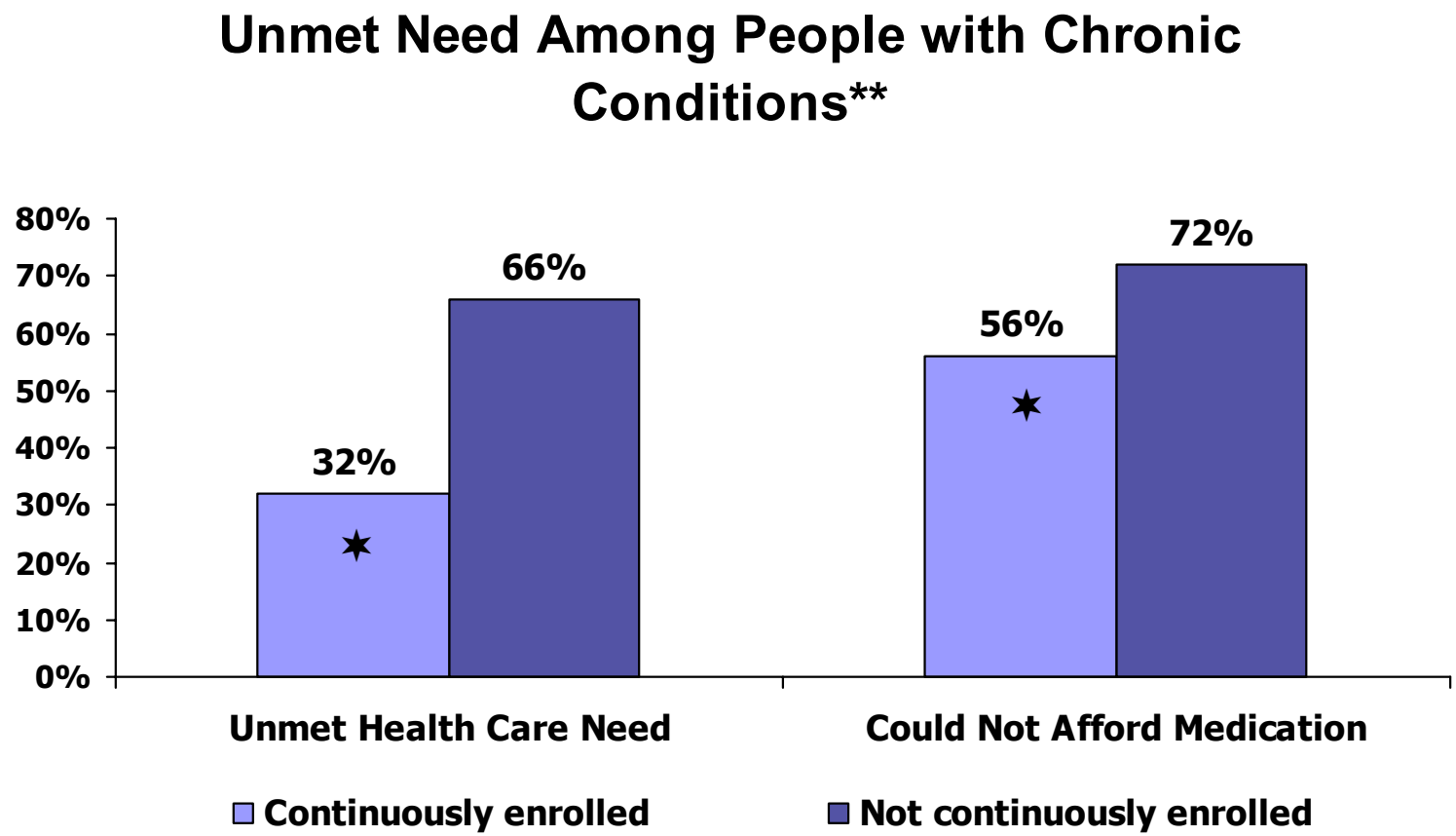
OHP Standard clients who lost coverage were more likely to report unmet mental health care needs…



Percent who reported needing but not receiving mental health care.

★ Significantly different, p<.01.

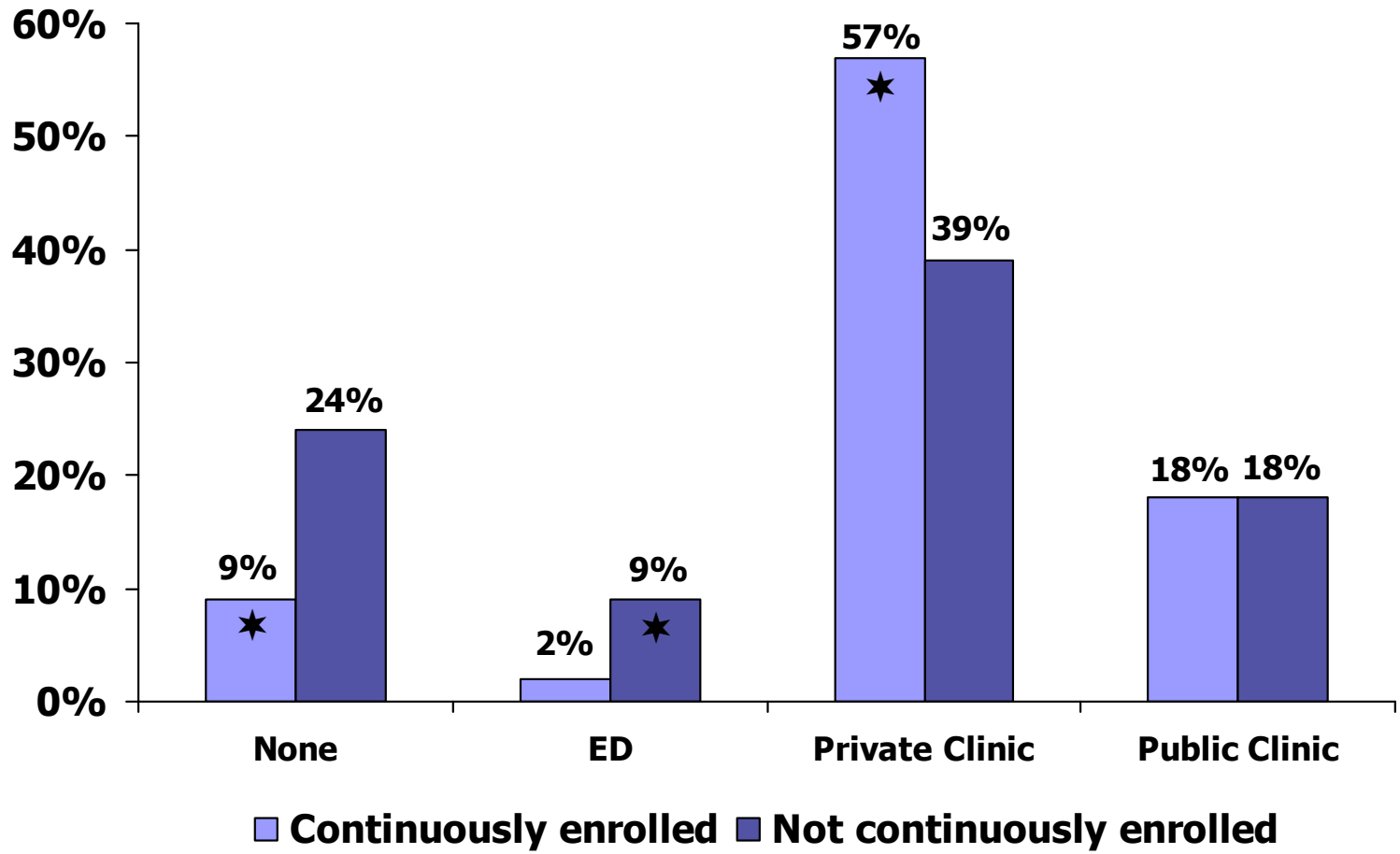
Loss of OHP Standard coverage particularly affected those with chronic conditions…



**Diabetes, Asthma, Hypertension, CHF, Emphysema

Significantly different, p<.01

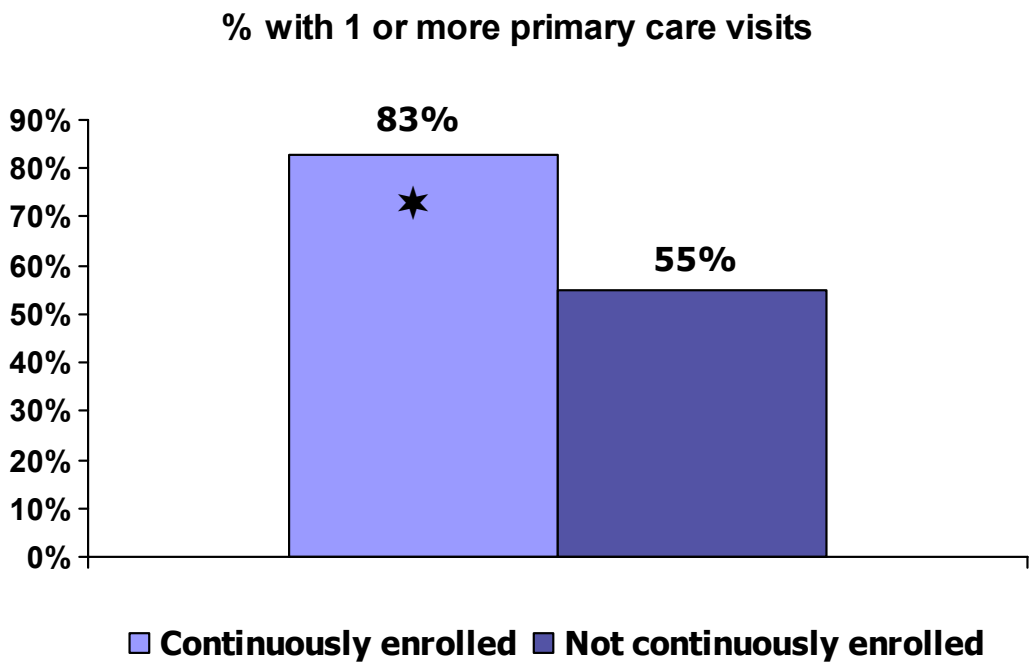
Former OHP Standard respondents were more likely to report ED as Usual Source of Care…



★ Significantly different, p<.01

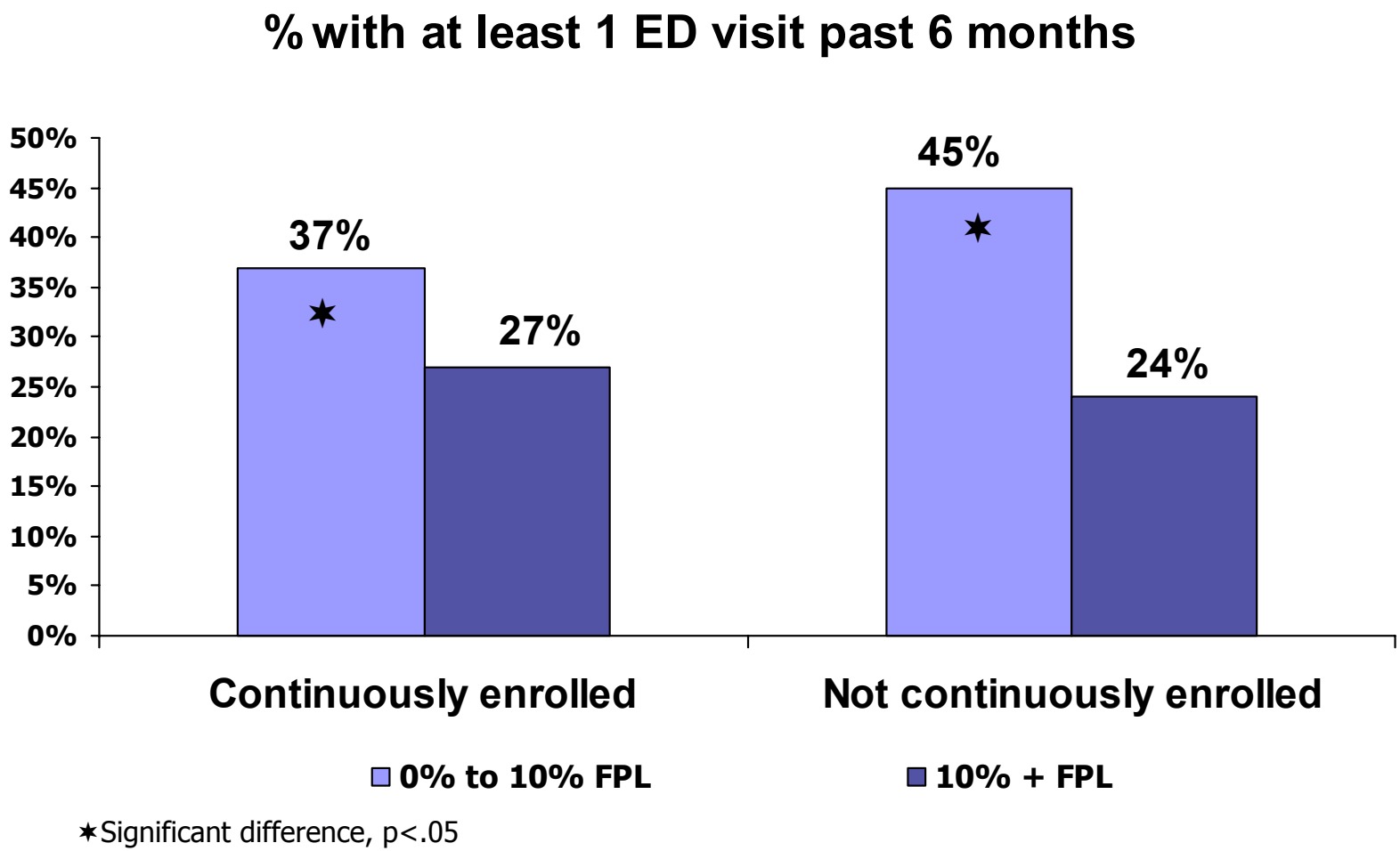
Section III
Impacts on Utilization: OHP Standard

Former OHP Standard clients utilize primary care services less…



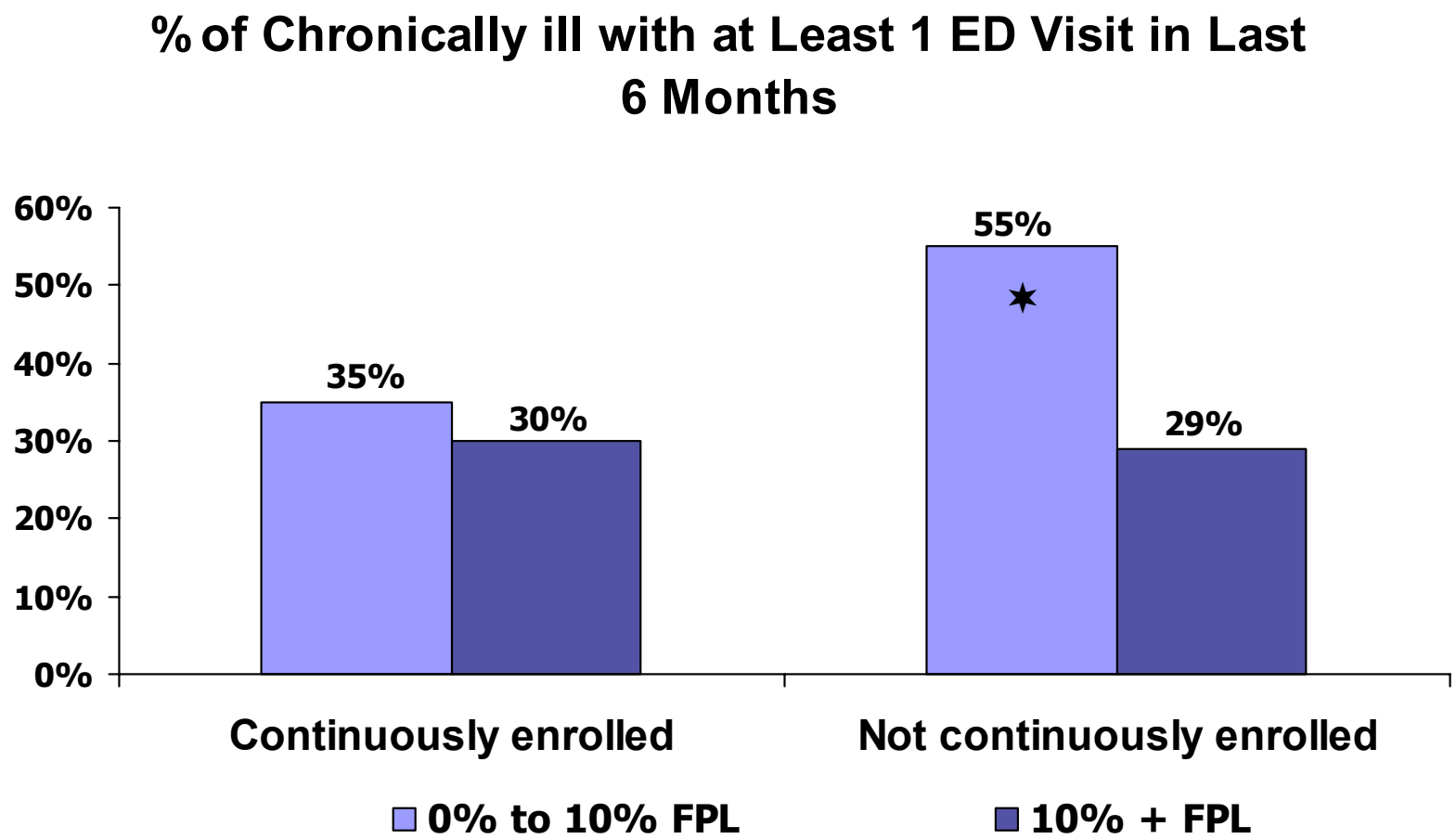
✶Significantly different, p<.01

Loss of coverage increased Emergency Department use, especially among lowest income group…



✶Significant difference, p<.05

Continuous enrollment mitigates ED use for lowest income persons with chronic illness…



✶Significant difference, p<.05.

Conclusion and Implications

- Enrollment – Standard Population
  - Most who lost coverage remained uninsured.
  - Premium Cost was most common reason for loss of coverage.
  - Lowest income group was disproportionately affected by cost sharing.
  - Most would reapply if premiums were decreased.

Conclusion and Implications

- Access
  - Those who lost coverage had higher unmet needs for medical care, urgent care, mental health care and prescription medications.
  - Persons with chronic illness who lost coverage were more likely to report unmet health care needs.
  - Cost was primary reason for unmet health care needs.

Conclusion and Implications

- Utilization
  - Those who lost coverage were nearly 3 times more likely to have no usual source of care and were 4-5 times more likely to report the Emergency Department as usual source of care.
  - Those who lost coverage were less likely to have a primary care visit.
  - Loss of coverage increased the likelihood of an ED visit among individuals in the lowest income group especially those with chronic conditions.

Data Limitations

- Analysis is based on preliminary mail-return data including only the English speaking population.
- Data on enrollment, access, and utilization are based on self-report.
- Survey respondents may have higher rates of chronic illness than general OHP population.
- This is the baseline, cross-sectional survey and associations may not be causal.

Next Steps

- This is the baseline survey for a proposed longitudinal cohort design.
- Funding is currently being sought to complete 2 additional surveys at 12 and 18 months using a combination of mail and telephone surveys.
- Follow-up surveys will allow causal analysis of the impact of program changes on OHP Standard.

An Evaluation of Prescription Drug Copayments in the Oregon Health Plan

Preliminary Analysis

Dan Hartung, PharmD

OSU - College of Pharmacy

Background

- Cost-Sharing Premise
  - Requires beneficiary to pay a portion of the cost of service/product
  - Provide market based approach to encourage use of low-cost products or services
- Rx Cost-Sharing
  - 98% employer sponsored health plans
  - governmental (Veterans Administration, Department of Defense, Medicaid)

Rx Copayments in Medicaid

- 81% of states employ Rx copay structure
- Federal Medicaid mandate
  - Cost sharing be restricted to “nominal” amount
- Categorical exclusions
  - Pregnant women
  - Nursing and community based care facilities
  - Children <19

Kaiser commission on Medicaid and the Uninsured:
Rx Benefits Survey 2003

OHP Experience

- January 1, 2003: cost-sharing implemented
  - Rx
  - Outpatient services
- February, 2003: OHP2 Expansion
  - OHP Plus- categorically eligible
    - Rx, outpatient service copayment ($2-$3)
  - OHP Standard – working poor
    - Rx, outpatient, inpatient, etc copayment ($2-250)
    - Monthly premium

OHP Rx Copayment Structure

February 1, 2003

	Plus	Standard	Carveout Drugs
Generic	$2	$2	$2
Brand	$3	$15	$3

*Carve-out Drugs are those that coverage is maintained for all OHP clients by OMAP regardless of their enrollment in a fully capitated health plan (antidepressants, antipsychotics, and mood stabilizers).

*$3 Standard Clients for branded HIV, Cancer, and antirejection

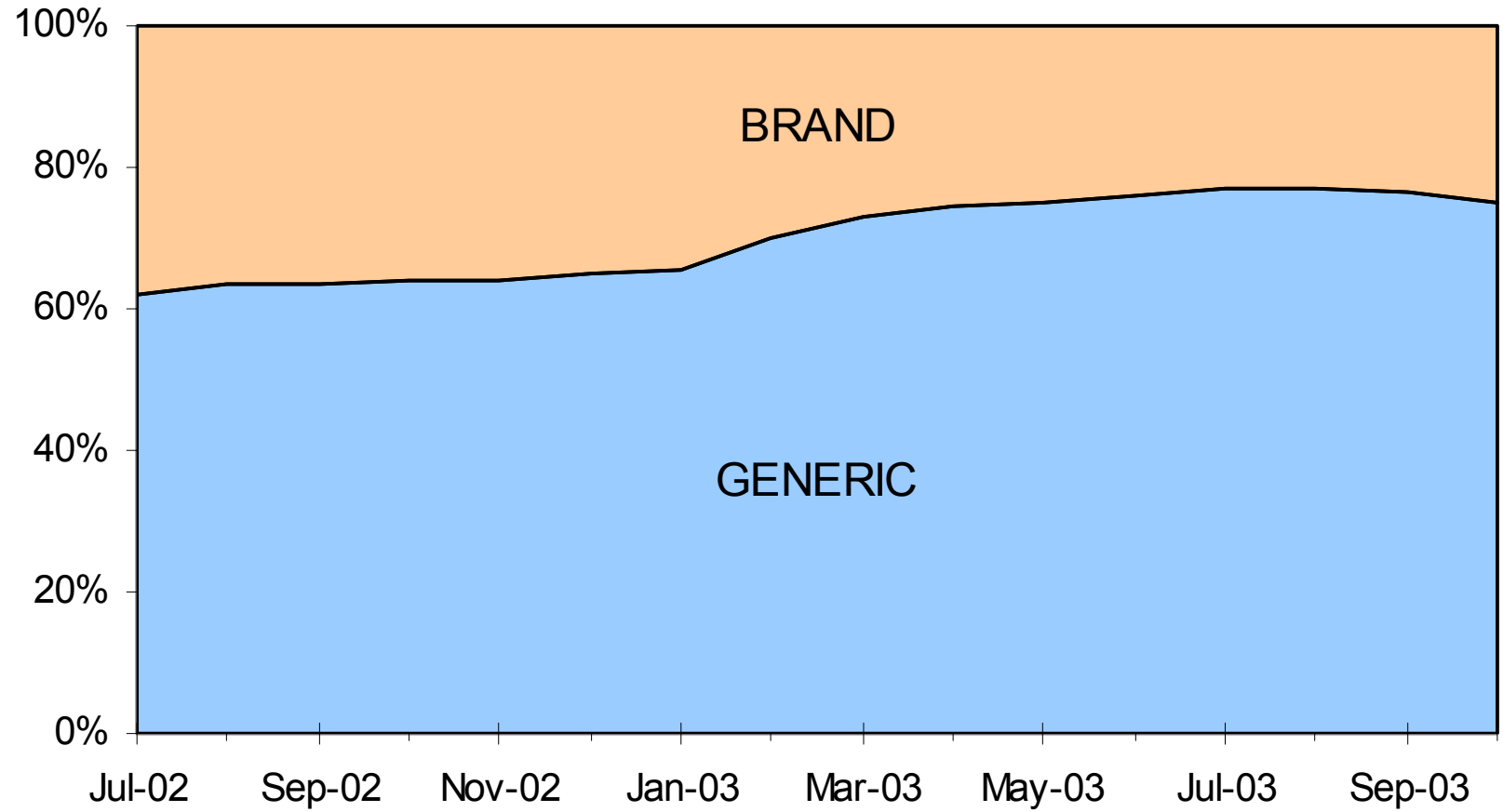
Methods of Evaluation

- Brand/Generic Mix
- Average $/Rx
- Rx/Volume (count of no. dispensed Per Member Per Month)
- $ Per Member Per Month
- Cohort Analysis – continuous eligibility (not enrolled in a Fully Capitated Health Plan)
  - Aggregate
  - Specific classes: cardiovascular, respiratory, diabetes, GI acid suppressant, Non Steroidal Anti-Inflammatory Drugs, narcotic analgesics

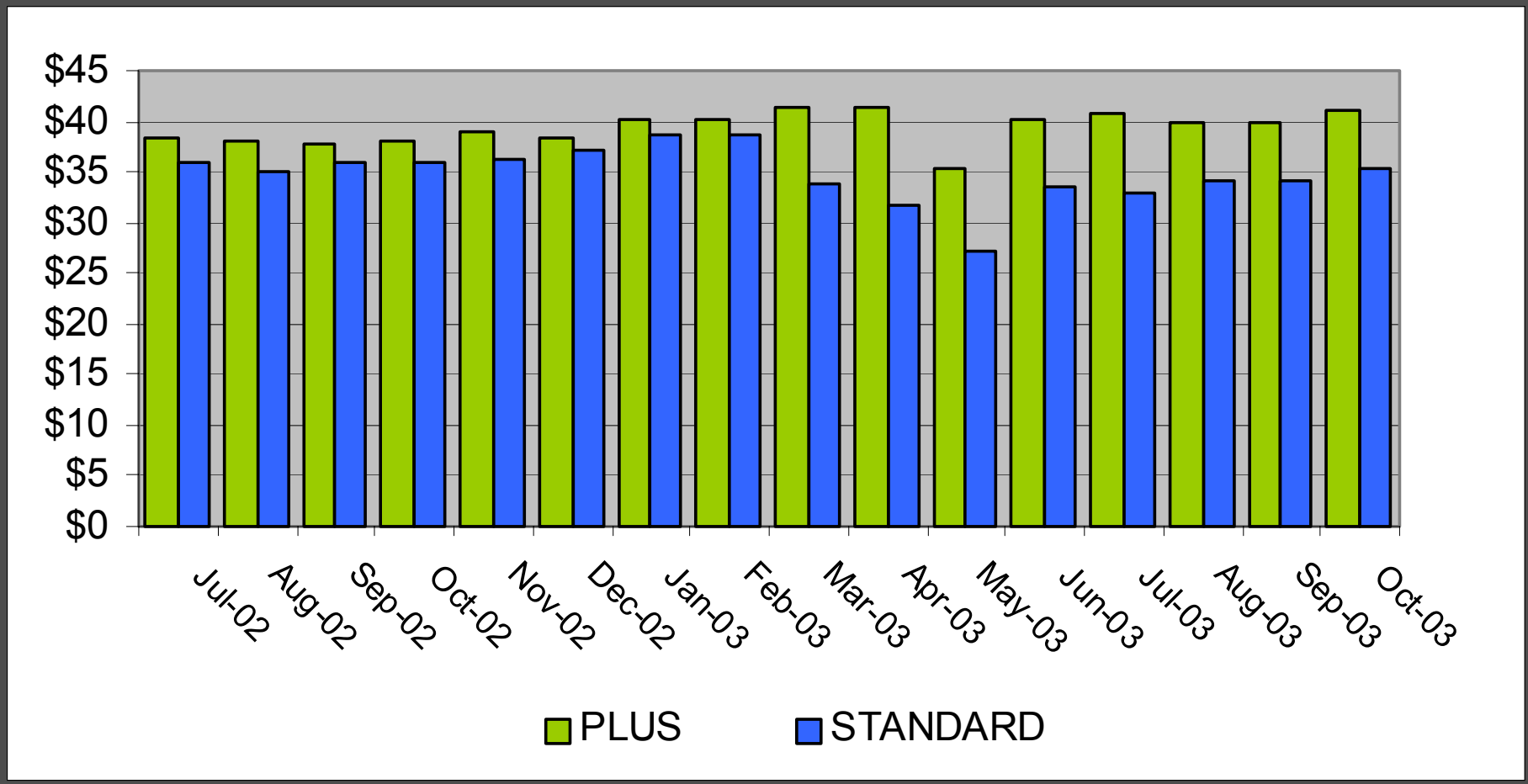
Exclusions

- Medically Needy
- Pregnant Women
- Age <19
- Native American/Native Alaskan
- Long Term Care facility
- Drug classes: family planning, infant formulas, nutritional supplements

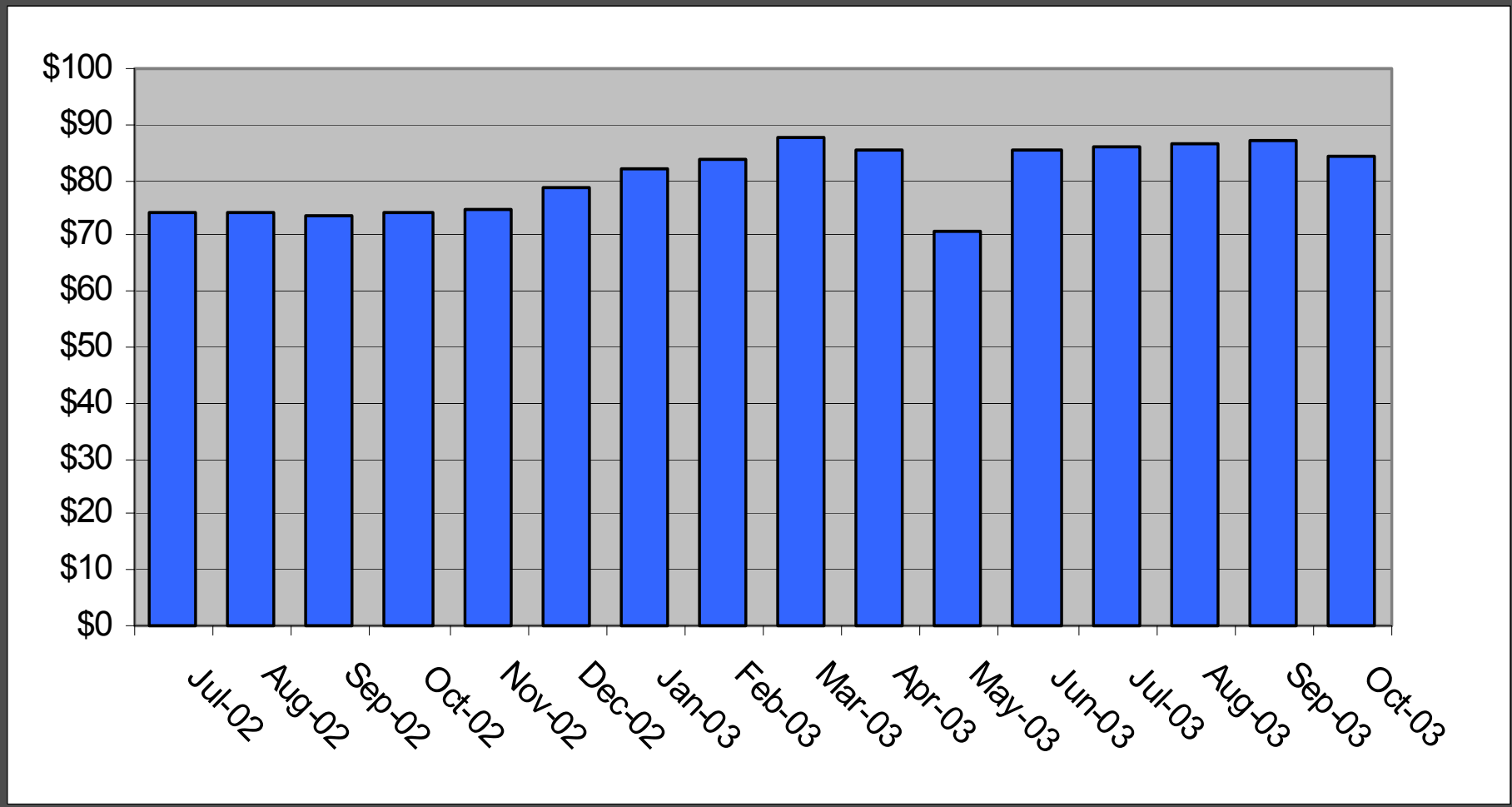
Brand/Generic Volume Mix
OHP Standard



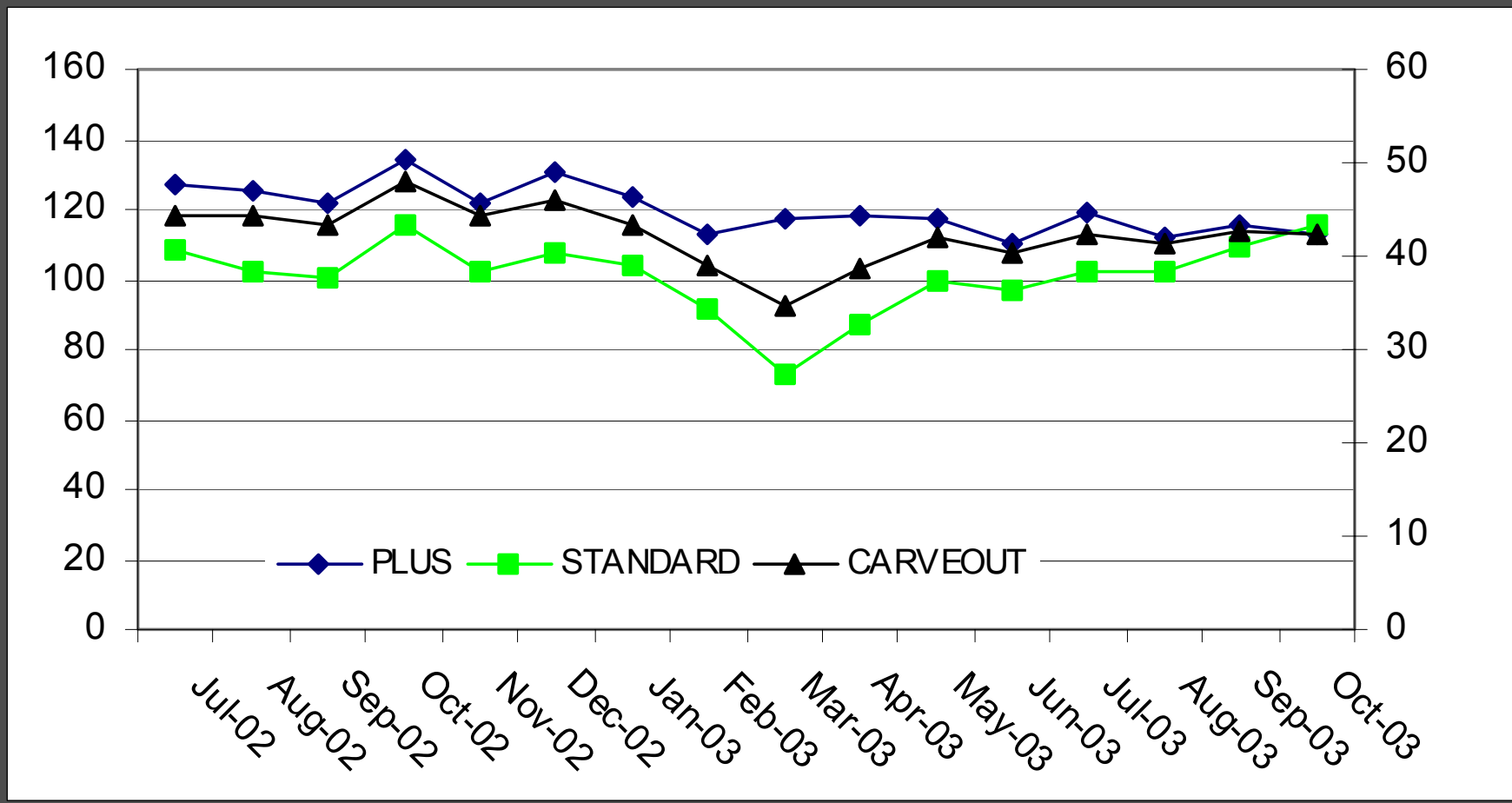
Average Cost/Rx
Non-carveout



Average Cost/Rx
Carveout



Rx Dispensed PMPM



Rx Per 100 members

Cohort Analysis

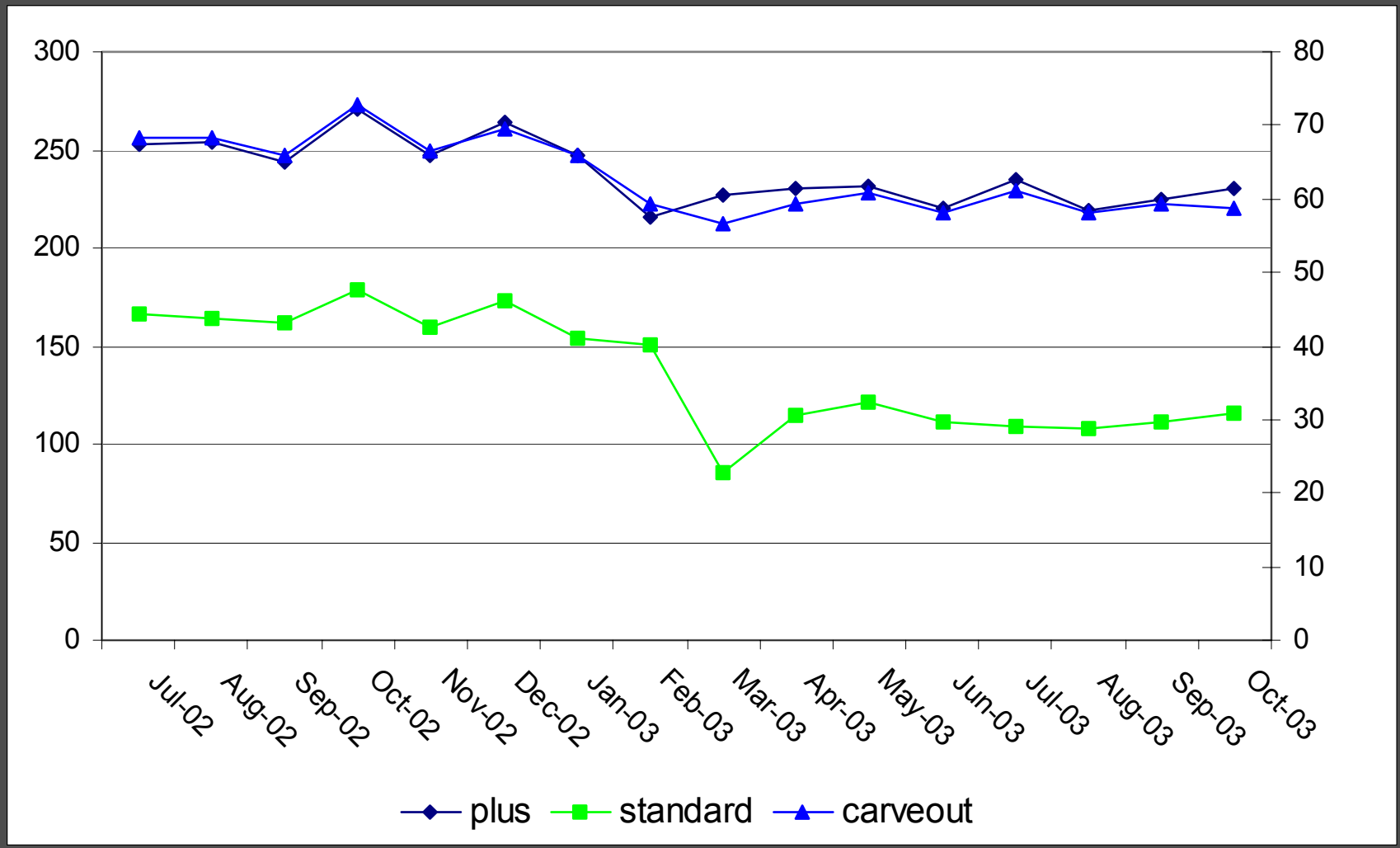
Continuous eligible members with all same exclusions

- Standard/Plus Non-carveout – no Fully Capitated Health Plan
- Carveout – Fully Capitated Health Plan enrollment permitted

Plus	**Standard**	**Carveout**
N = 20294	N = 4244	N = 77437
Ave Age = 50	Ave Age = 43	Ave Age = 45

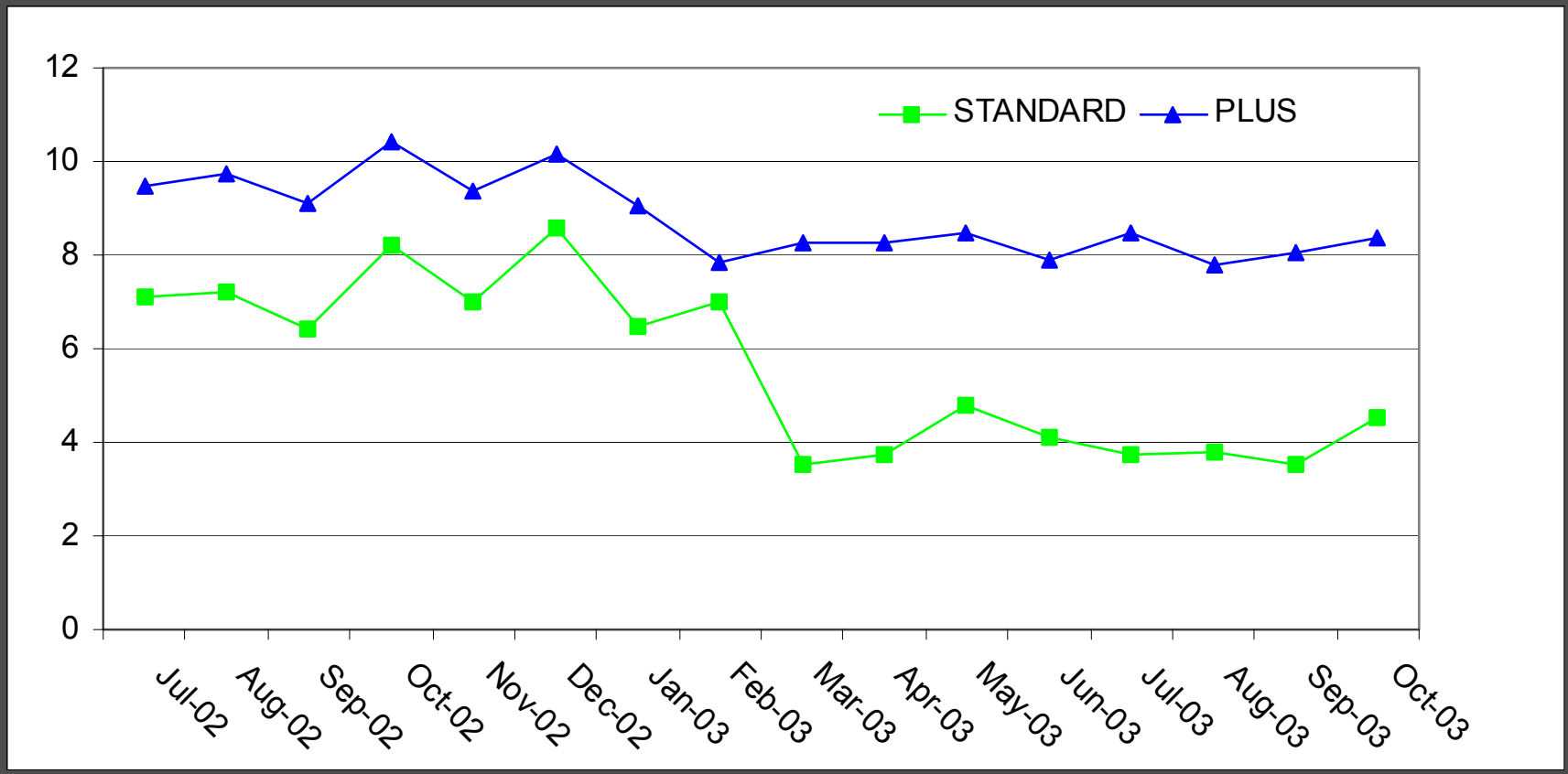
Rx Dispensed PMPM

Cohort Analysis



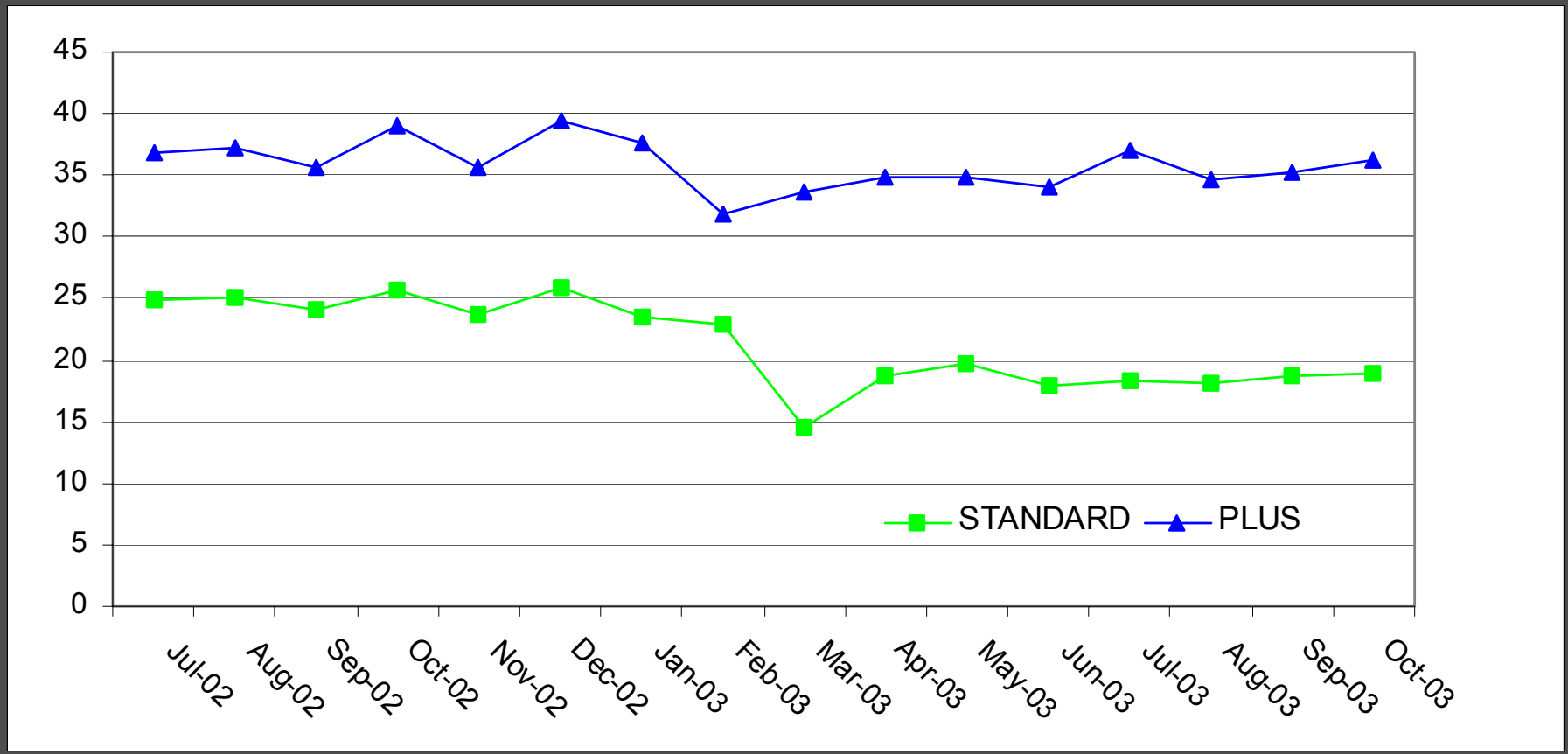
Rx Per 100 members

Respiratory Drugs
Cohort Analysis



Rx Per 100 members

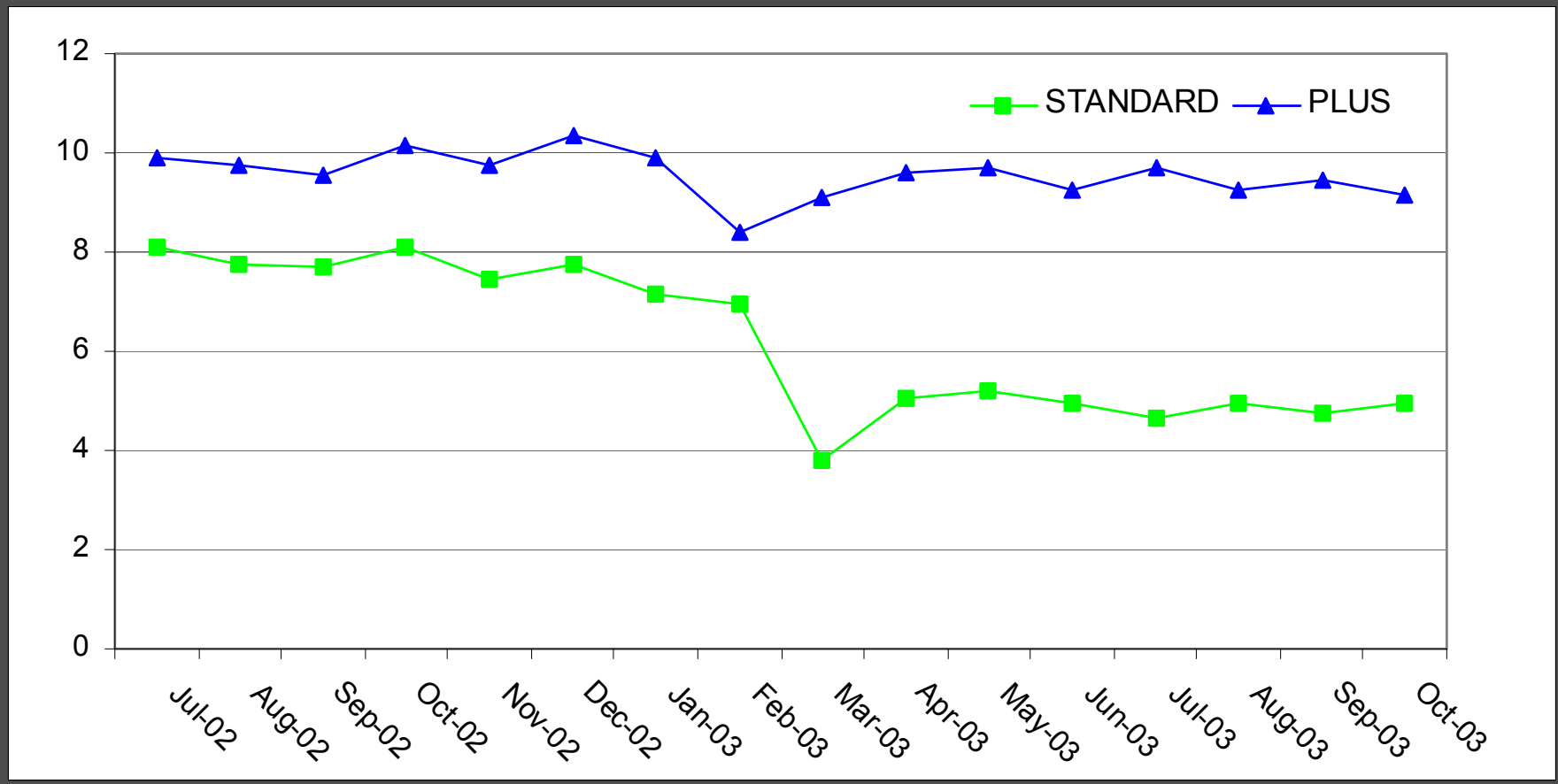
Cardiovascular
Cohort Analysis



Rx Per 100 members

Anti-Diabetic Drugs

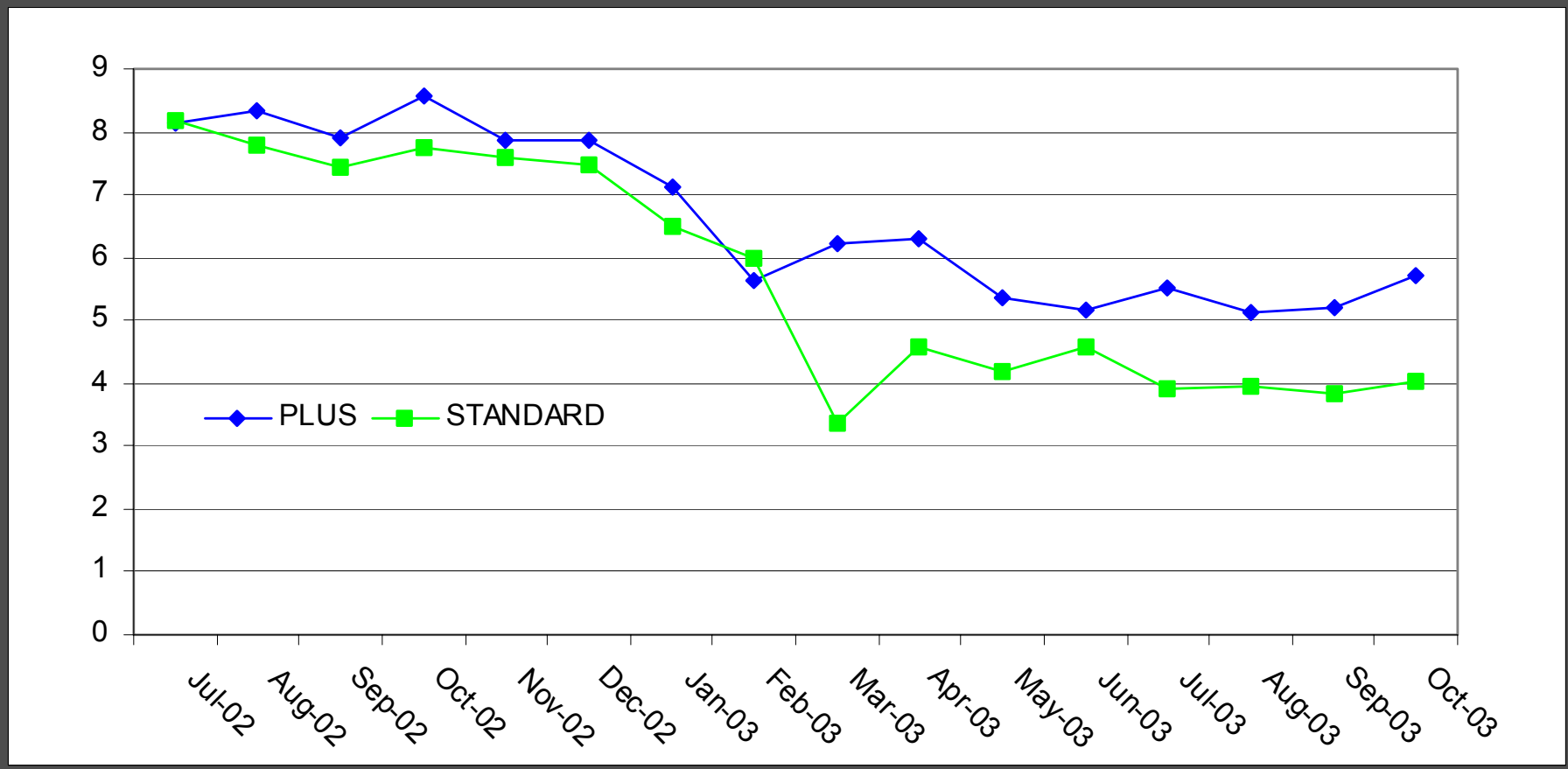
Cohort Analysis



Rx Per 100 members

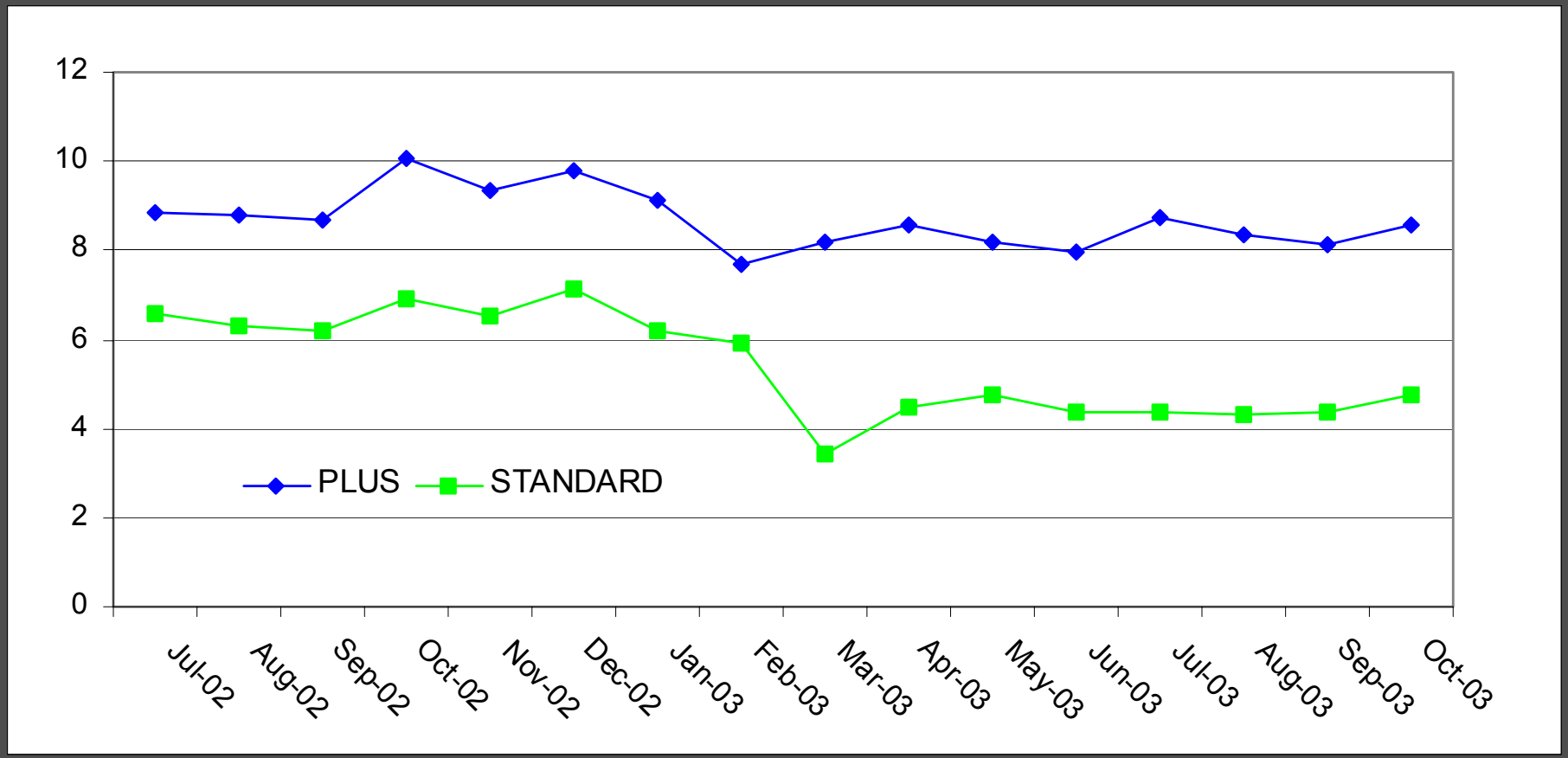
Non-Steroidal Anti-inflammatory

Cohort Analysis



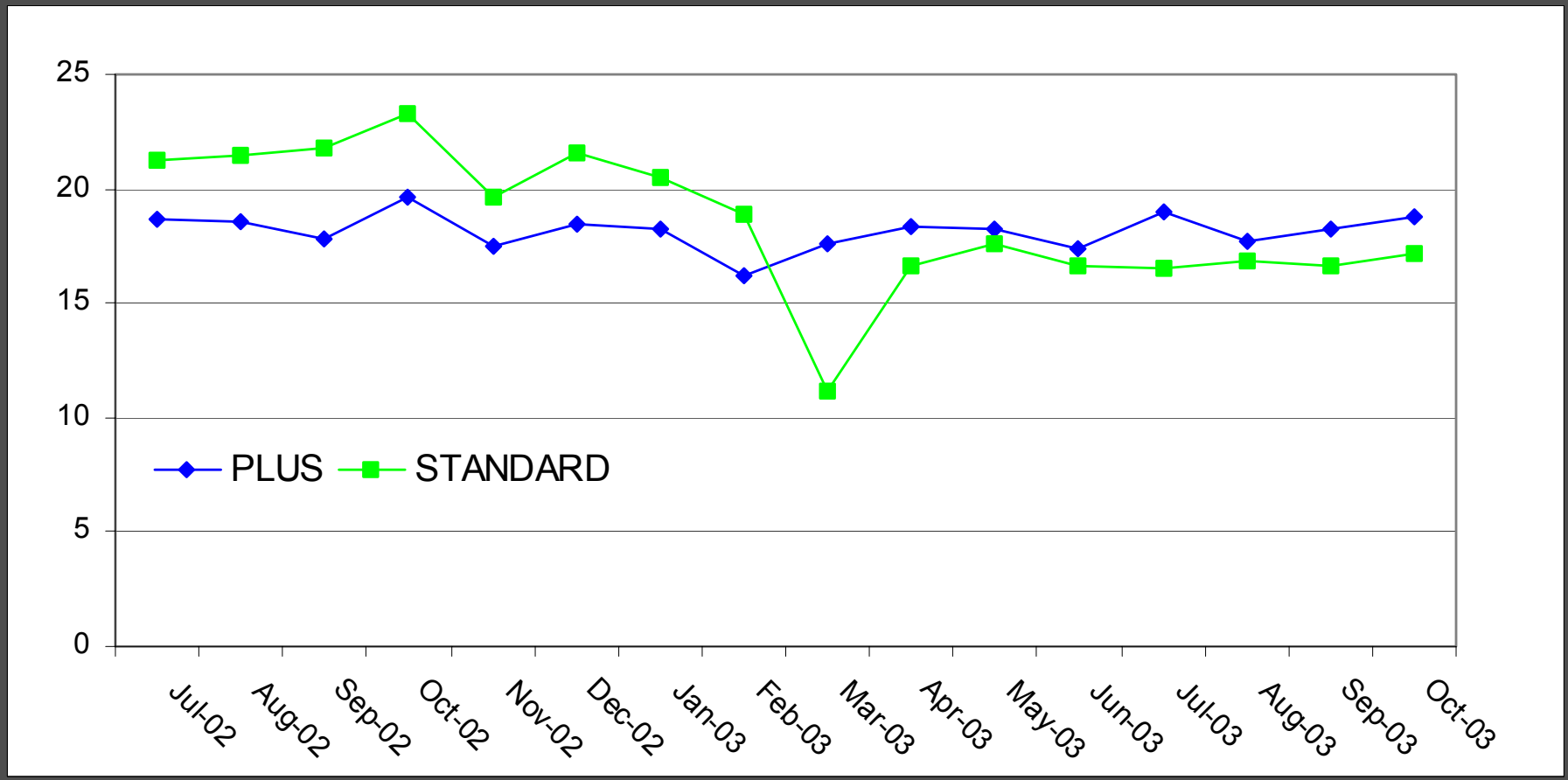
Rx Per 100 members

GI Acid Suppressants
Cohort Analysis



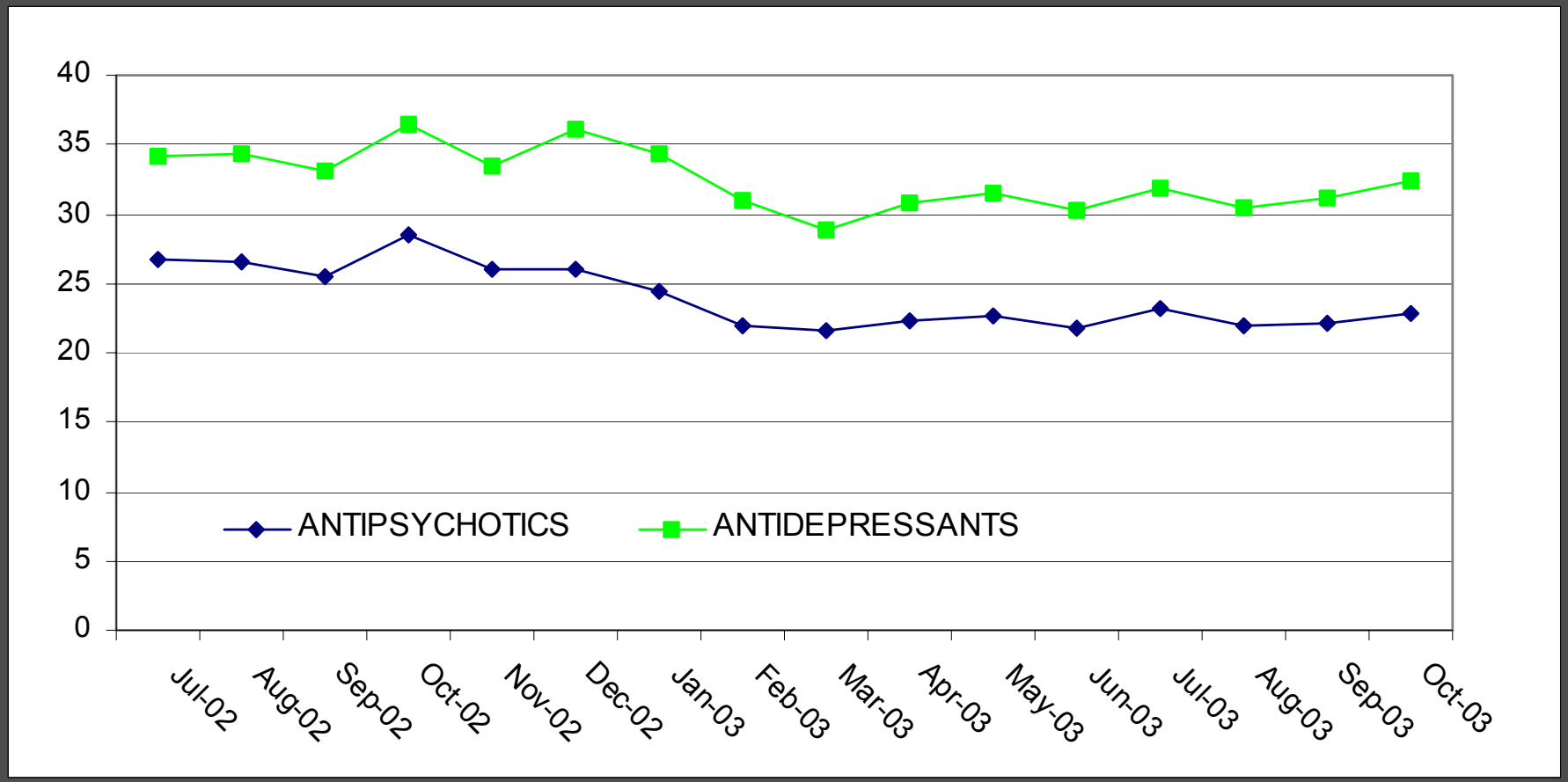
Rx Per 100 members

Narcotic Analgesics
Cohort Analysis



Rx Per 100 members

Carveout
Cohort Analysis



Rx Per 100 members

Summary

- Average cost/rx
  - ↓ Standard
  - ↑ Plus
  - ↑ Carveout
- Increase in generic market share
  - Standard > >> Plus >>>> Carveout
- Marked reductions in Rx utilization (cohort)
  - Standard: ↓ 33%
  - Plus: ↓11%
  - Carveout: ↓15%

Summary

- Reduction varied by therapeutic category (cohort)
  - Non-Steroidal Anti-Inflammatory Drugs (NSAIDs): 45% (Standard), 30% (Plus)
  - Respiratory: 45% (Standard), 15% (Plus)
  - Diabetes: 37% (Standard), 6% (Plus)
  - Narcotics: 23% (Standard), 2% (Plus)

Limitations

- Health outcomes not assessed
- No control cohort
  - Discontinuation of critical medications
  - Shifting to generic alternatives
  - Medical service use (e.g. Emergency Department visits)

Limitations

- Impact of other concomitant policies
  - –Temporary suspension of benefits May 2003
  - –Physician Managed Prescription Drug Program (PMPDP) In May 2003, prescribers of drugs not on the PMPDP lists were required to actively request a "Prior Authorization" by calling the State's pharmacy claims administrator. Prescribers were required only to listen to or read an educational message regarding the PMPDP research in order to receive the exception. The 2003 legislature passed a mandate (HB 3624) that prohibited OMAP from using "Prior Authorization."
  - –October 1, 2003 the PDL reverted back to a voluntary process.

Demographic Changes in Rural Oregon 1990 to 2000 and Dynamics of Future Change

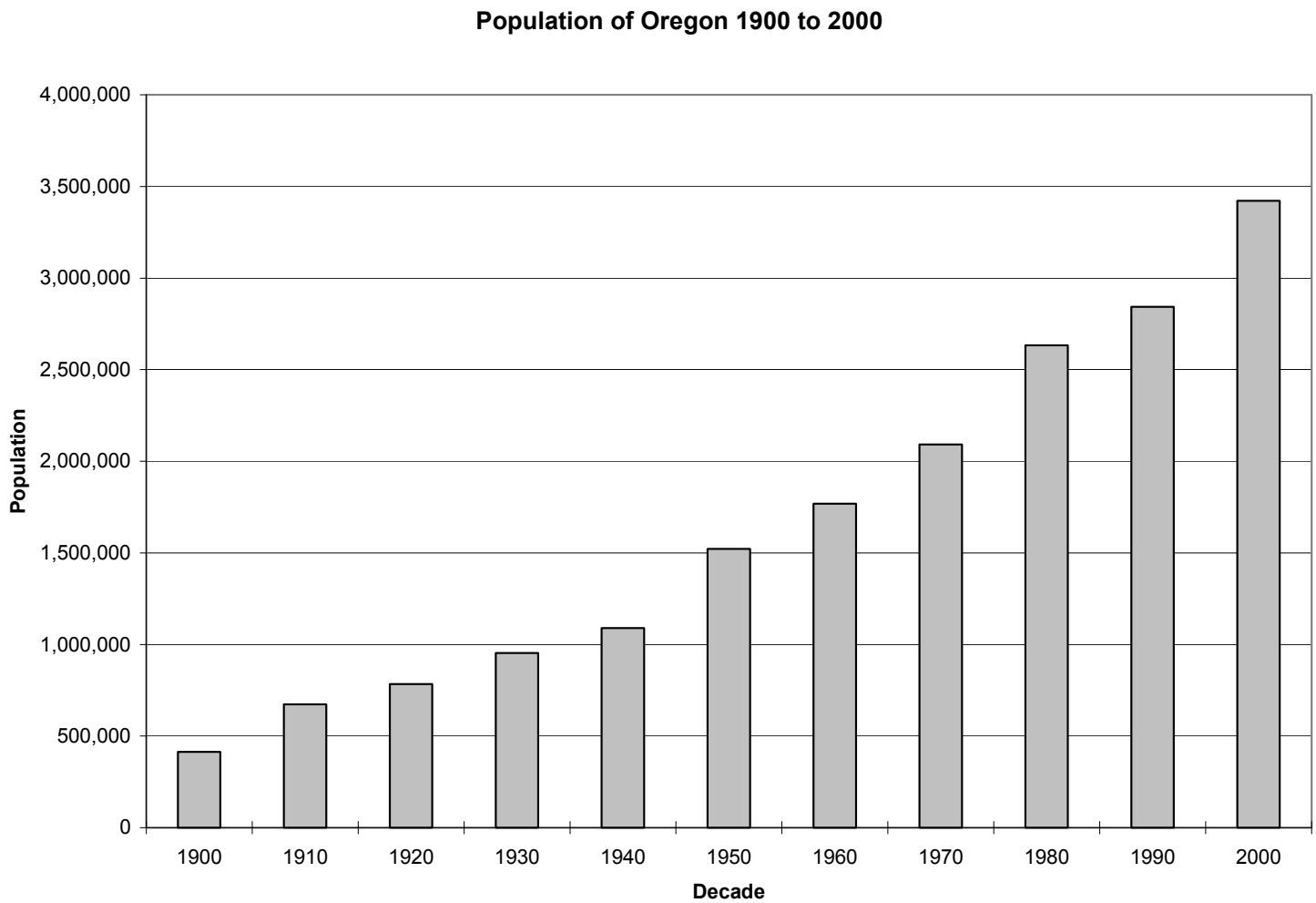
Presentation to
Oregon Health Research and Evaluation Collaborative (OHREC)
Salem, Oregon
April 20, 2004

George C. Hough Jr., Ph.D.
Population Research Center
Portland State University

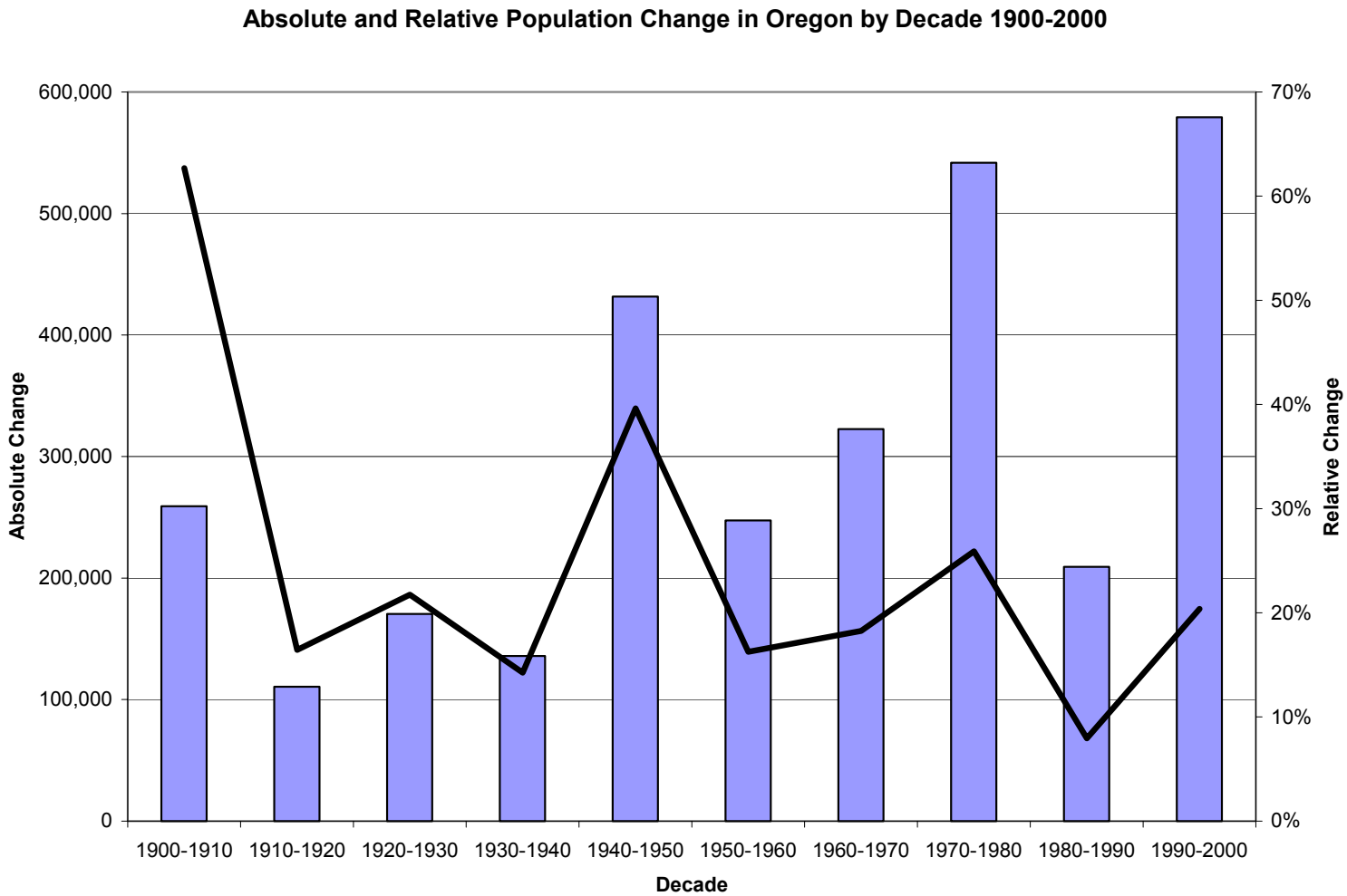
Population Change

- Oregon grew in Absolute and Relative Ways reflecting economic conditions from 1900-2000
- Washington county led the way in Absolute and Relative Change adding over 130,000 person and growing by over 40 percent from 1990-2000
- Deschutes County had the highest Relative Growth at almost 54 percent, but Absolute Growth of just over 40,000 persons

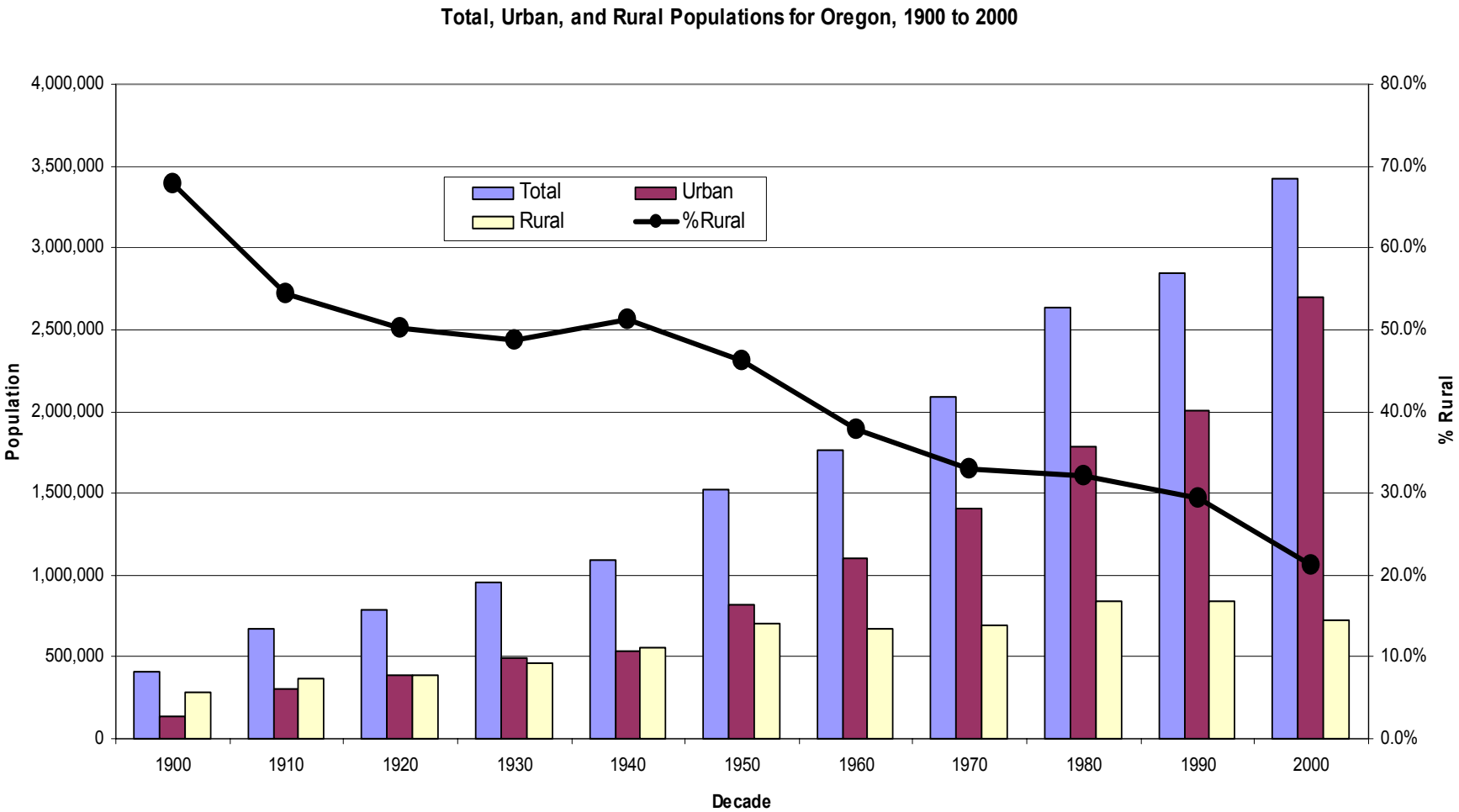
Oregon Grew Consistently During the Century



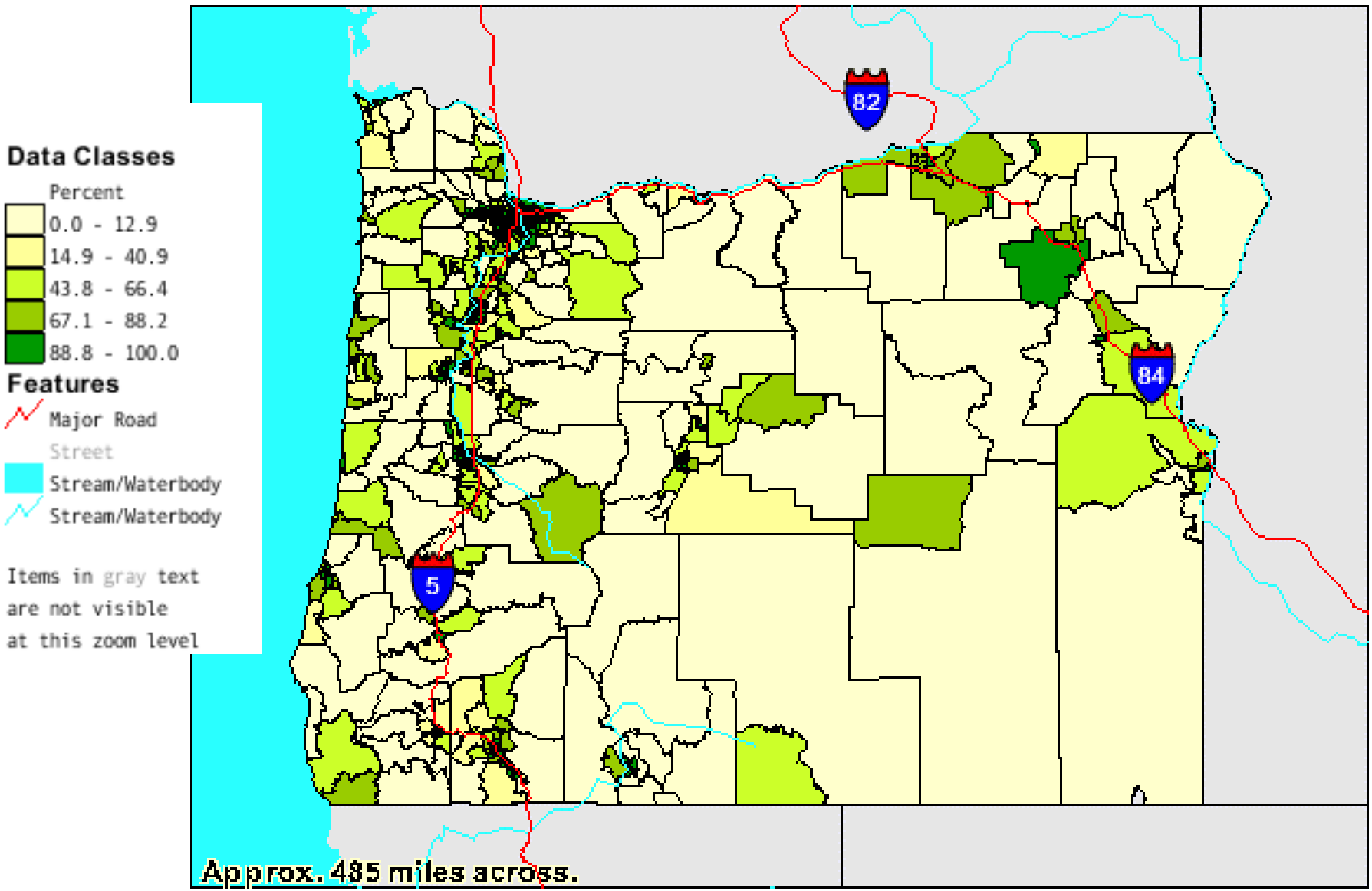
Population Changes 1900 to 2000 Reflect Decade Economic Conditions



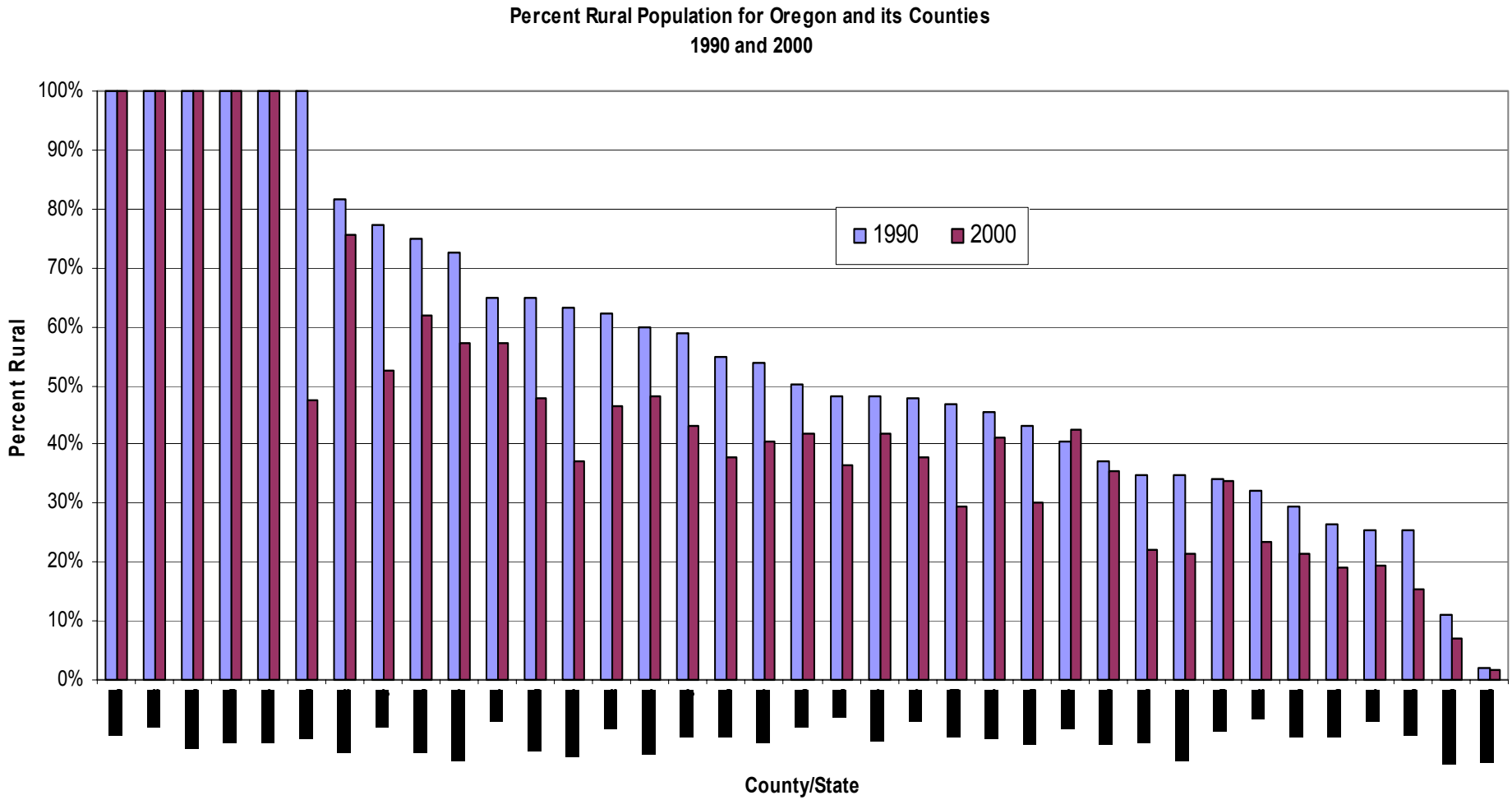
Urban/Rural Populations 1900 to 2000 Reflect Decline in Oregon as a Natural Resource State Economy



Oregon's Urban Population 2000 – The Coast, The Valley, Interstates



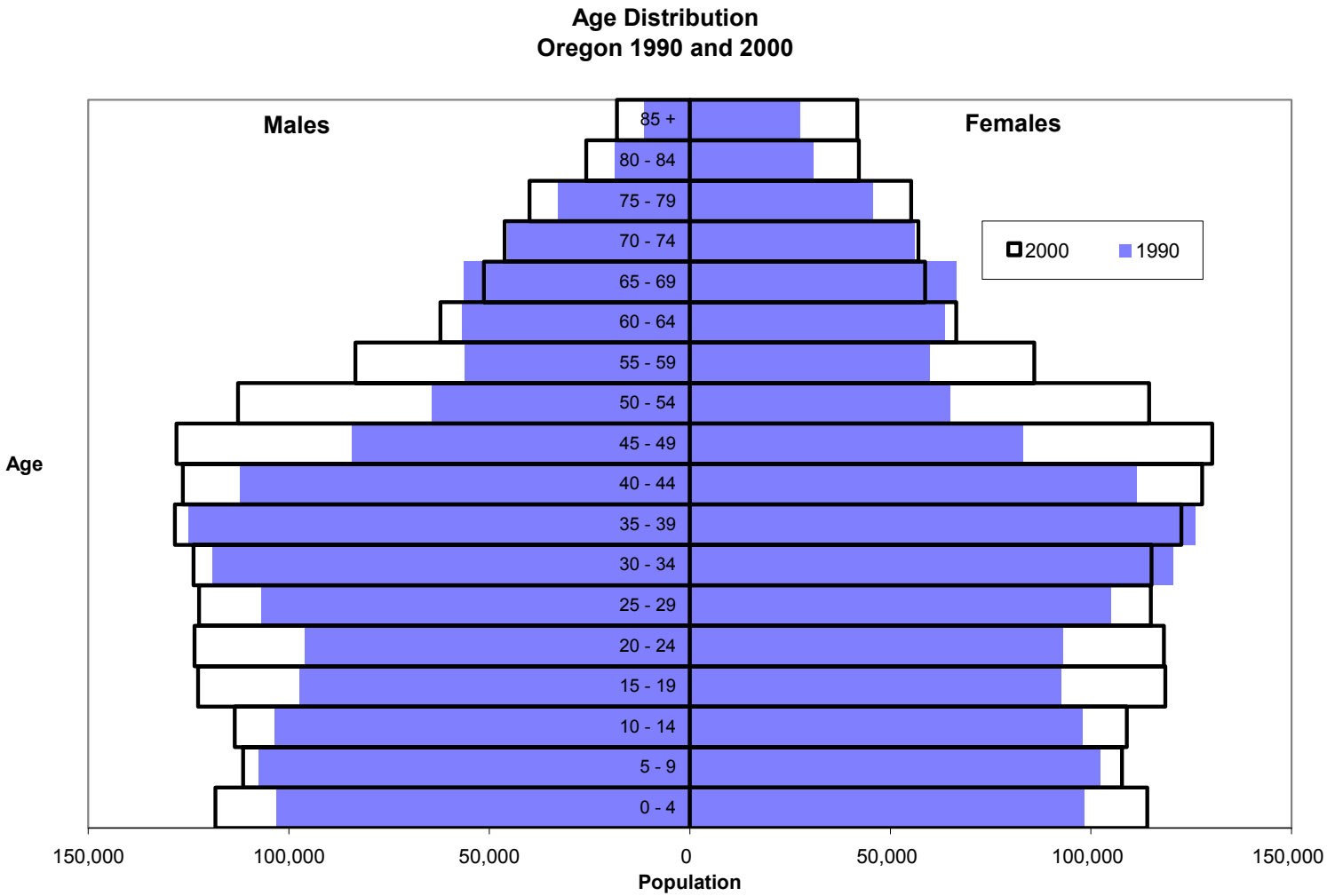
Some of Oregon's Rural Counties Experienced Dramatic Urbanization During the 1990s



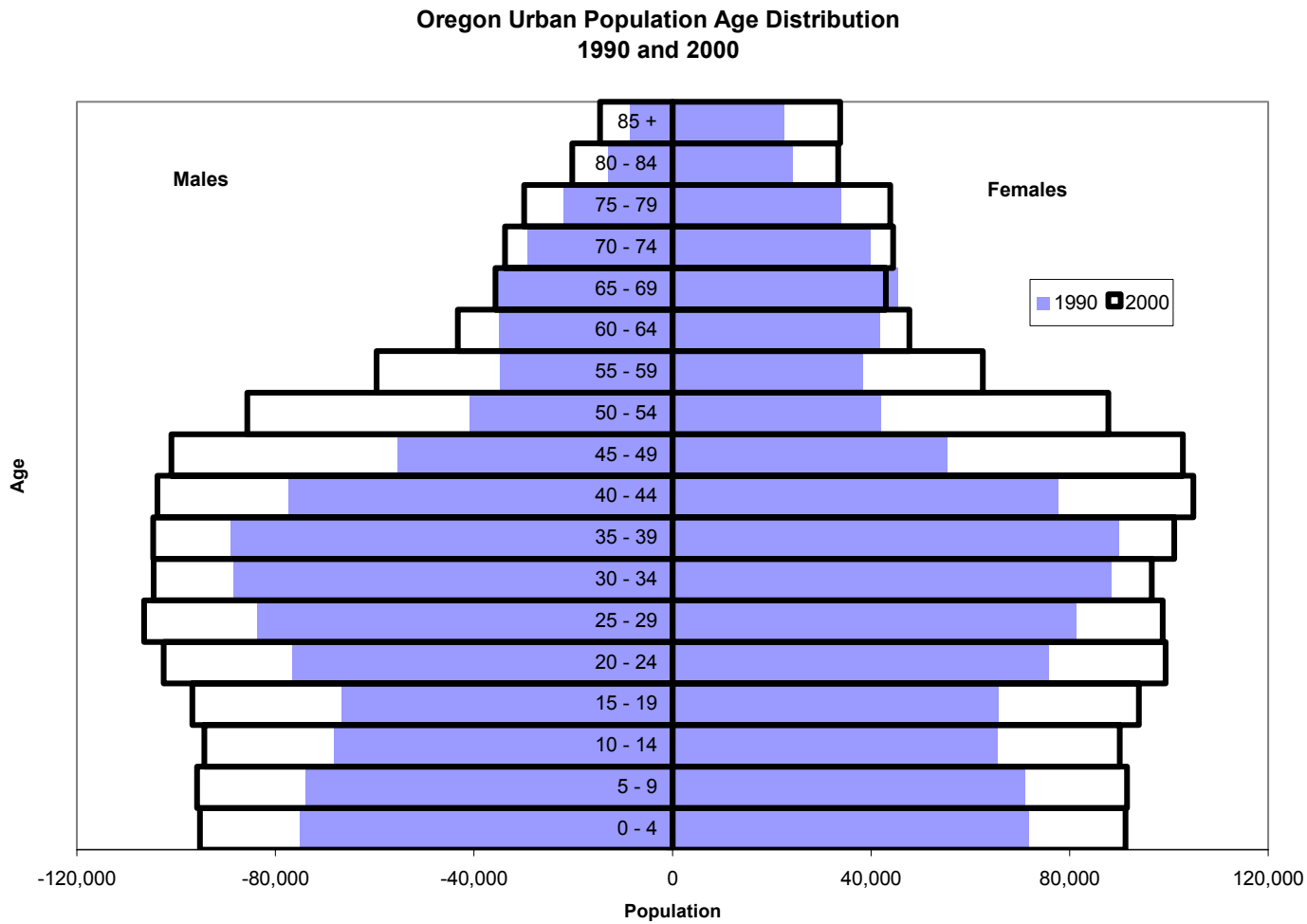
Age Dynamics for Oregon

- Oregon Gained 400,000 residents through Net In-Migration, 430,000 through Births and Lost 273,000 through Deaths for the Decade
- Urban and Rural Age Changes Reveal Opposite Dynamics – Rapid Aging in Rural Counties
- Deschutes County Experienced Growth Across All Age Groups due to a Large Influx of New Residents
- Curry County Also Experienced Growth, but Represented a Retirement Destination
- Columbia County appealed to those later in the lifecycle with Proximity to Urban Amenities
- Tillamook County Represented a Stable Rural County, Offering Economic Opportunities to Many Age Segments

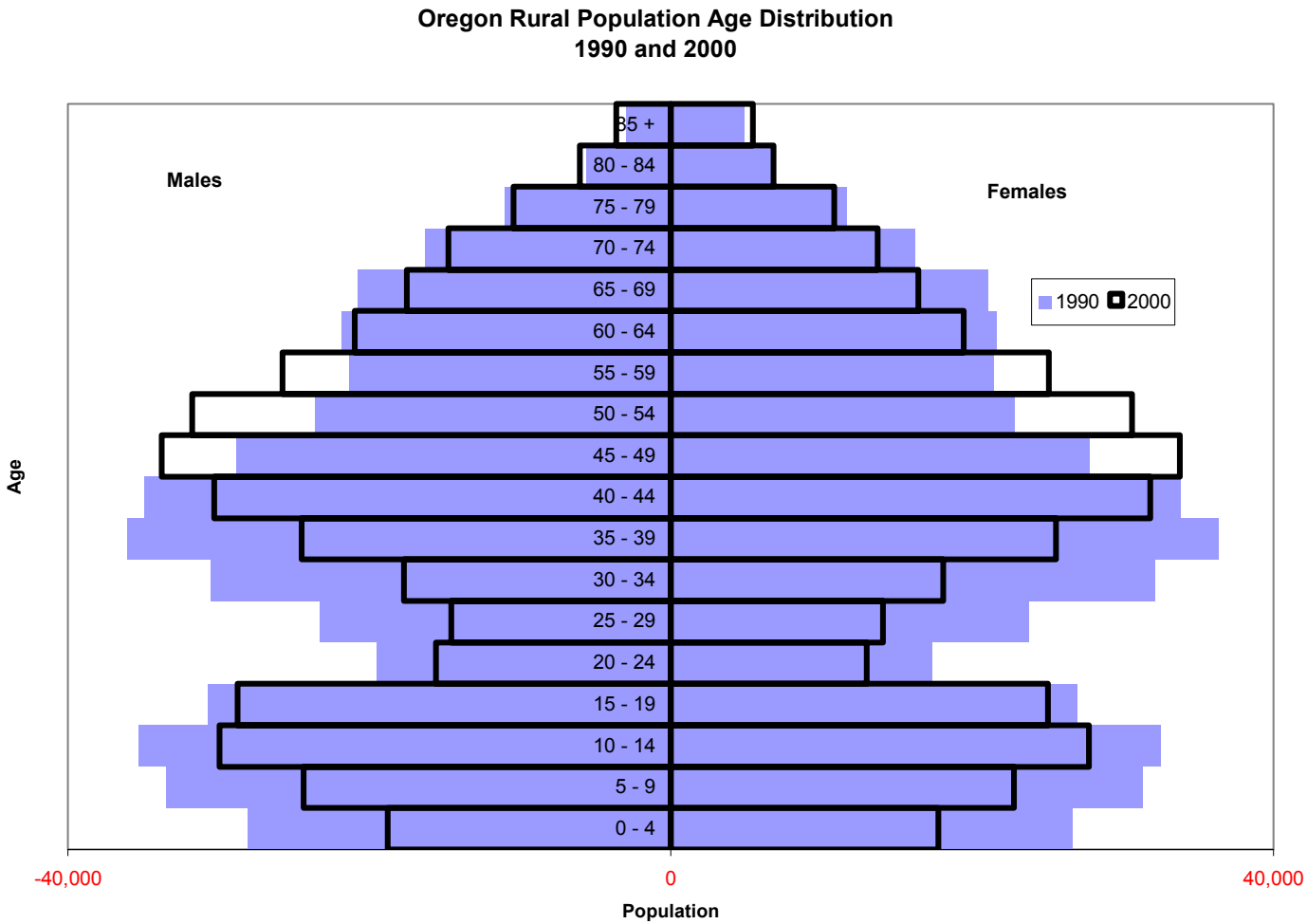
The Oregon Population Saw Gains in All Ages Except Some of the Elderly Groups and Females in their 30s



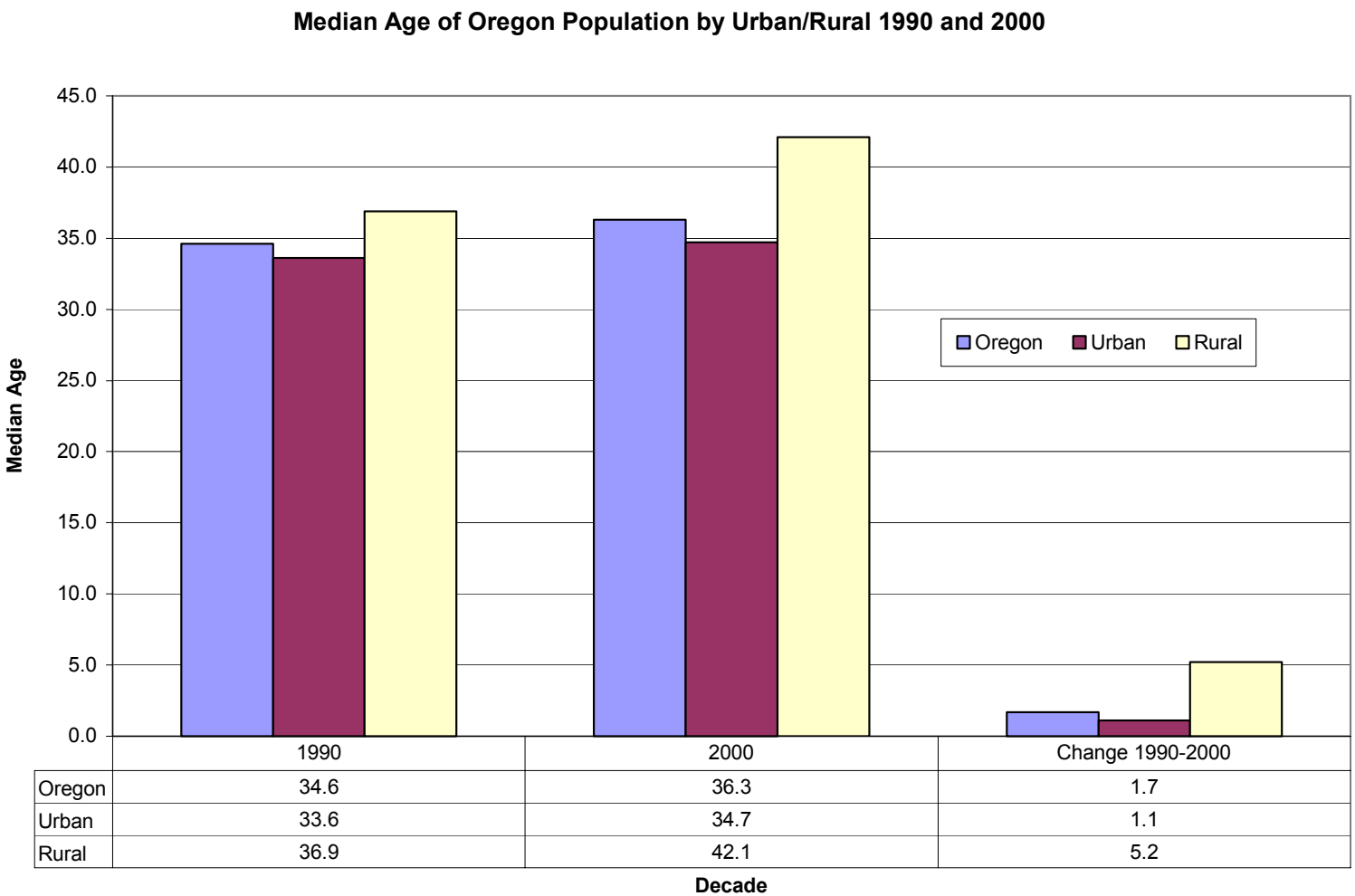
Urban Oregon Population Experienced Gains in All Age Groups



Rural Oregon Population Experienced Losses in Most Age Groups

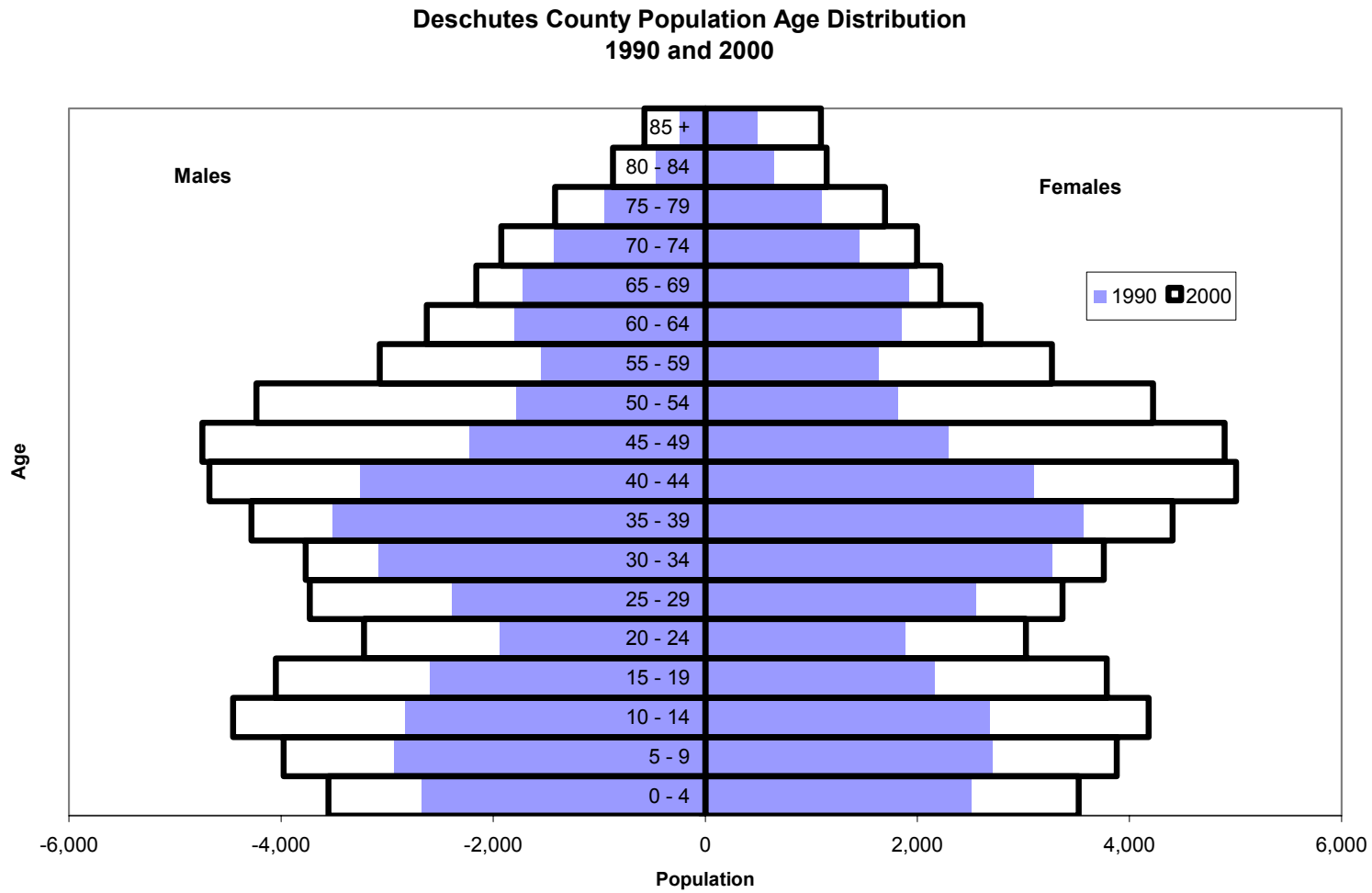


Rural Oregon Population Experienced Dramatic Aging of the Population

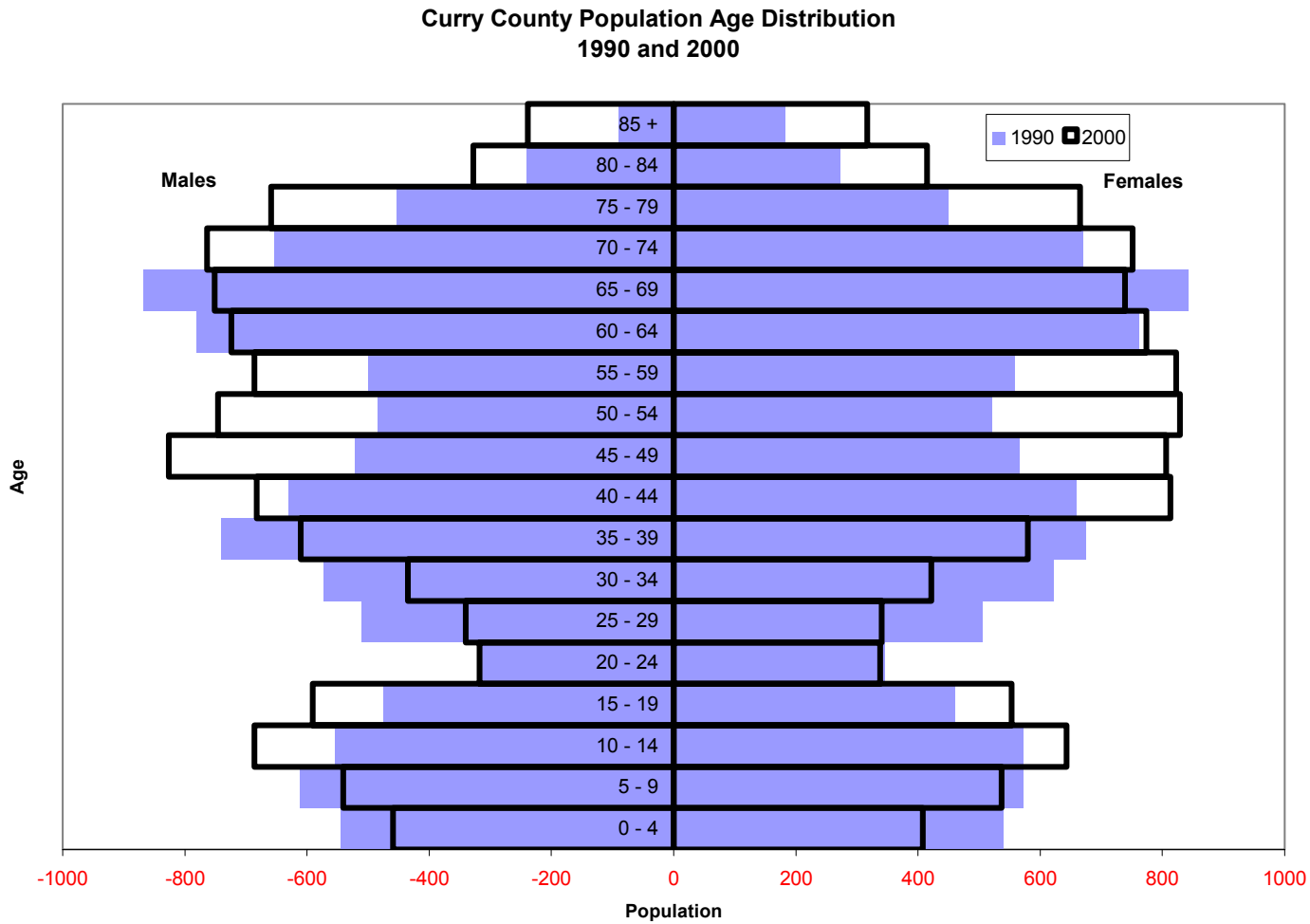


	1990	2000	Change 1990-2000
Oregon	34.6	36.3	1.7
Urban	33.6	34.7	1.1
Rural	36.9	42.1	5.2

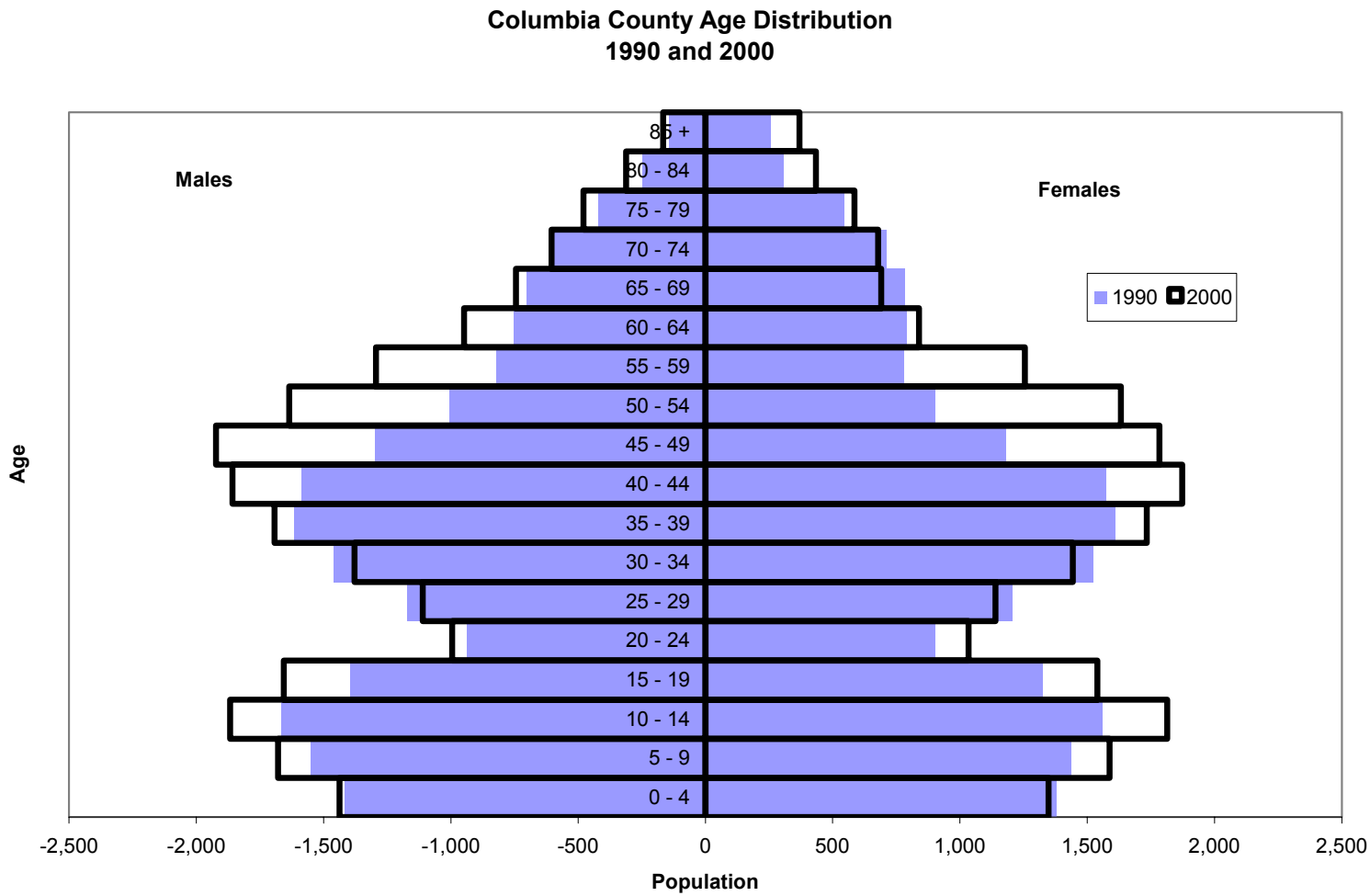
Deschutes County Population Changed from a Rural to Urban County During the 1990s



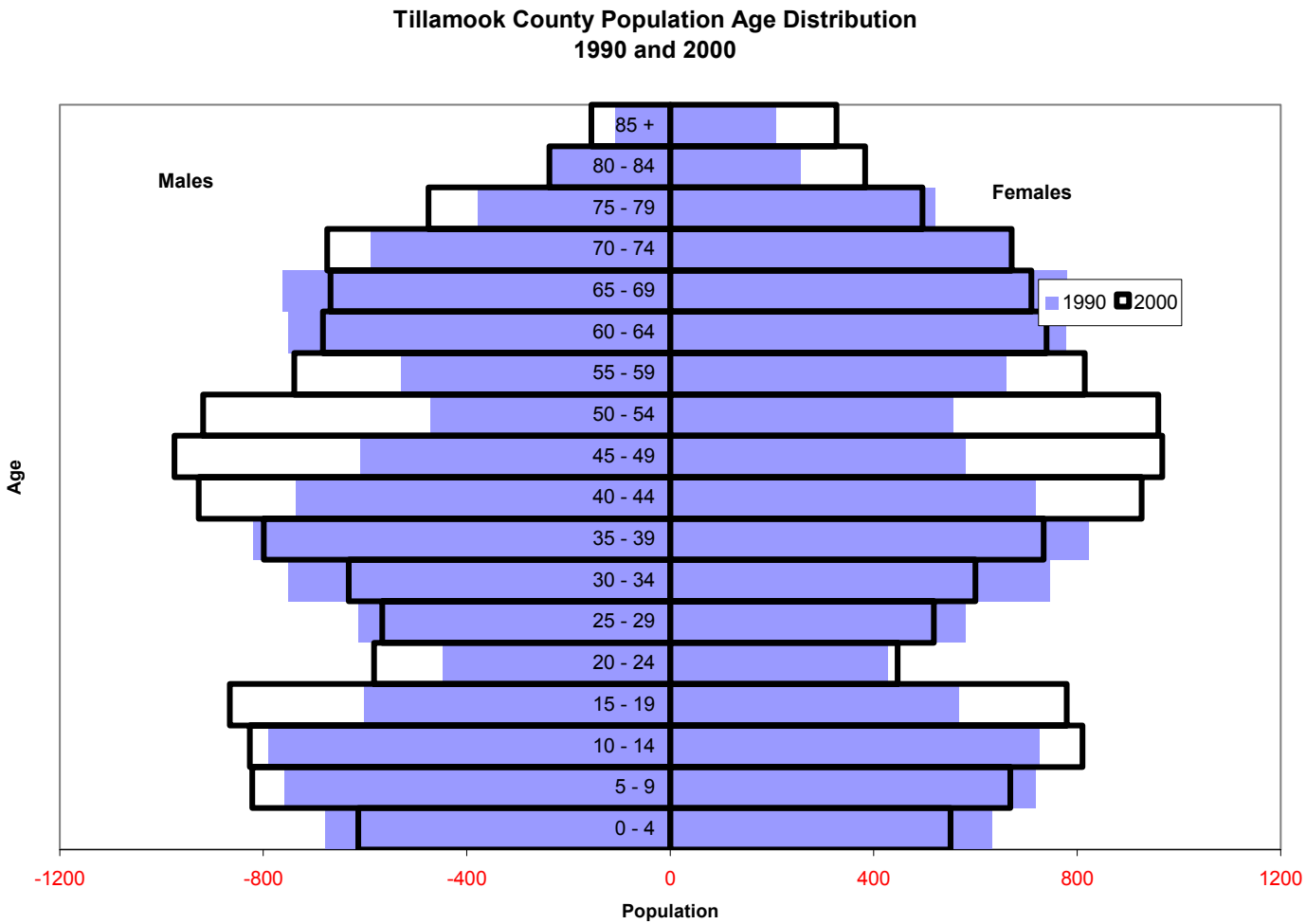
Curry County Population Changed from a Rural to Urban Retirement County During the 1990s



Columbia County Population Aged in Place and Drew In-Migrants Later in the Life Cycle – Proximity to Urban Jobs



Tillamook County Population Aged in Place and Drew In-Migrants Later in the Life Cycle – Stability as a Rural County



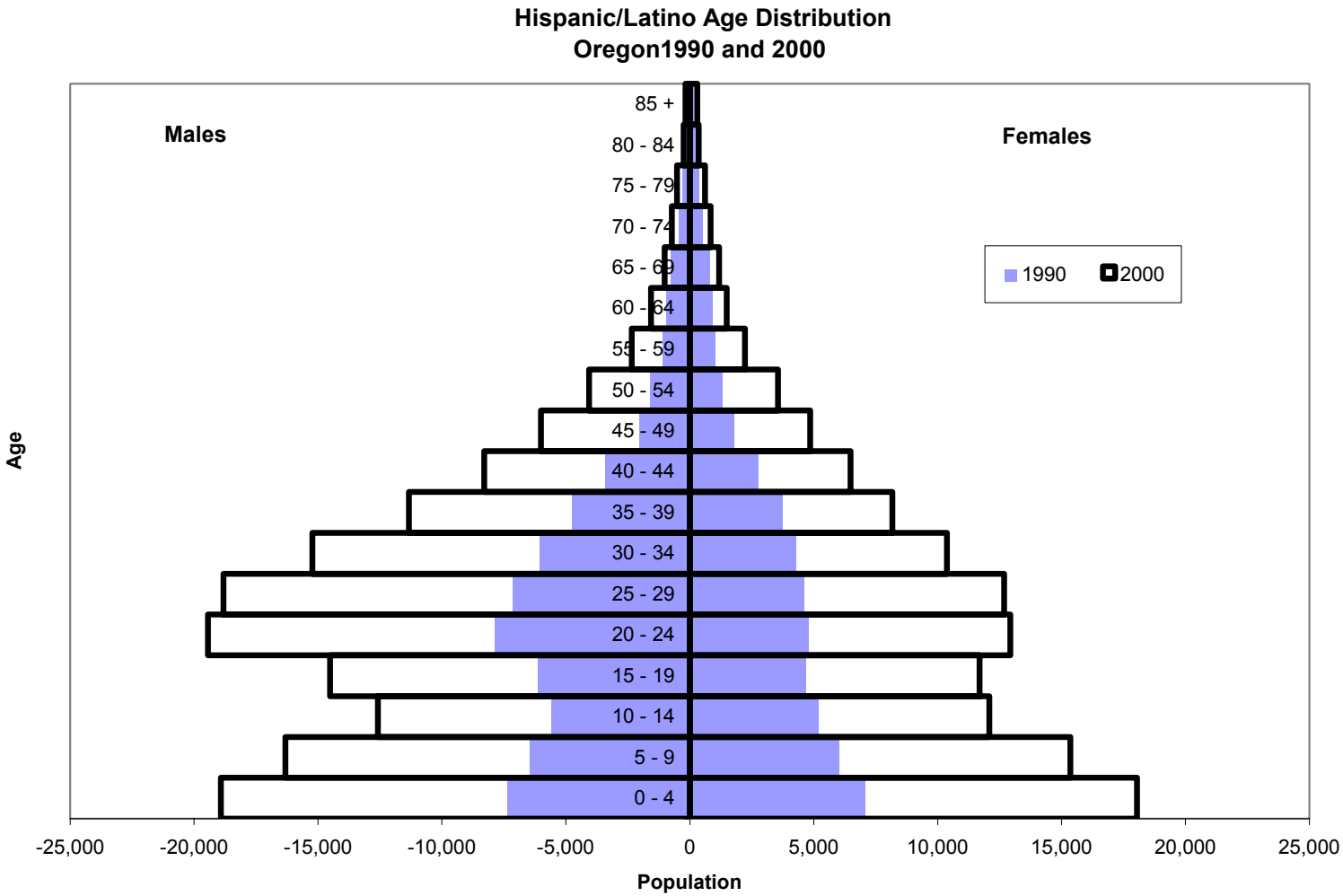
Race/Ethnicity and Age Dynamics

- Some Rural Counties Are in a Process of Demographic Replacement – Aging White Population is Dying and Minority Populations are Moving In and Having Children, especially Latinos
- The Hispanic/Latino population is growing and will continue to grow, based on in-migration and fertility
- Latinos are Not Dispersed Throughout the Rural Landscape – Their Populations are Concentrated in the Small Cities within Rural Counties
- Three Examples – Hood River, Morrow, and Malheur Counties
- In general, minority representation is growing in Oregon, especially among the younger ages

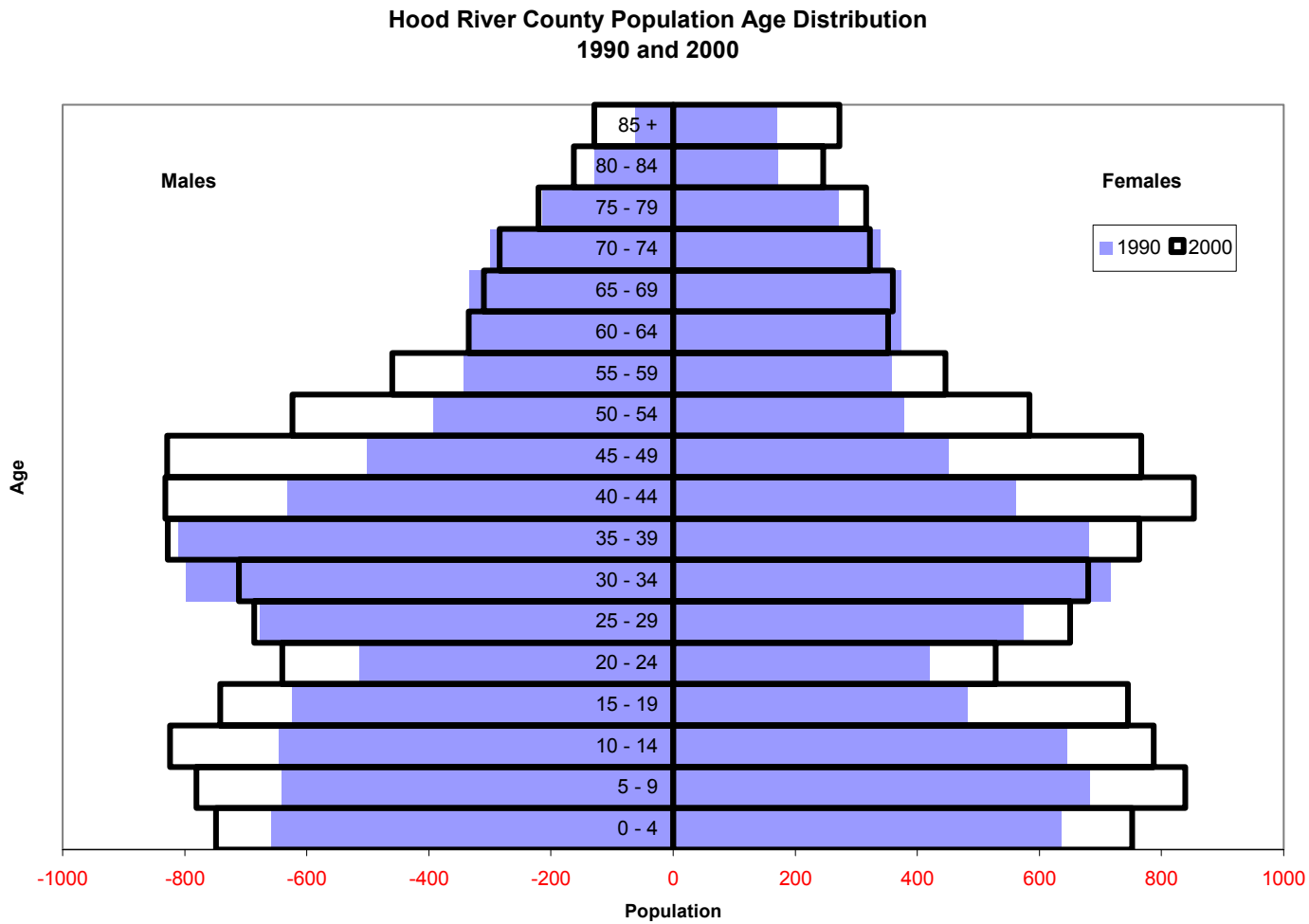
Latino Population is Growing in Absolute and Relative Ways

Hispanic/Latino (of any race) April 1, 1990 and 2000, Oregon and its Counties						
Area	**2000**	**1990**	**Change 1990-2000**	**Change (%) 1990-2000**	**Total Population (%) 2000**	**Total Population (%) 1990**
Oregon	**275,314**	**112,708**	**162,606**	**144.3%**	**8.0%**	**4.0%**
Clatsop County	1,597	648	949	146.5%	4.5%	1.9%
Crook County	1,082	388	694	178.9%	5.6%	2.7%
Curry County	761	354	407	115.0%	3.6%	1.8%
Deschutes County	4,304	1,526	2,778	182.0%	3.7%	2.0%
Hood River County	5,107	2,752	2,355	85.6%	25.0%	16.3%
Jefferson County	3,372	1,448	1,924	132.9%	17.7%	10.6%
Josephine County	3,229	1,749	1,480	84.6%	4.3%	2.8%
Klamath County	4,961	2,984	1,977	66.3%	7.8%	5.2%
Lincoln County	2,119	598	1,521	254.3%	4.8%	1.5%
Malheur County	8,099	5,155	2,944	57.1%	25.6%	19.8%
Morrow County	2,686	825	1,861	225.6%	24.4%	10.8%
Tillamook County	1,244	374	870	232.6%	5.1%	1.7%
Wasco County	2,214	1,065	1,149	107.9%	9.3%	4.9%
Wheeler County	79	12	67	558.3%	5.1%	0.9%
Prepared by Population Research Center, Portland State University, (503) 725-3922. Sources: 1990 and 2000 Census of Population						

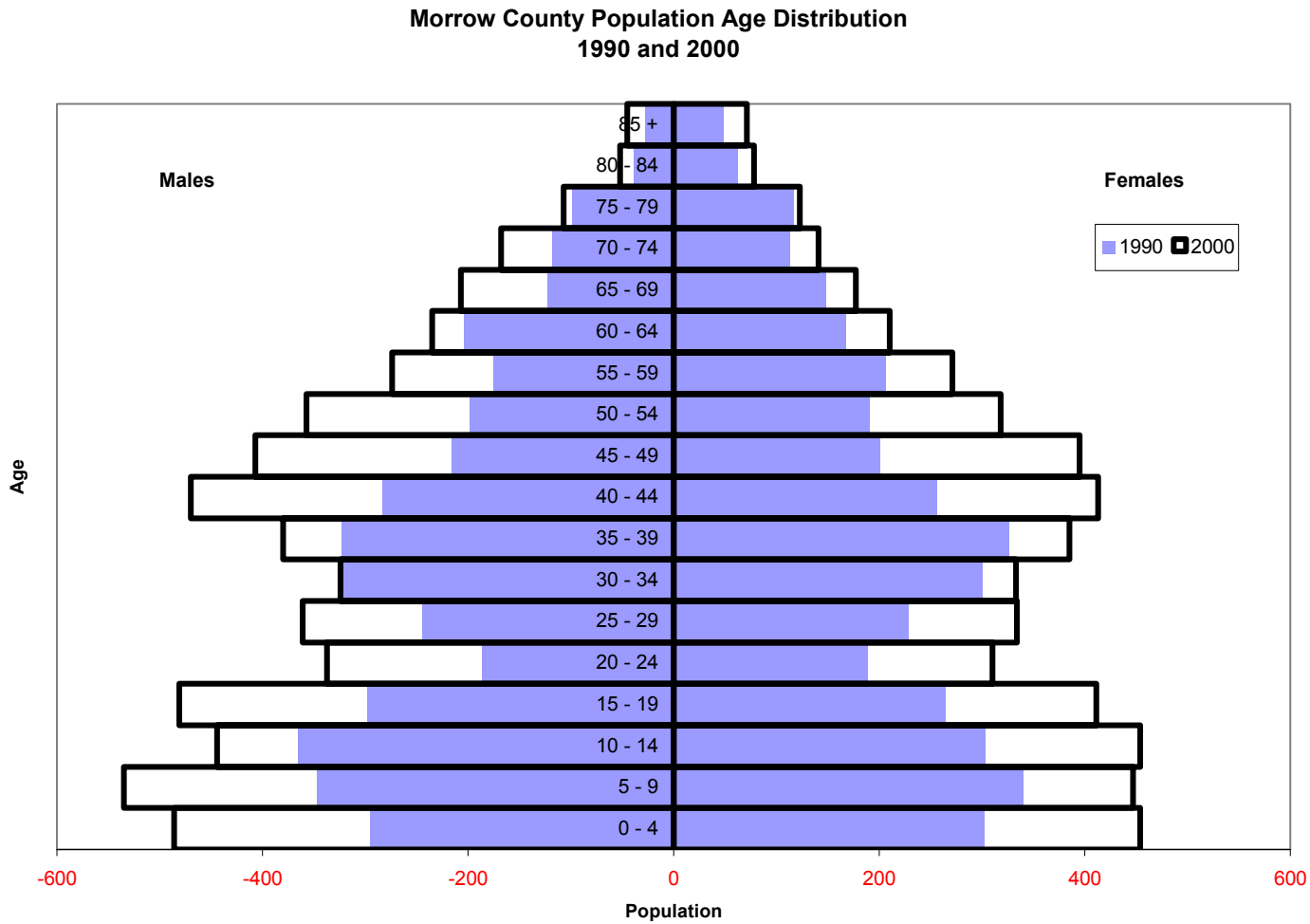
Hispanic/Latino Population is Shaped by Both In-Migration (Male Dominated) and Fertility



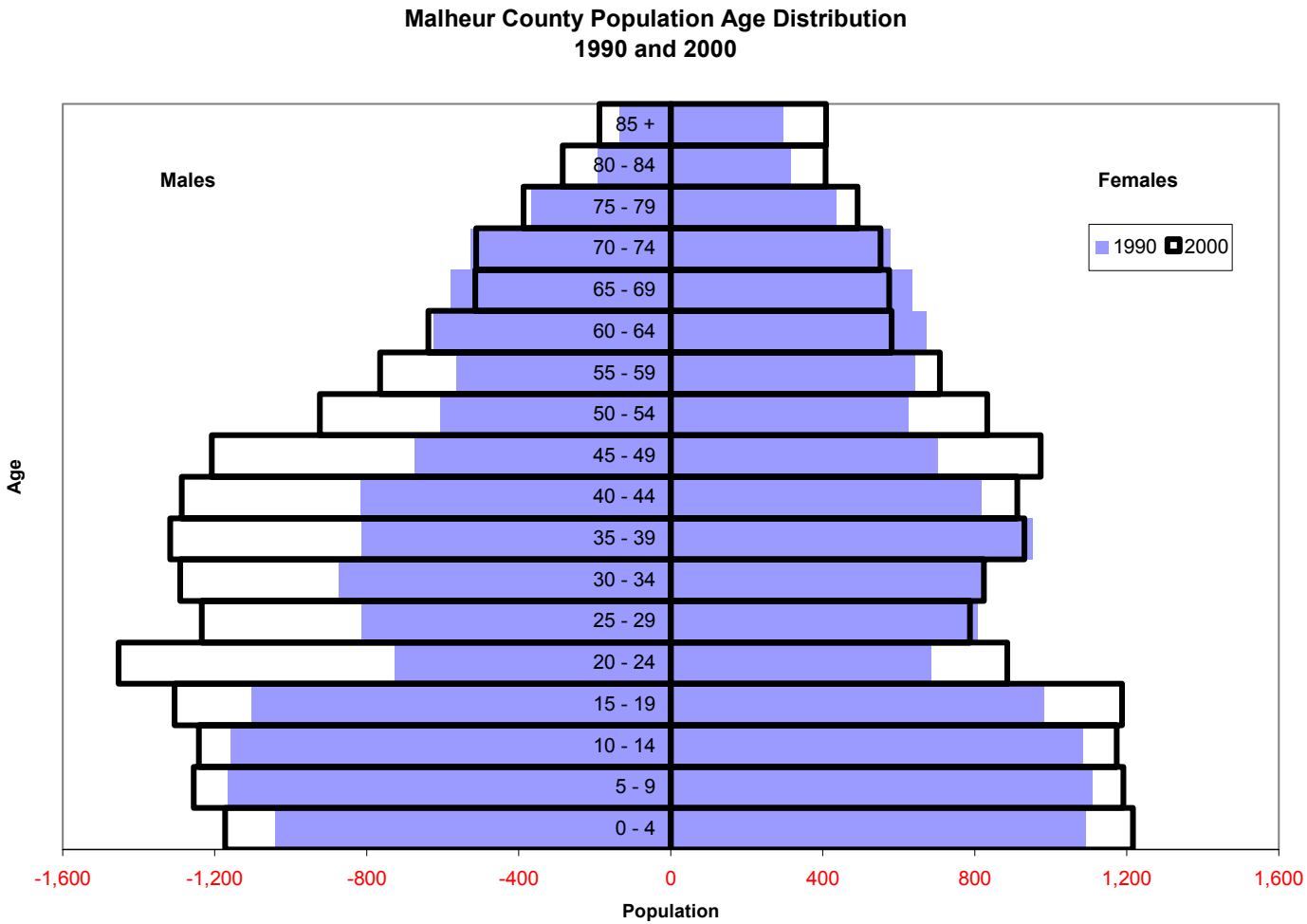
Latino Population in Hood River County is Fully Integrated into the Age Distribution – Barely Noticeable in Rural County



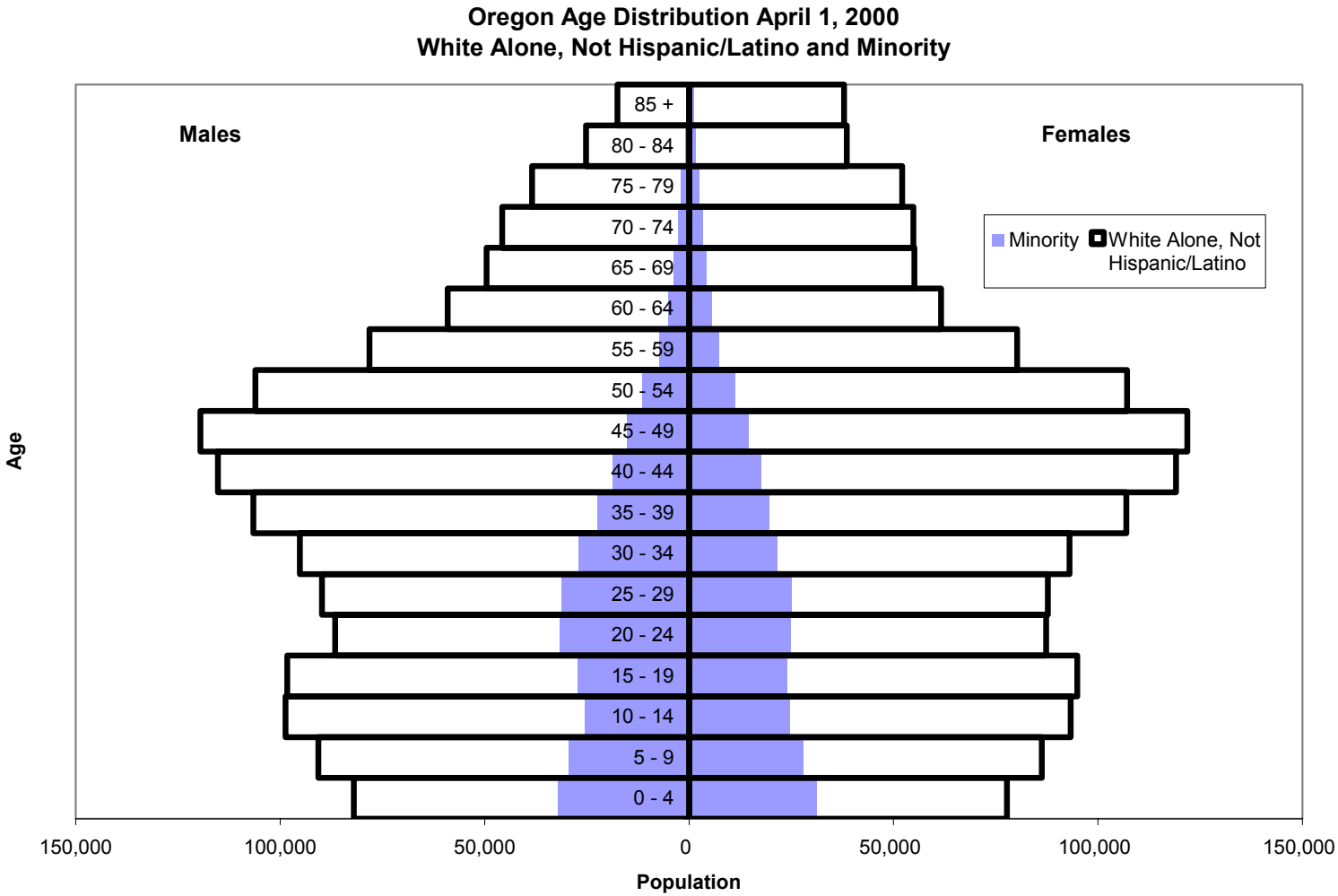
Latino Population in Morrow County is Masked in Overall Positive Change Across All Age Groups



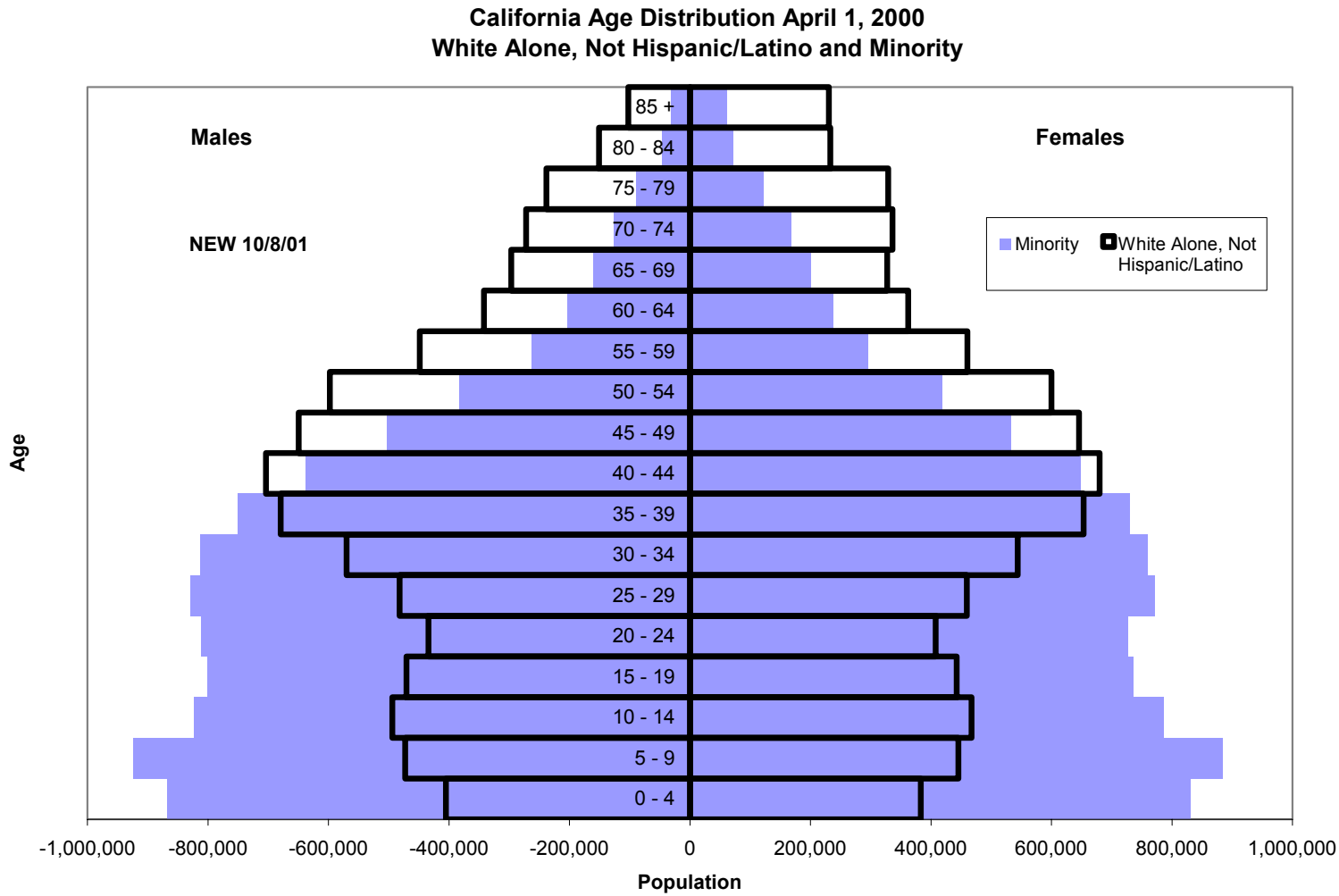
Latino Population in Malheur County is Barely Noticeable as Larger Institutional Forces Dominate Change



Minority Representation is Growing in Oregon Especially at the Earlier Ages



And Now For Something Completely Different…California!!!!



Emergency Department Utilization

by Enrollees in Oregon Health Plan Managed Care Plans, 2002–2003

EQRO Task 1 Rapid Cycle Improvement

OMPRO

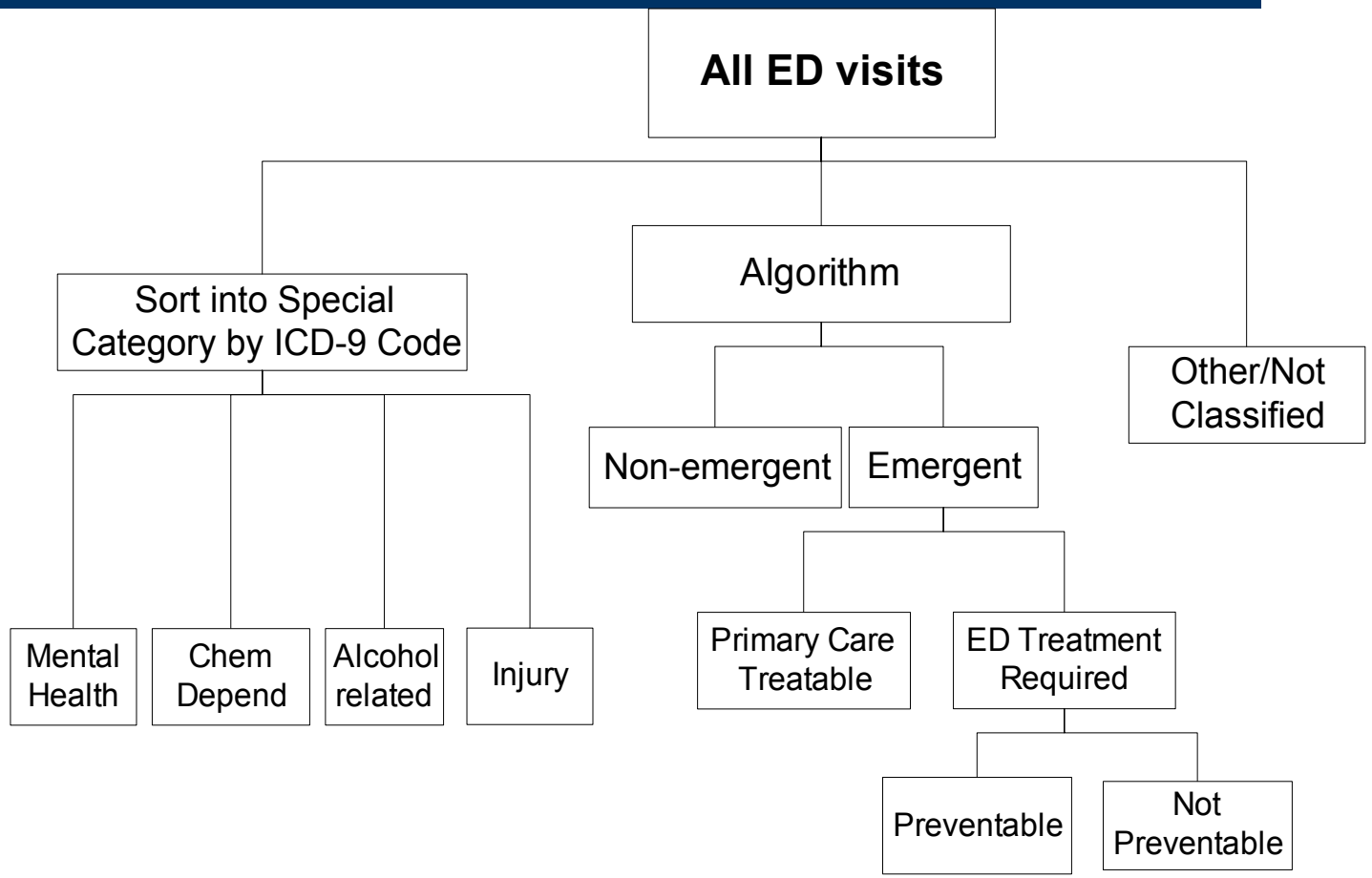
OMAP Data Used for Analysis

- Data were extracted from the OMAP claims and encounter database February 2004
- Inclusion criteria
  - ED visits identified by HEDIS criteria (Revenue Code and CPT)
  - ED visits from 2002 and 2003
  - Managed care and fee-for-service
  - Age 0 - 64 years old
  - Any length of enrollment
- Unique ED visit defined by a unique combination of:
  - Patient ID, claim number, date of visit, primary diagnosis

Algorithm to Categorize ED Visits

- Retrospective analysis of ICD-9 codes
- ED use could be an indicator of access to care
  - Are patients being seen in the ED for conditions that could be treated in the physician's office?
  - Are patients waiting too long to be seen and needing ED treatment for preventable conditions?

Algorithm to Categorize ED Visits



Four ED Visit Categories

- Nonemergent
- Emergent, Primary Care Treatable
- Emergent, ED Care Needed, Preventable
- Emergent, ED Care Needed, Not Preventable

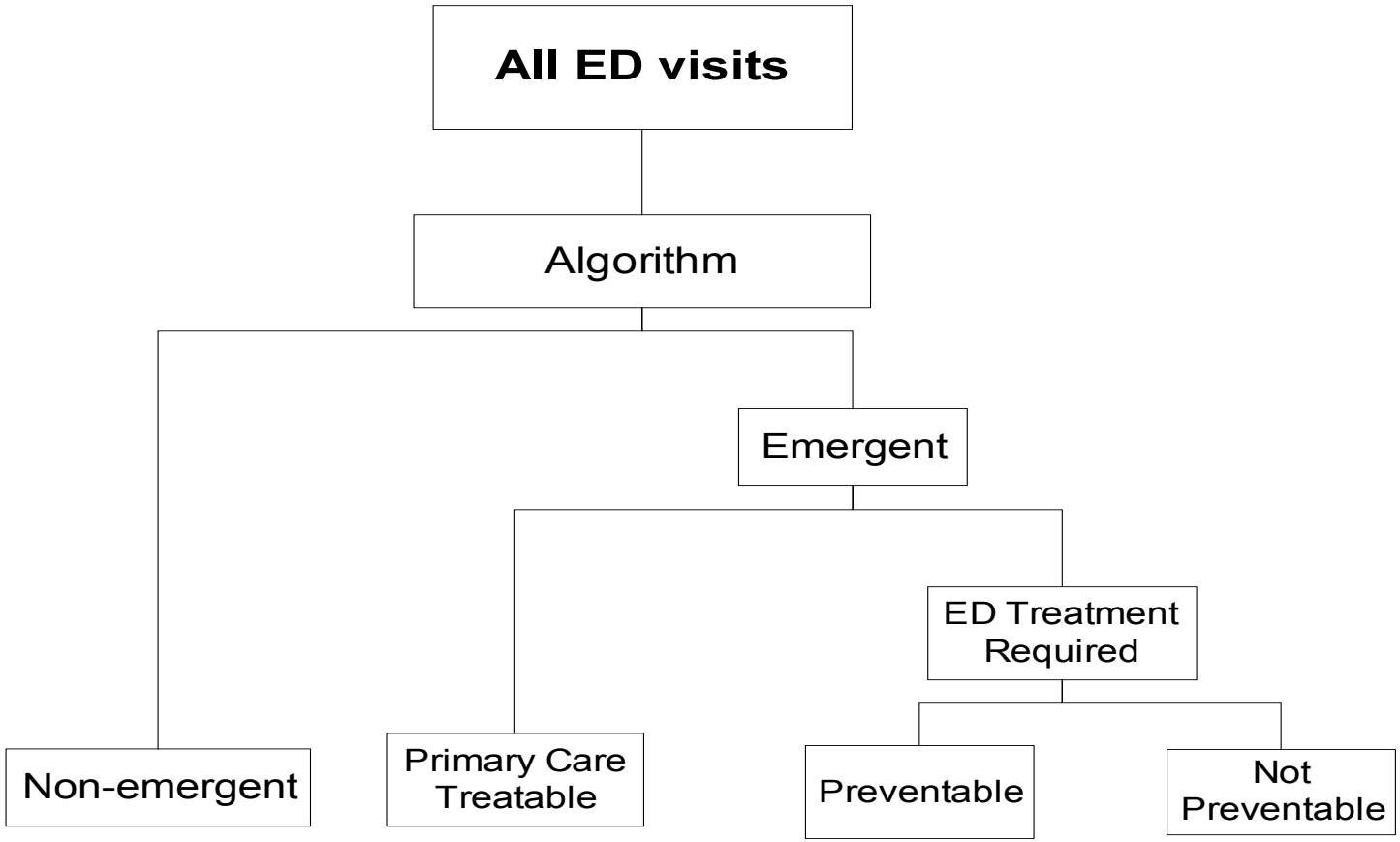
Algorithm

- Algorithm developed by a panel of ED physicians
  - Reviewed ~ 5,000 ED records
  - Assessed initial complaints, vital signs, age, medical history, procedures and resources used in the ED

- Probability that the ICD-9 code falls into one or another category
  - Acute Pyelonephritis 590.10
    - 100% in Emergent, ED Care Needed, but Preventable
  - Pyelonephritis not specified as acute or chronic 590.80
    - 33% in Nonemergent
    - 67% in Emergent, ED Care Needed, but Preventable

Billings, J, Parikh, N, Mijanovich, T. Emergency room use: The New York story. The Commonwealth Fund www.comwf.org November 2000.

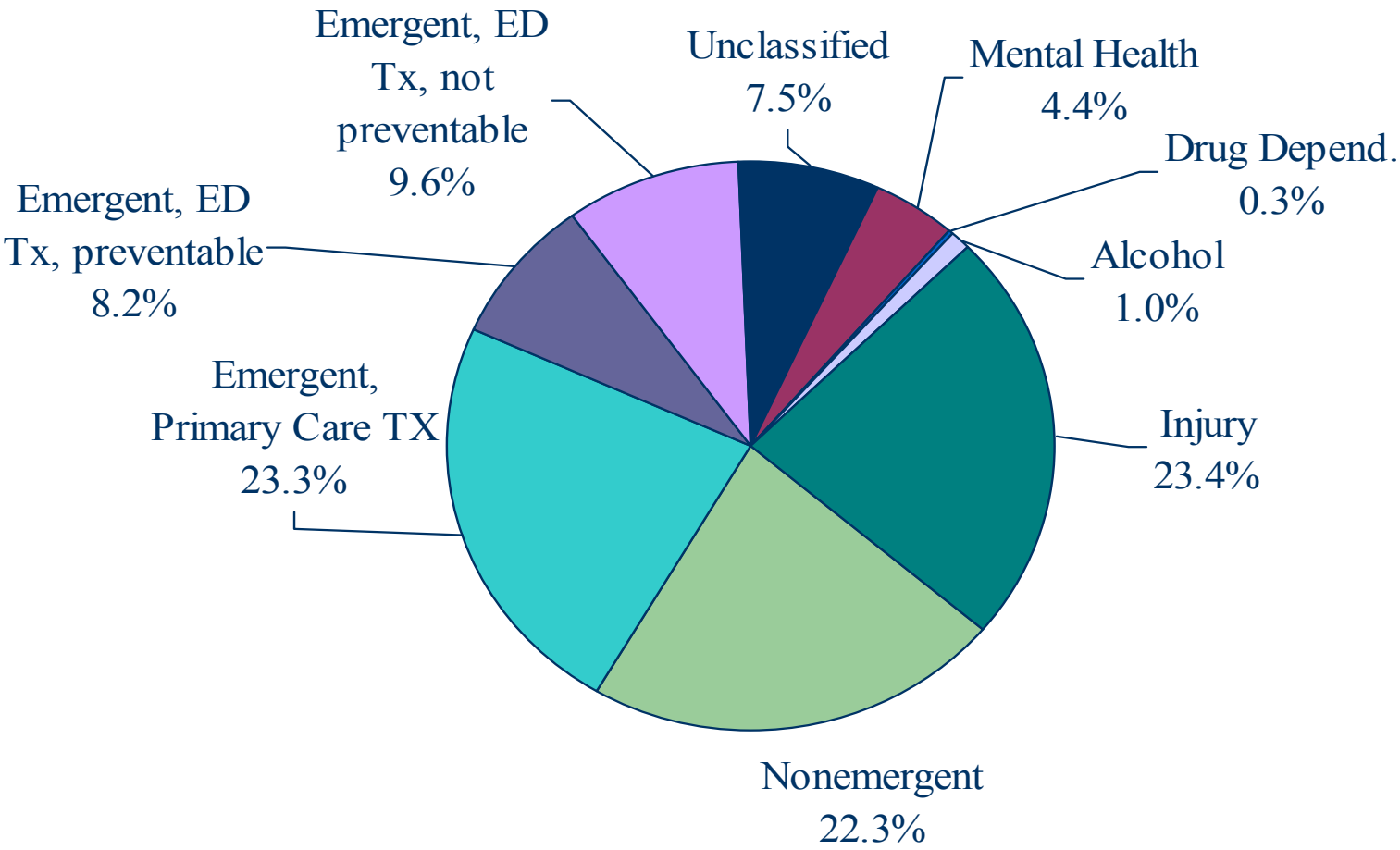
Algorithm to Categorize ED Visits



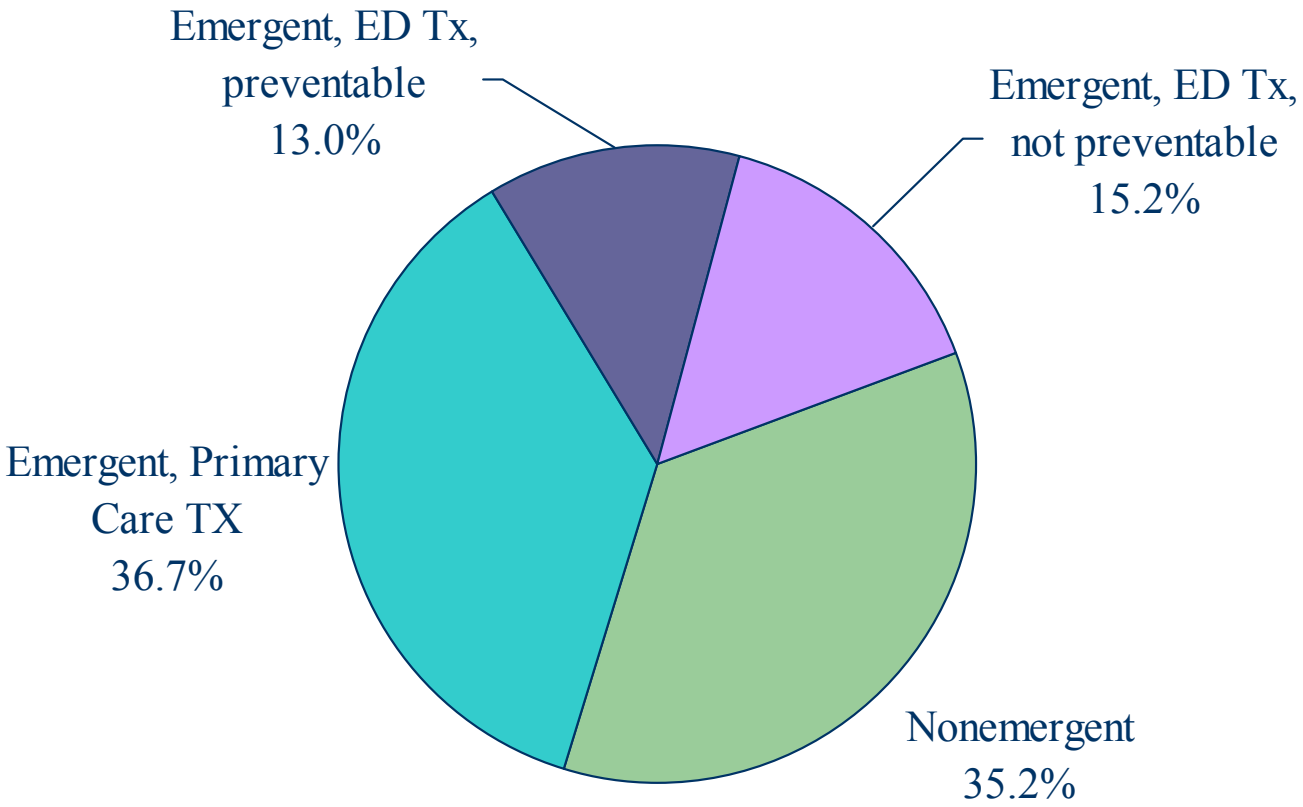
Data Analysis Findings

- Higher proportion of mental health, alcohol, drug dependency for ≥18 compared to <18
- Higher proportion of injuries for <18 compared to ≥18
- Higher proportion of injuries for male versus female
- Higher proportion of nonemergent visits for female versus male

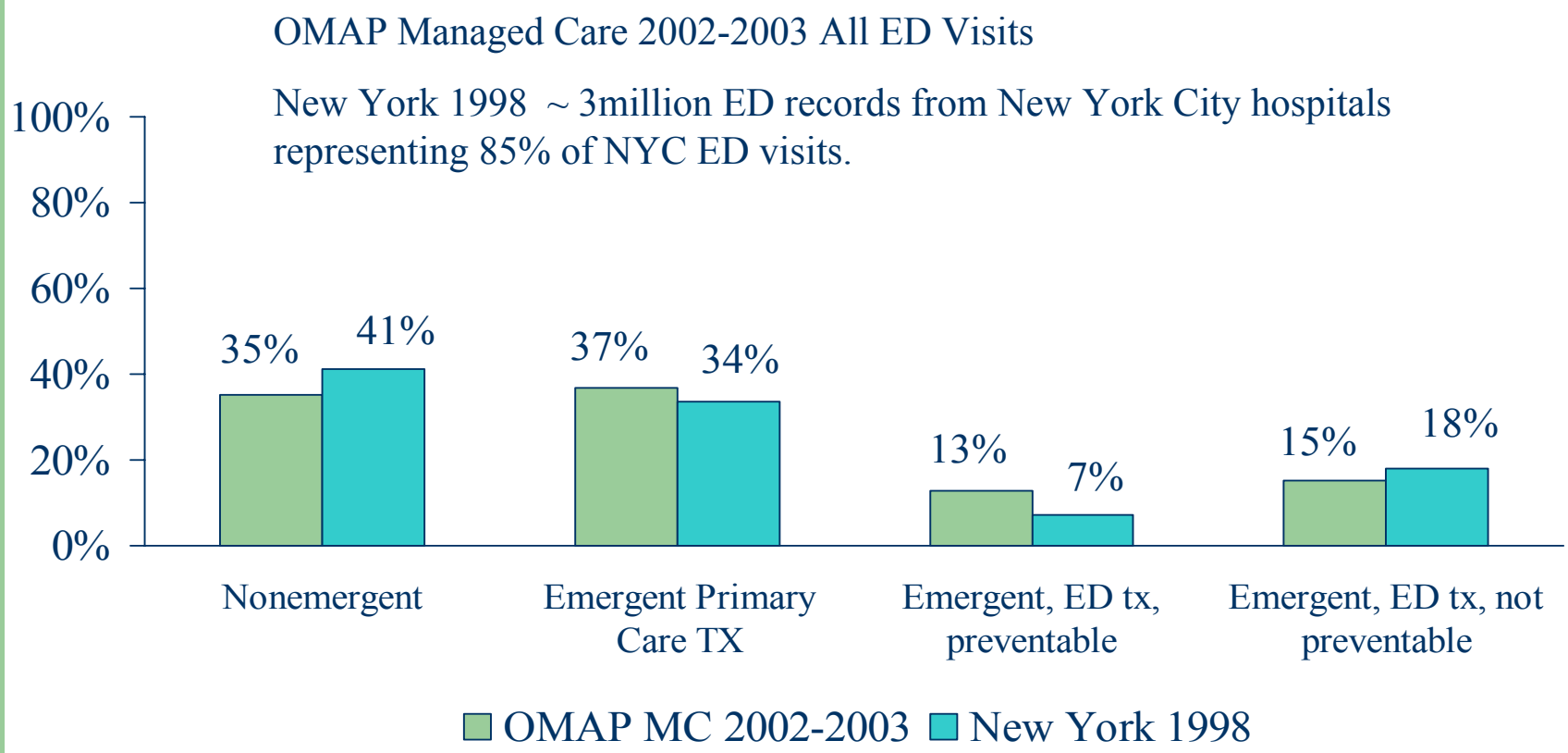
OMAP Managed Care 2002-2003



OMAP MC 2002-2003 Algorithm

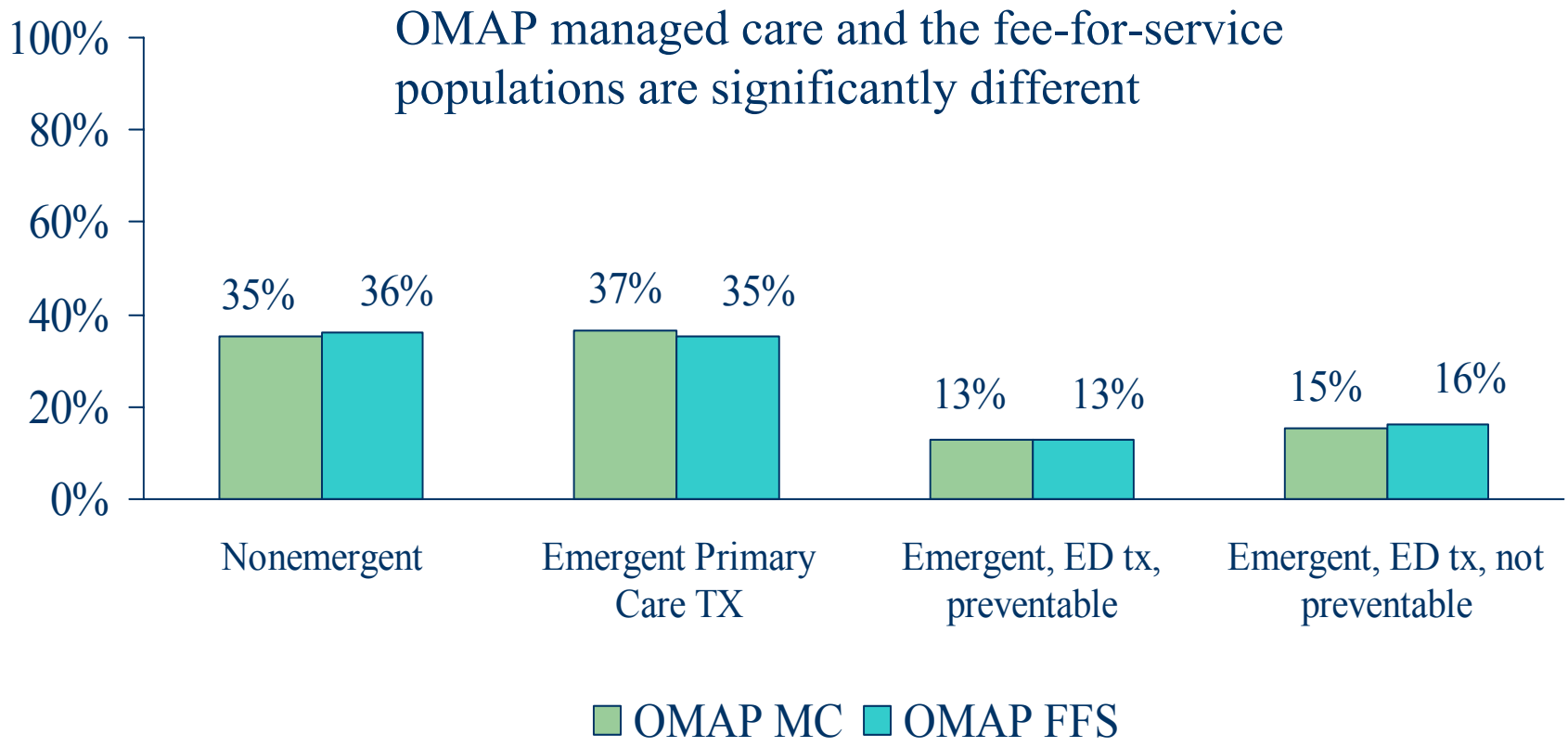


OMAP MC and New York

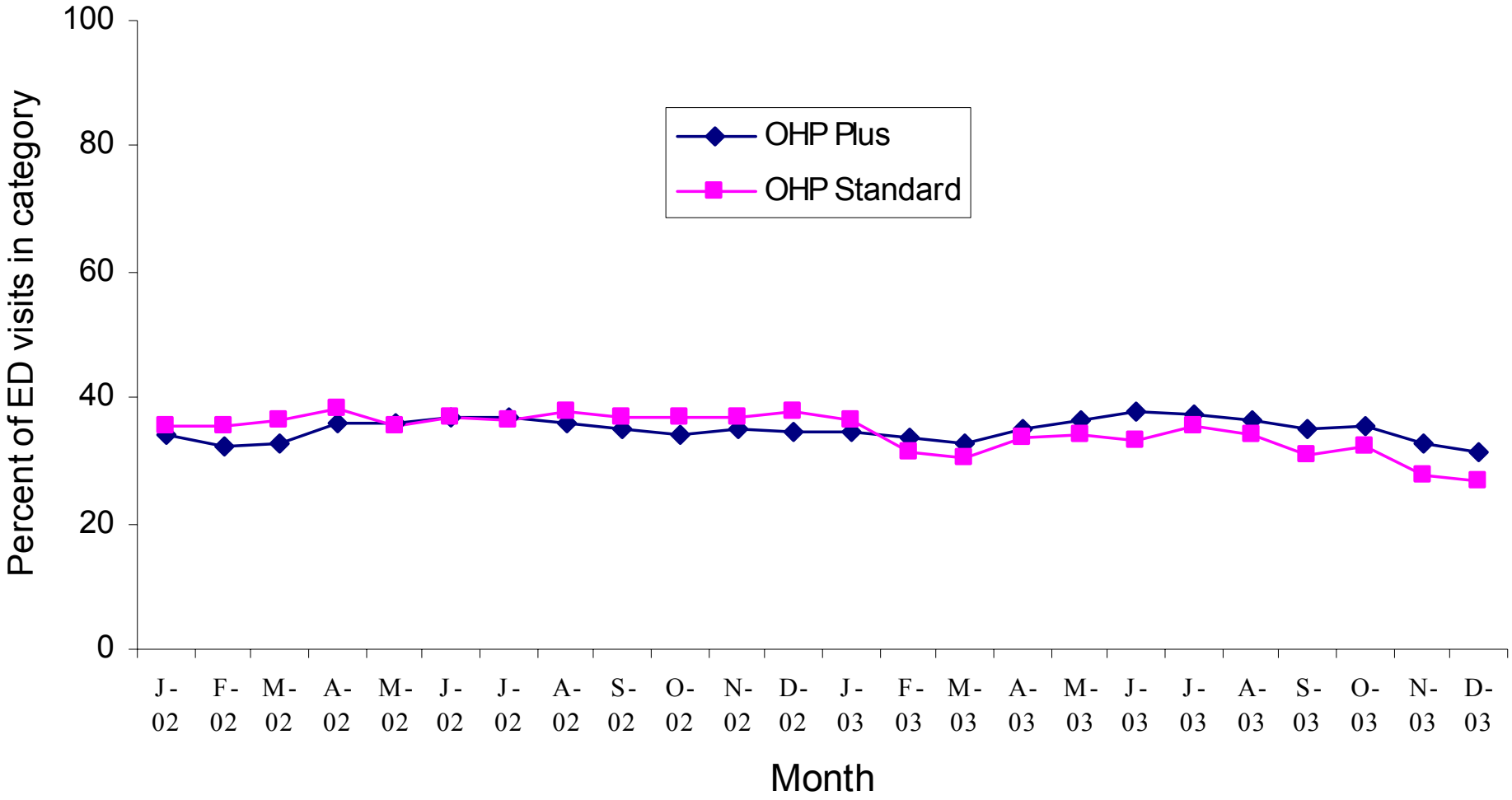


Billings, J, Parikh, N, Mijanovich, T. Emergency department use: a substitute for primary care? The Commonwealth Fund www.comwf.org November 2000.

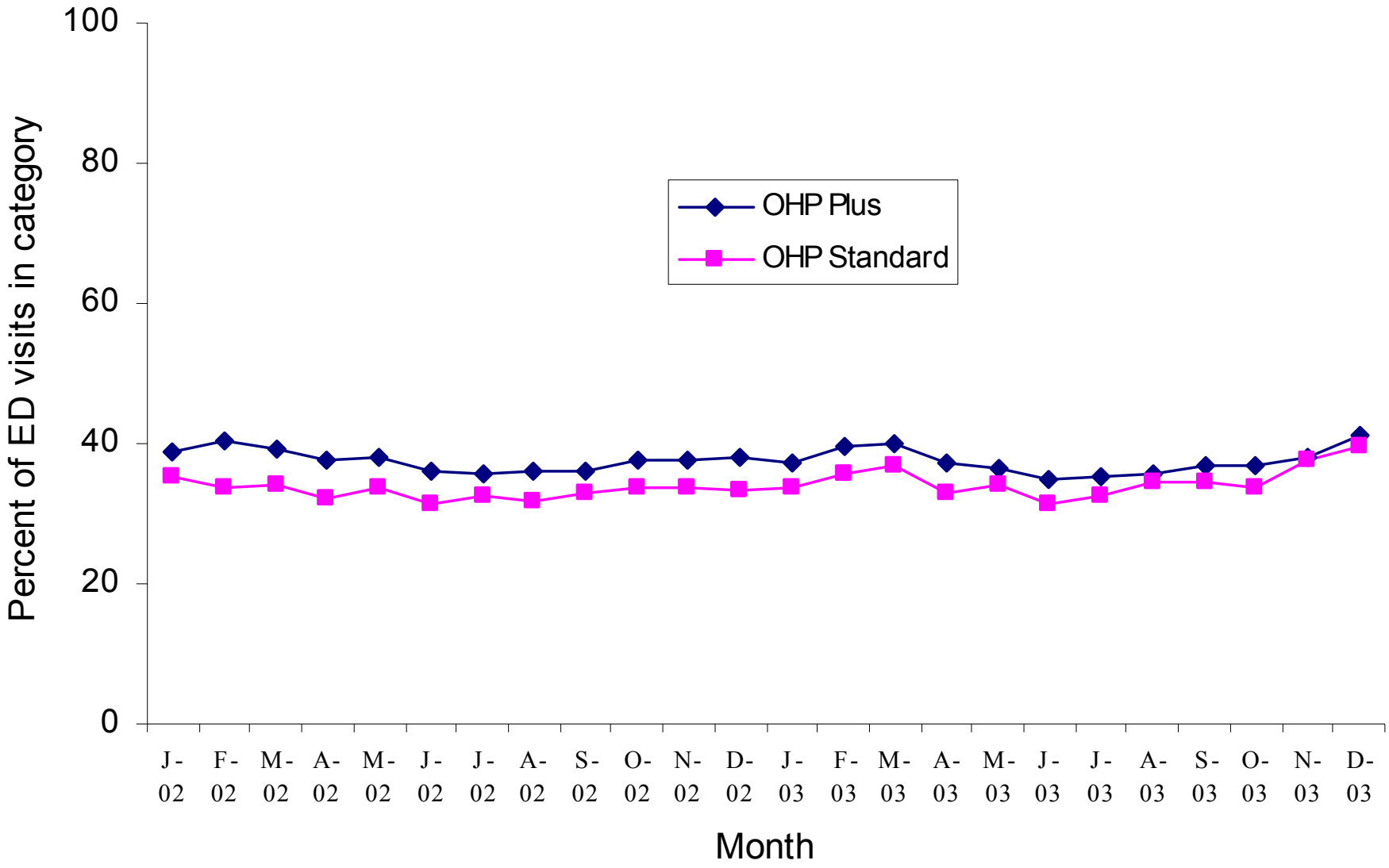
OMAP MC and OMAP FFS 2002 - 2003



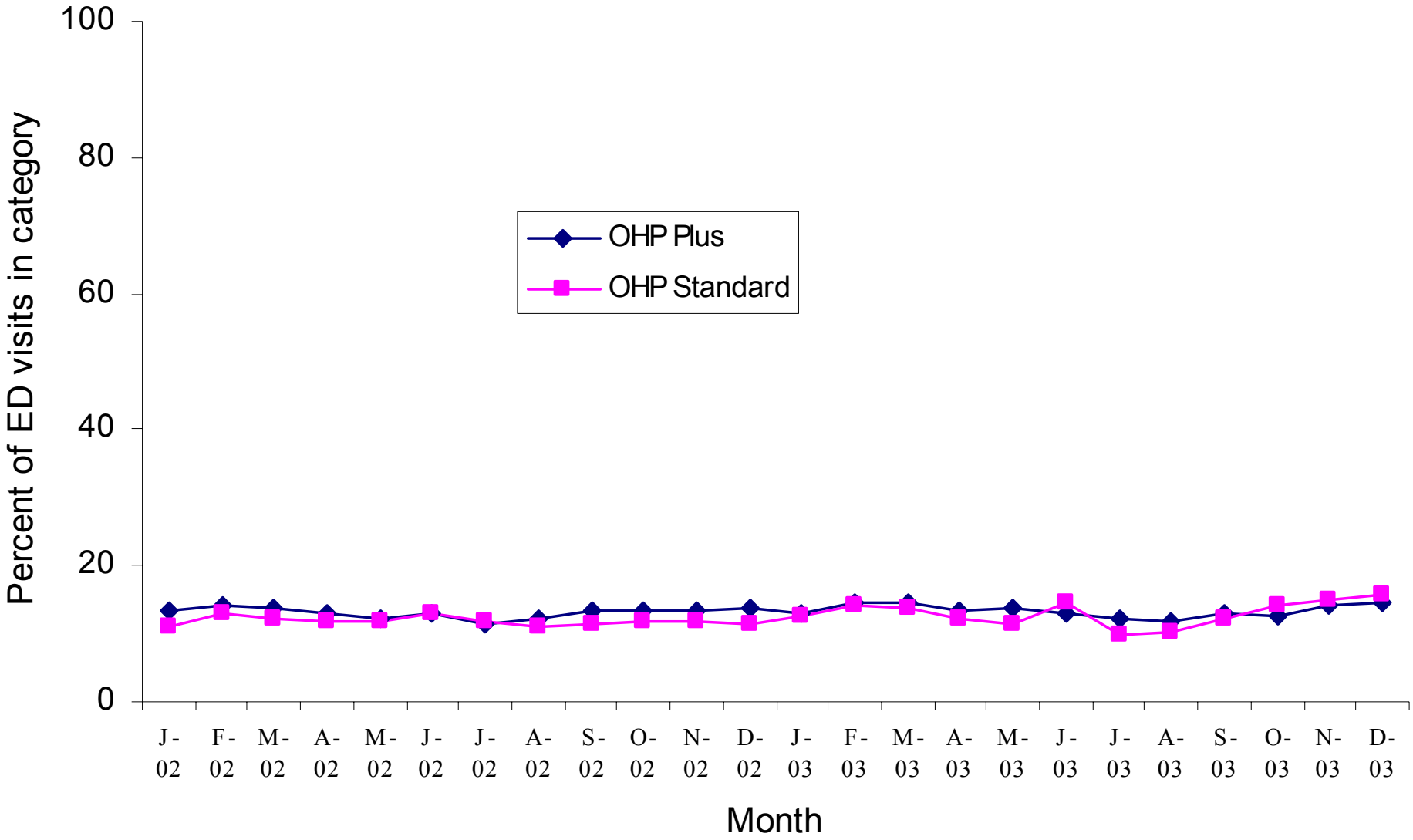
Nonemergent visits



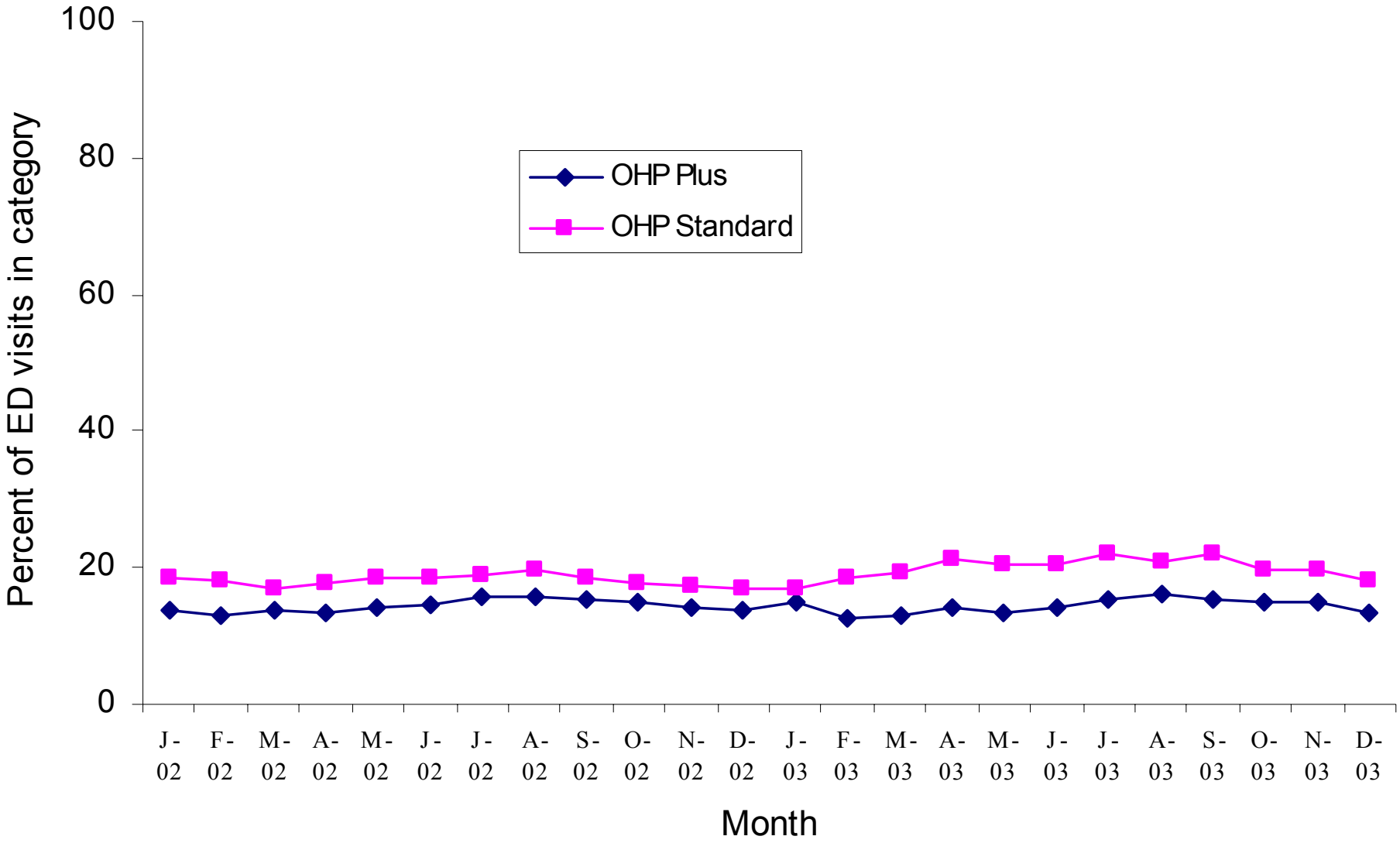
Emergent, primary care treatable visits



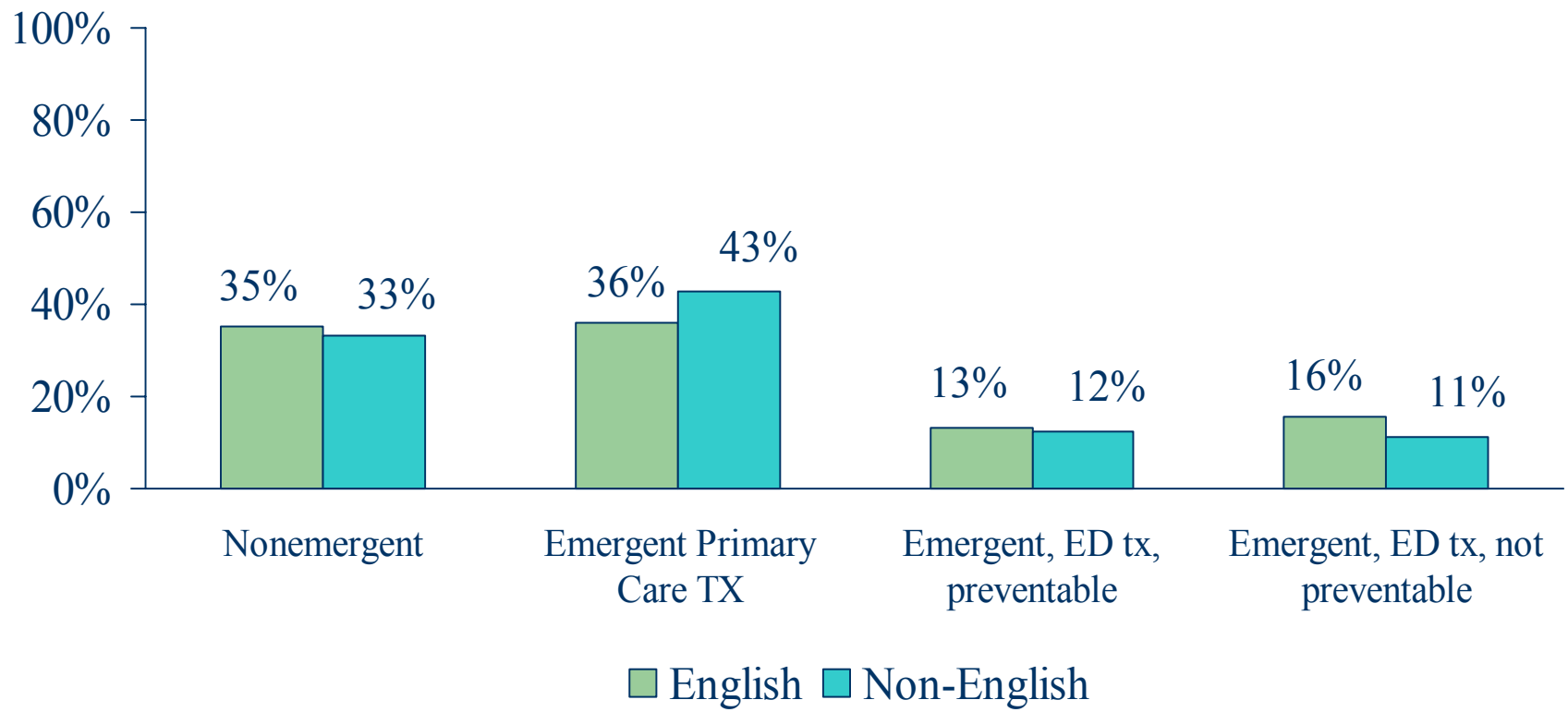
ED visit needed, preventable visits



ED visit needed, not preventable visits



Non-English Speaking Population
OMAP Managed Care 2002-2003



Data Limitations

- This analysis intends to identify the nature of ED visits, not the extent to which the ED is utilized.
- The data are proportions of visits not counts or rates.

Some Caveats

- Visits are sorted by diagnosis which is assigned after evaluation
- Patients don’t usually present with ICD-9 codes
- Most diagnoses spread across categories
- Prudent Layperson Rule

Prudent Layperson Standard

Emergency Medical Services are warranted when acute symptoms of sufficient severity are such that a prudent layperson, who possesses an average knowledge of health and medicine, would think that not seeking immediate medical attention would result in placing his/her health in serious jeopardy, or suffer serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Oregon Administrative Rules Department of Human Services, Departmental Administrative and Medical Assistance Programs 410-120-0000 (49)

Relationship Between Access and ED Visits

- Access to care in physician offices probably affects patterns of ED visits
- Many other variables also affect patterns of ED visits

2004 Oregon Health Policymaker Survey: Information Wants and Needs

Jessica Matchett
Intern, Oregon Health Policy & Research
MD/MPH student,
Oregon Health & Sciences University

From research to policy

- Policymakers receive large volumes of information on health policy research, but often don't get the answers they seek within these materials
- Health policy is only part of the job, but a complex and time consuming part; efficient communication around health policy research is essential
- **How can we make health policy research most useful to those making policy decisions?**

Basic Survey Statistics

- Legislators and staff identified with roles and responsibilities on health care committees
  - contacted by phone and/or email

  40 Elected: 10 surveyed

  15 Staff: 13 surveyed

  - 3 declined

- Telephone survey
  - 56 questions
  - Average length: 21 minutes

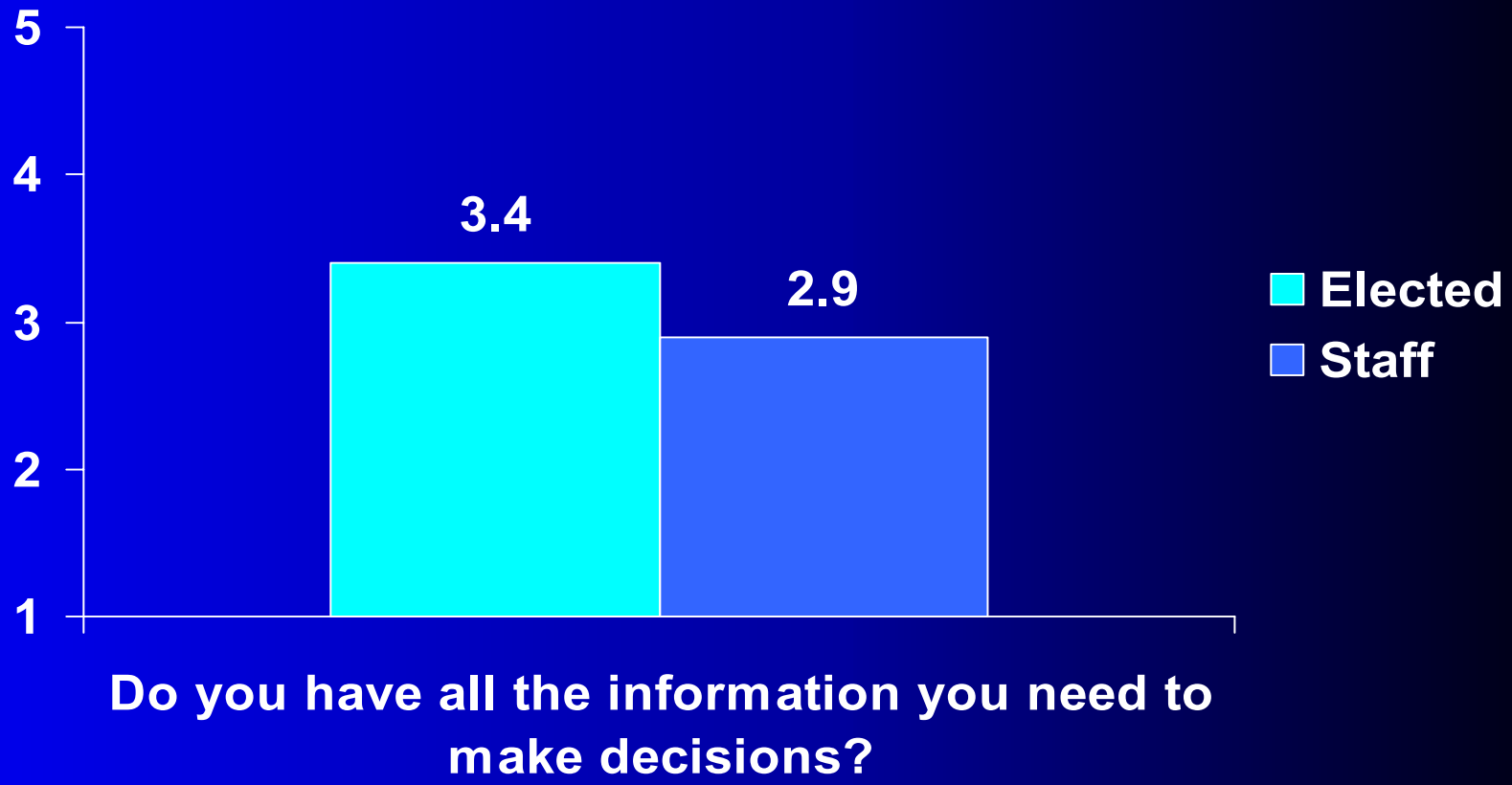
Who did we talk to?

- 5 Senators
- 5 Representatives
- 13 Staff

- Average number of years in position:
  - Elected: 5.0
  - Staff: 3.9

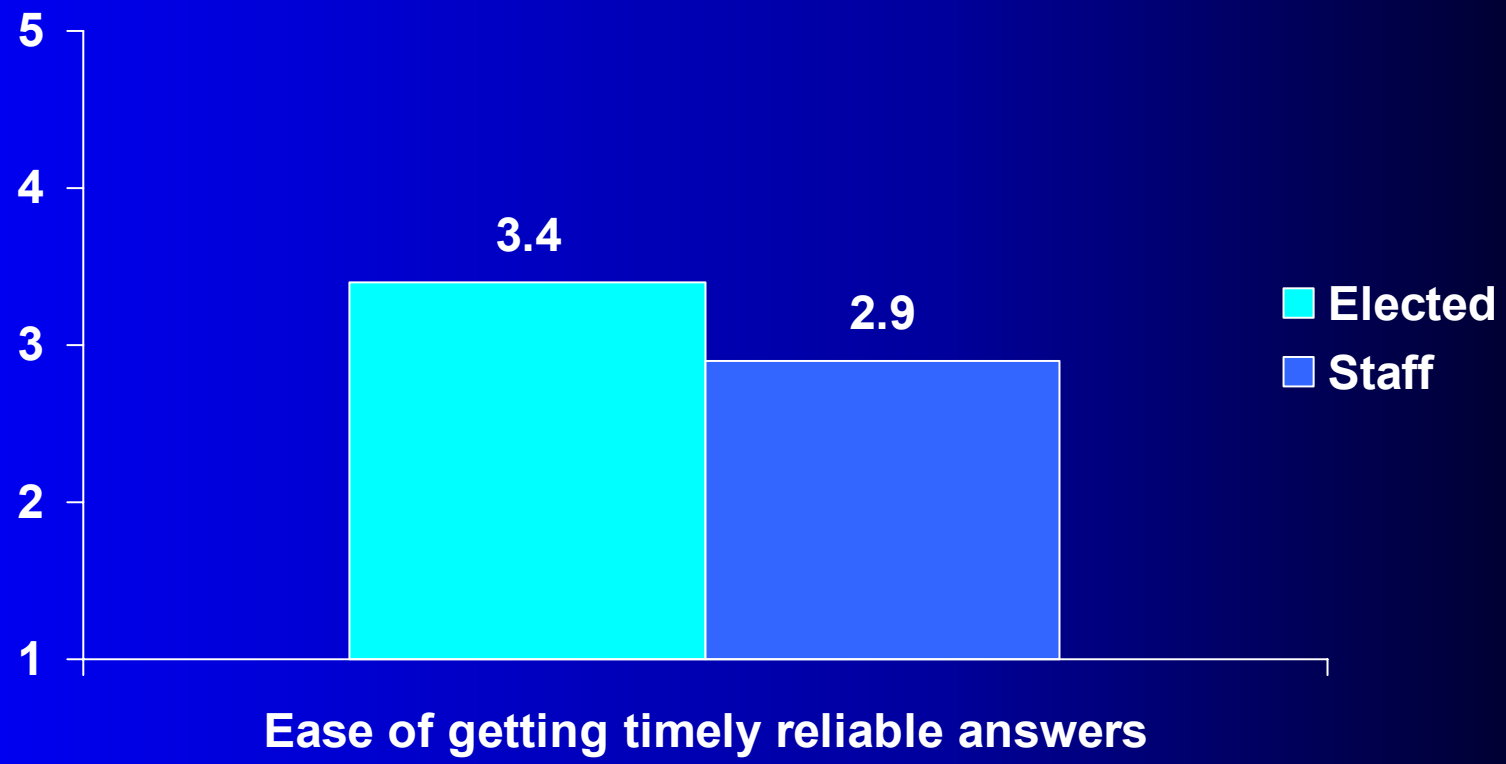
Staff were less likely to feel they had adequate information

(Mean score, 5-point scale: 1 = no reliable information, 5 = all the information I need)

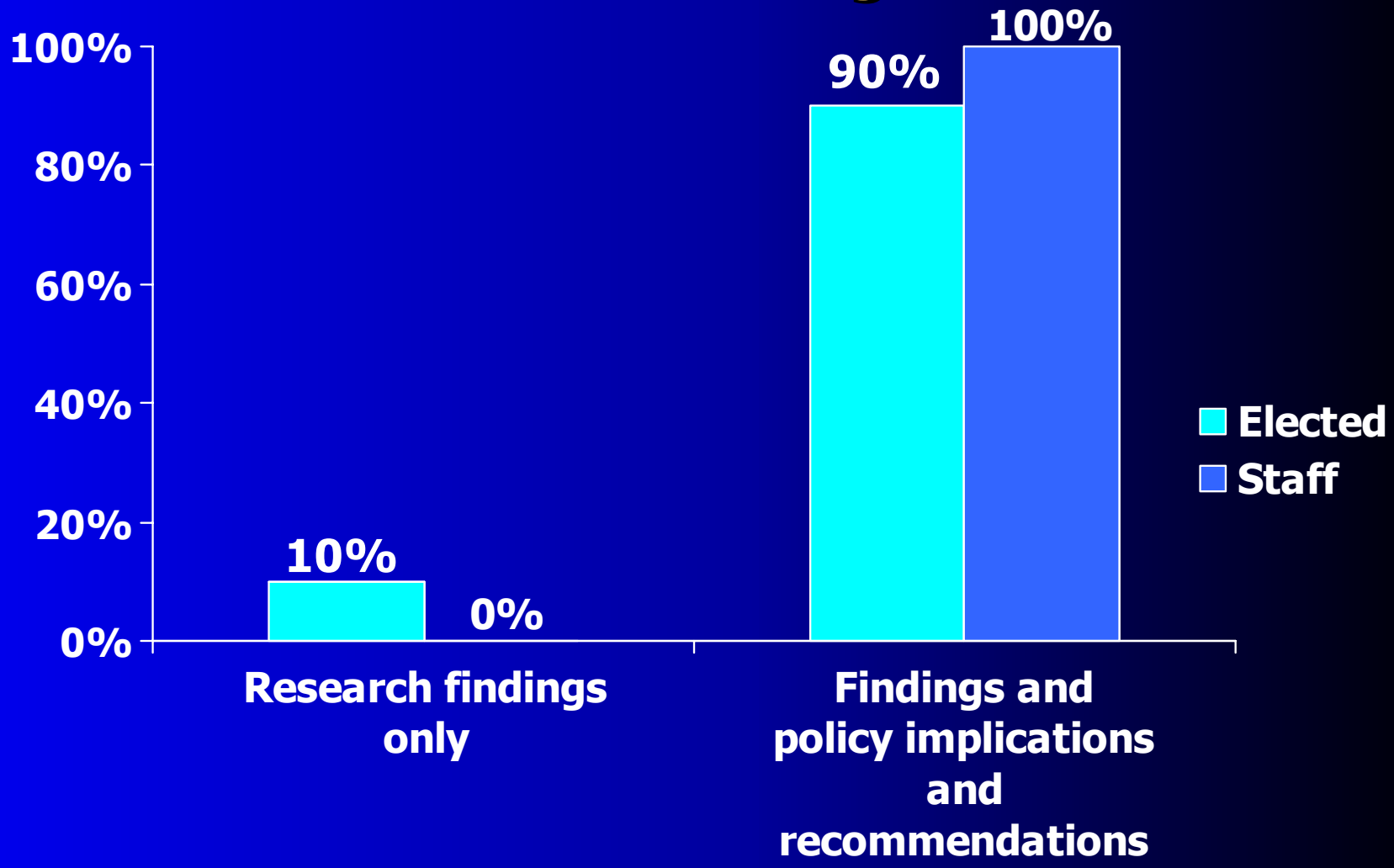


Staff felt it was more difficult to get timely, reliable answers

(Mean Score, 5-point scale: 1 = great difficulty, 5 = no problem)



Implications or recommendations for policy are helpful additions to research findings



Oregon-specific research data is preferred

- When given 3 ways research data can be gathered, 60% ranked them in this order:

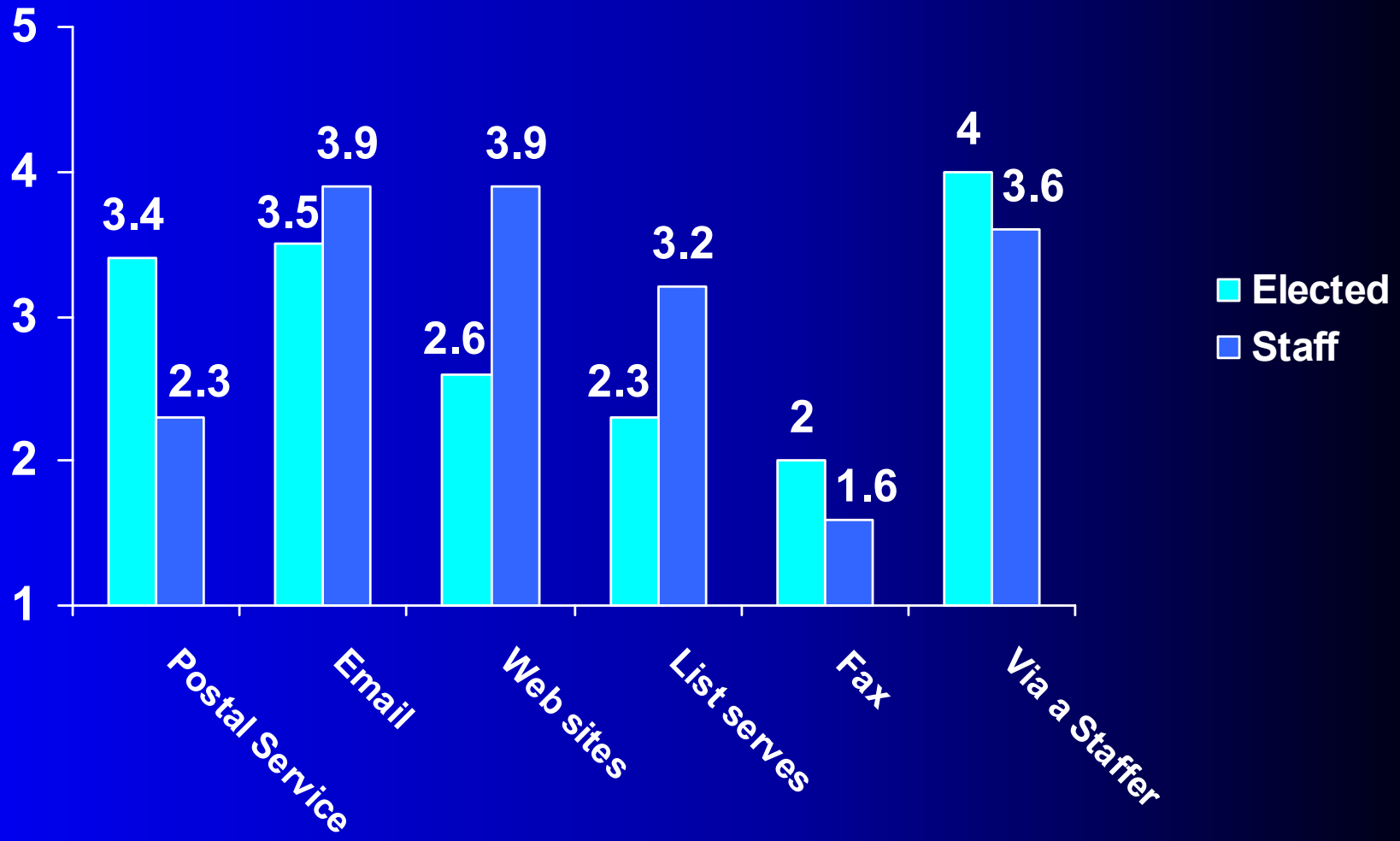
1. Gathered from populations in Oregon
   (78% ranked it 1st)

2. State to state comparative data

3. Gathered on a national basis

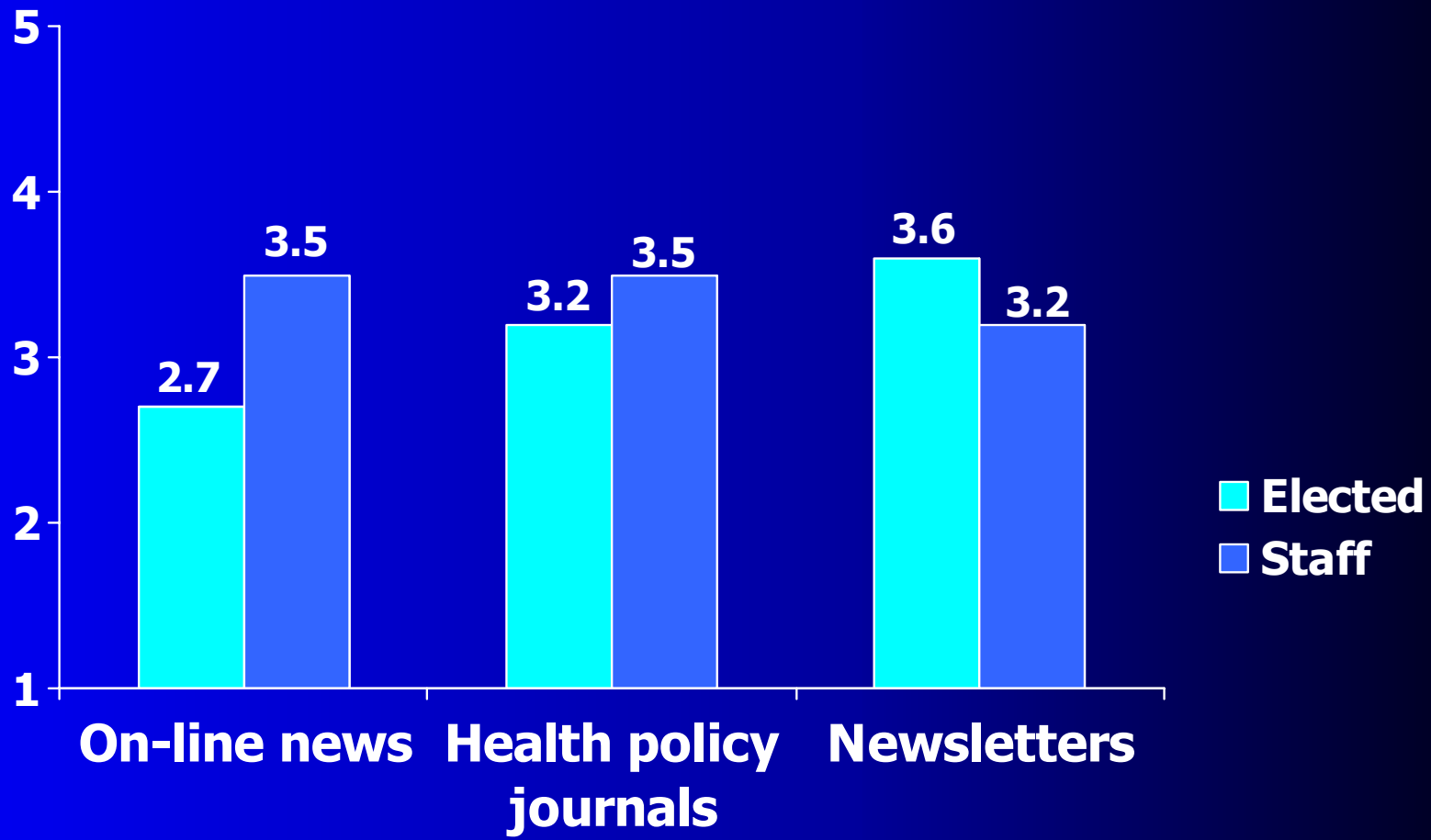
Legislators prefer to get information from staffers

(Mean Score, 5-point scale: 1 = least preferred, 5 = most preferred)



Useful sources of information

(Mean score, 5-point scale: 1 = useless, 5 = useful)



Useful sources of information

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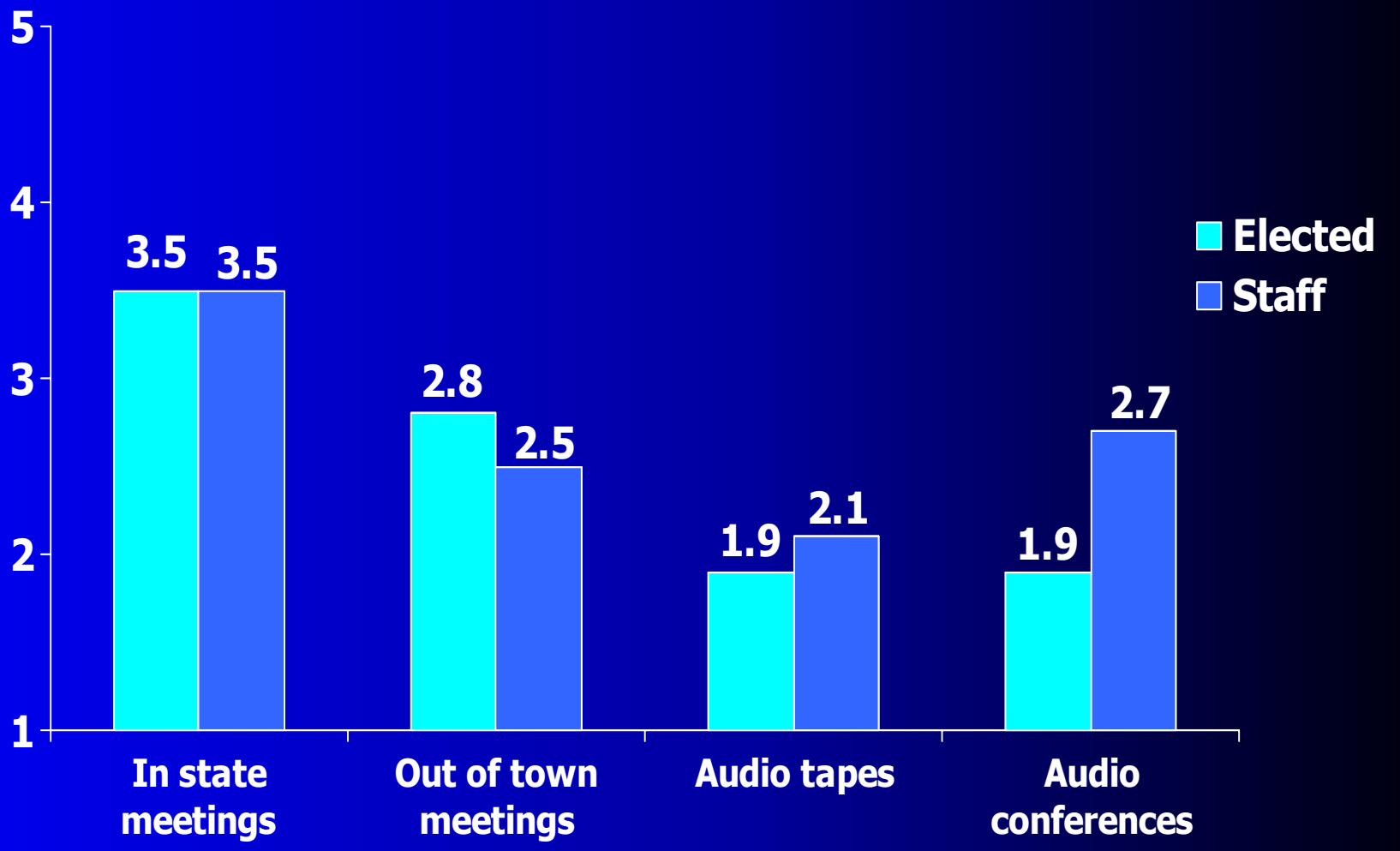
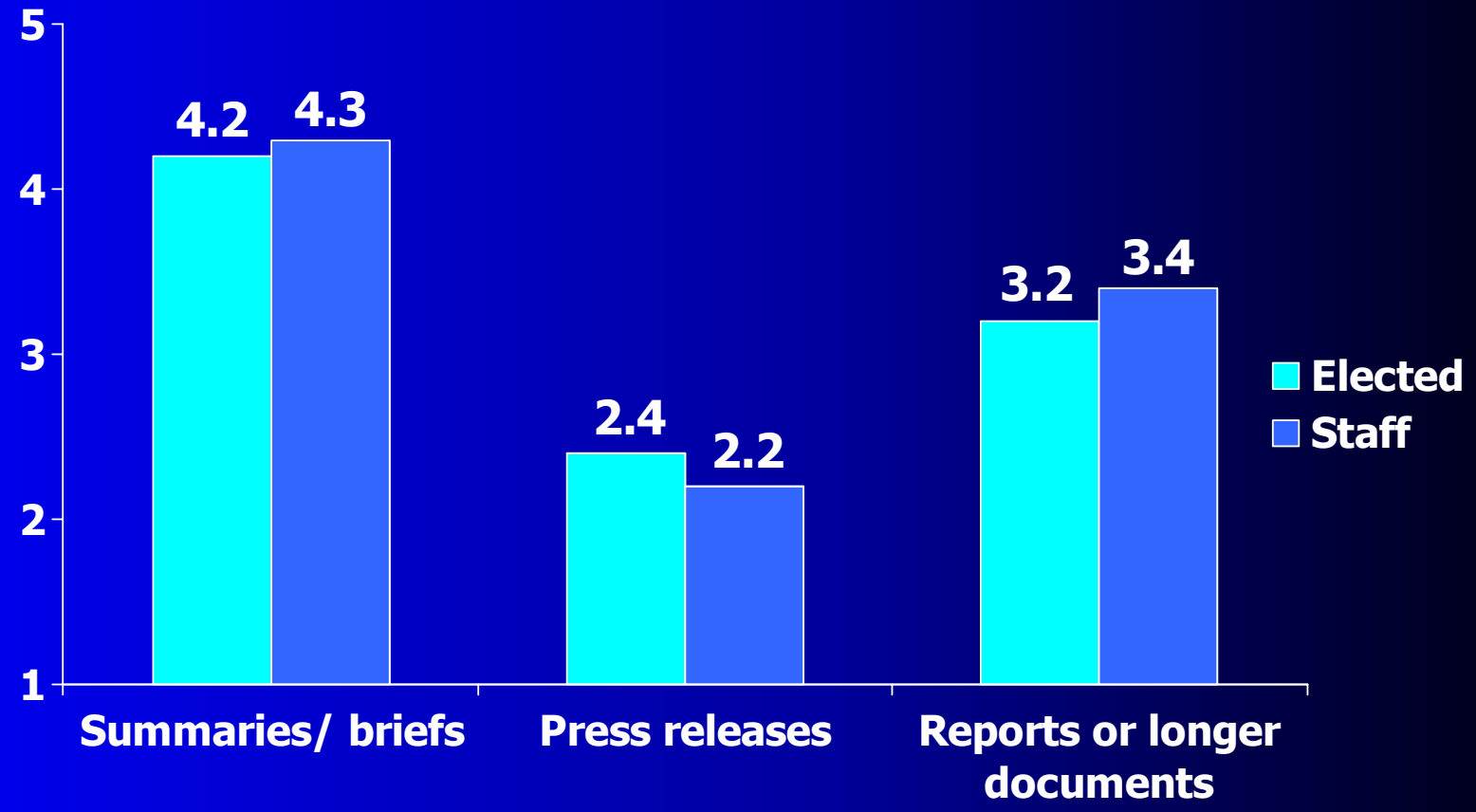


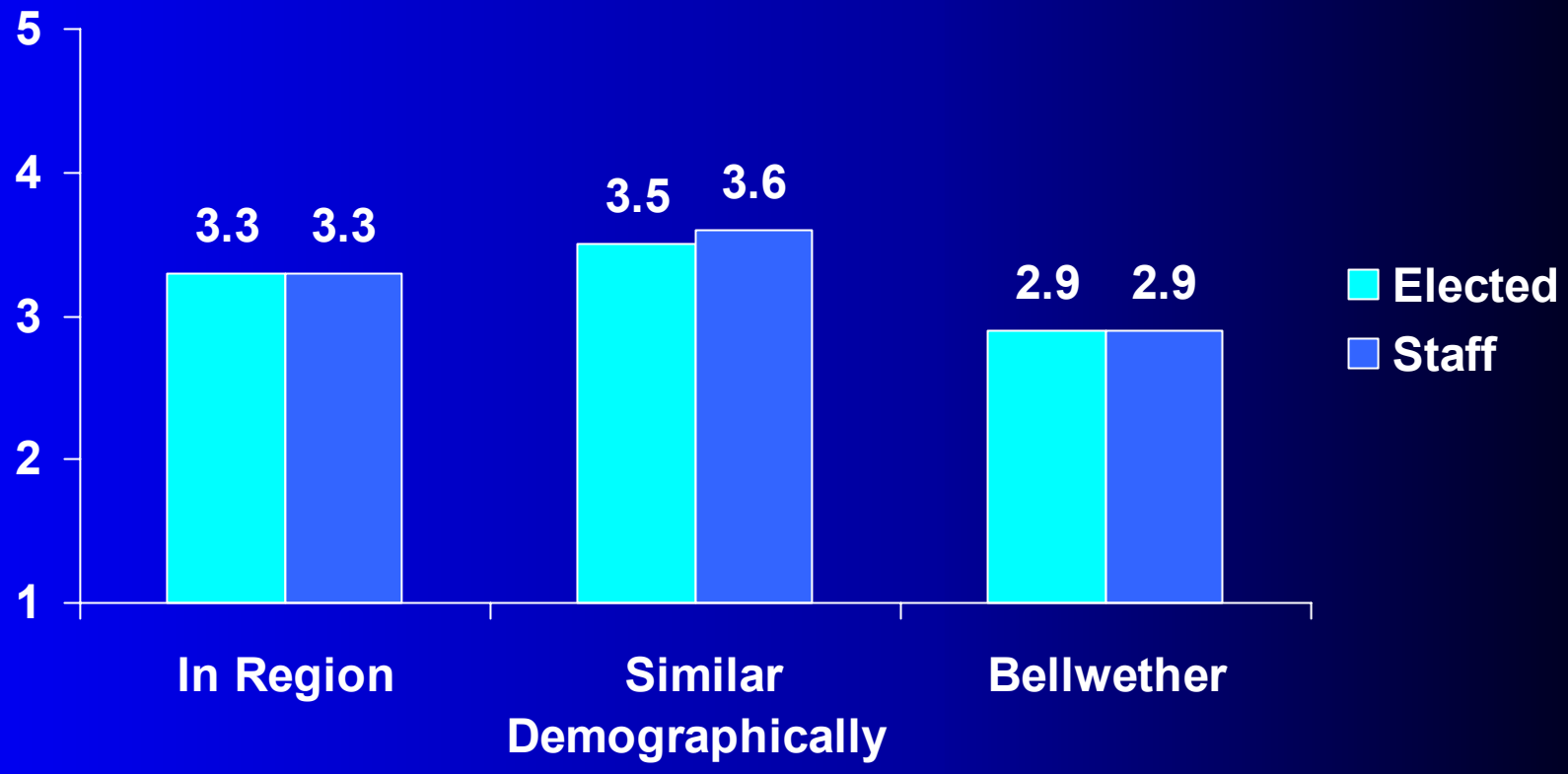
Legislators and staffers rated shorter summaries or briefs as the most useful source of health policy information

(Mean score, 5-point scale: 1 = useless, 5 = useful)



When looking at other states, both legislators and staffers are most interested in states similar to Oregon

(Mean score, 5-point scale: 1 = Useless, 5 = Useful)



What makes information about health policy useful to you?

- 65.2% - applicability
- 8.6% for each of:
  - Reliability/accuracy/objectivity
  - Broad issues/trends
  - Includes interpretations/perspectives
  - Clear graphs/tables
  - Brevity

What makes information about health policy less useful to you?

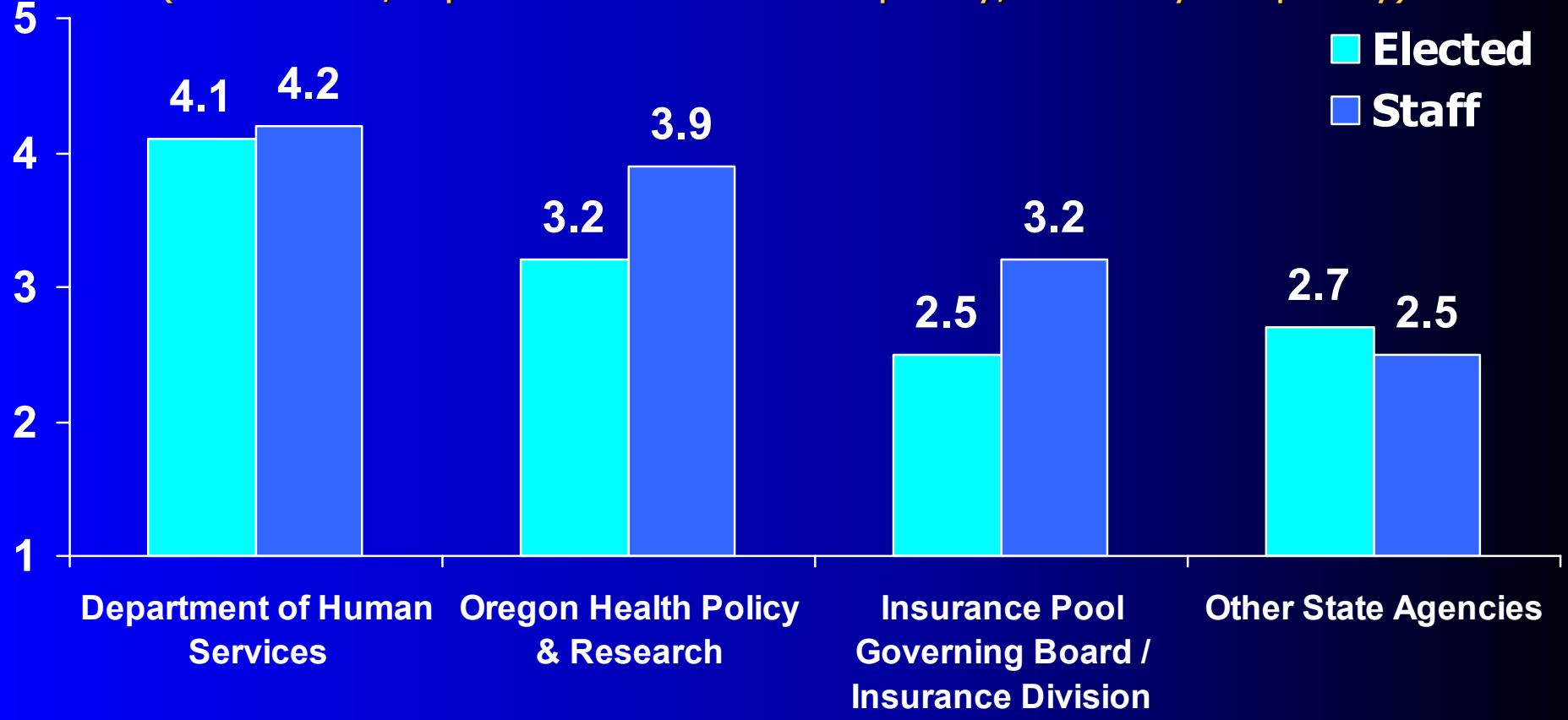
- 22% - Inapplicable/unrelated/irrelevant to current issues in Oregon
- 22% - Lots of numbers without any interpretation
- 17% - Excess bulk/volume
- 17% - Unreliable/biased/not backed by solid research
- 13% - Regurgitated/recycled/old data

Are there sources you tend to trust more than others?

- 96% responded YES…and specified:
  - 36% - Kaiser Family Foundation
  - 27% - National Council of State Legislatures
  - 23% - Robert Wood Johnson Foundation
  - 23% - Journals (JAMA, Health Affairs, other nationally published journals)
  - 18% - Academic and university sources
  - 9% - Oregon Health Policy & Research

DHS and staffers are the most frequently sought out sources of health policy information

(Mean Score, 5-point scale: 1 = Not frequently, 5 = Very Frequently)



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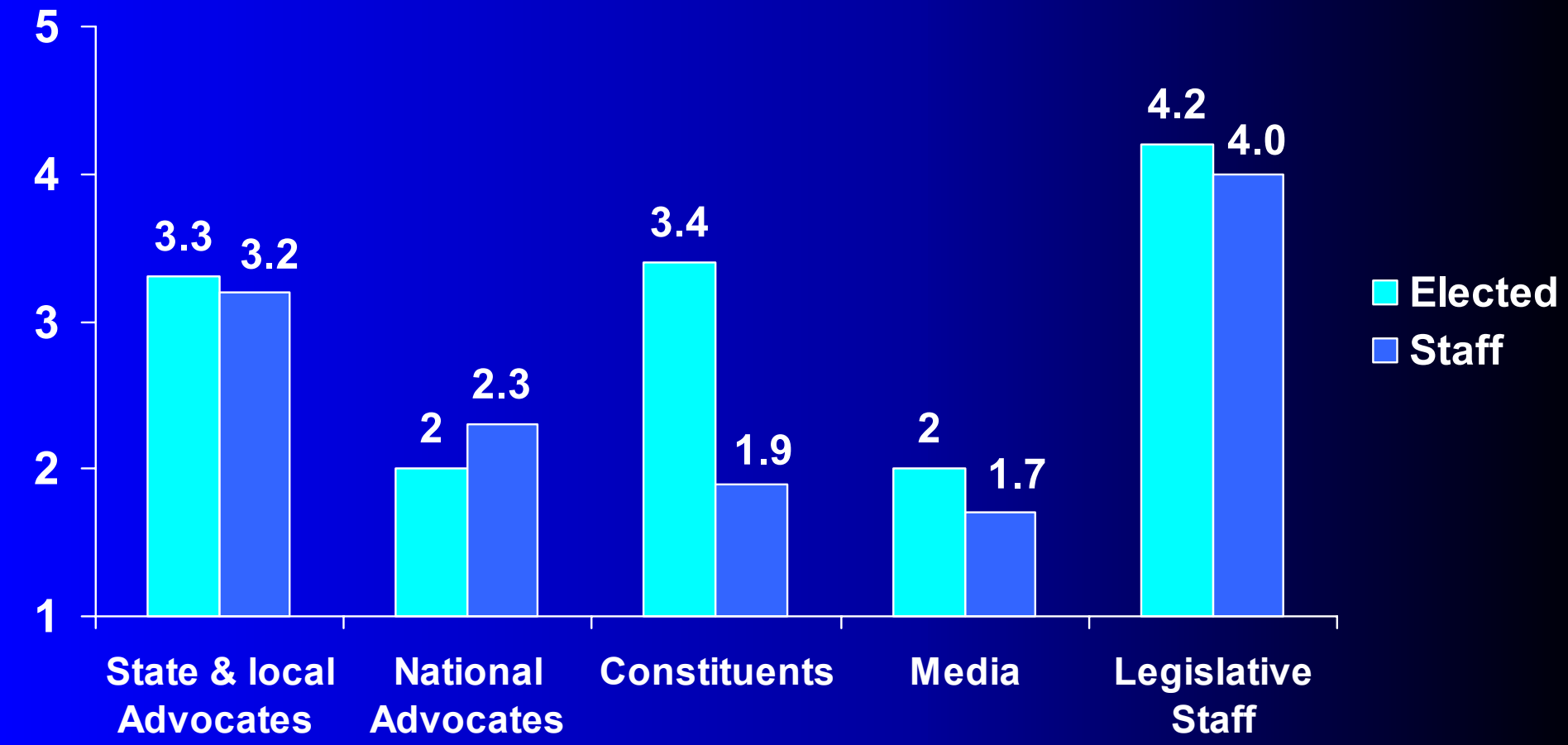

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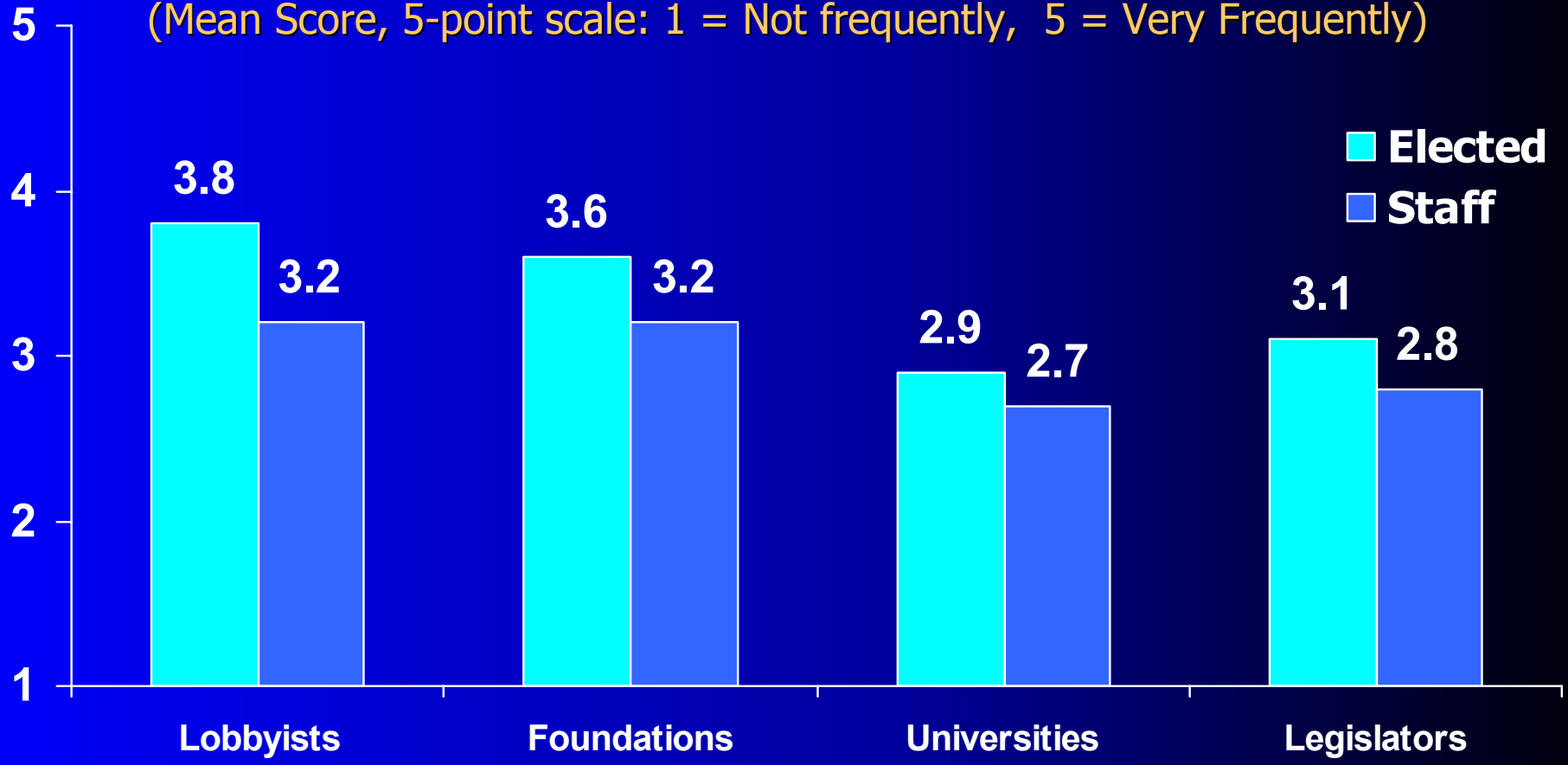


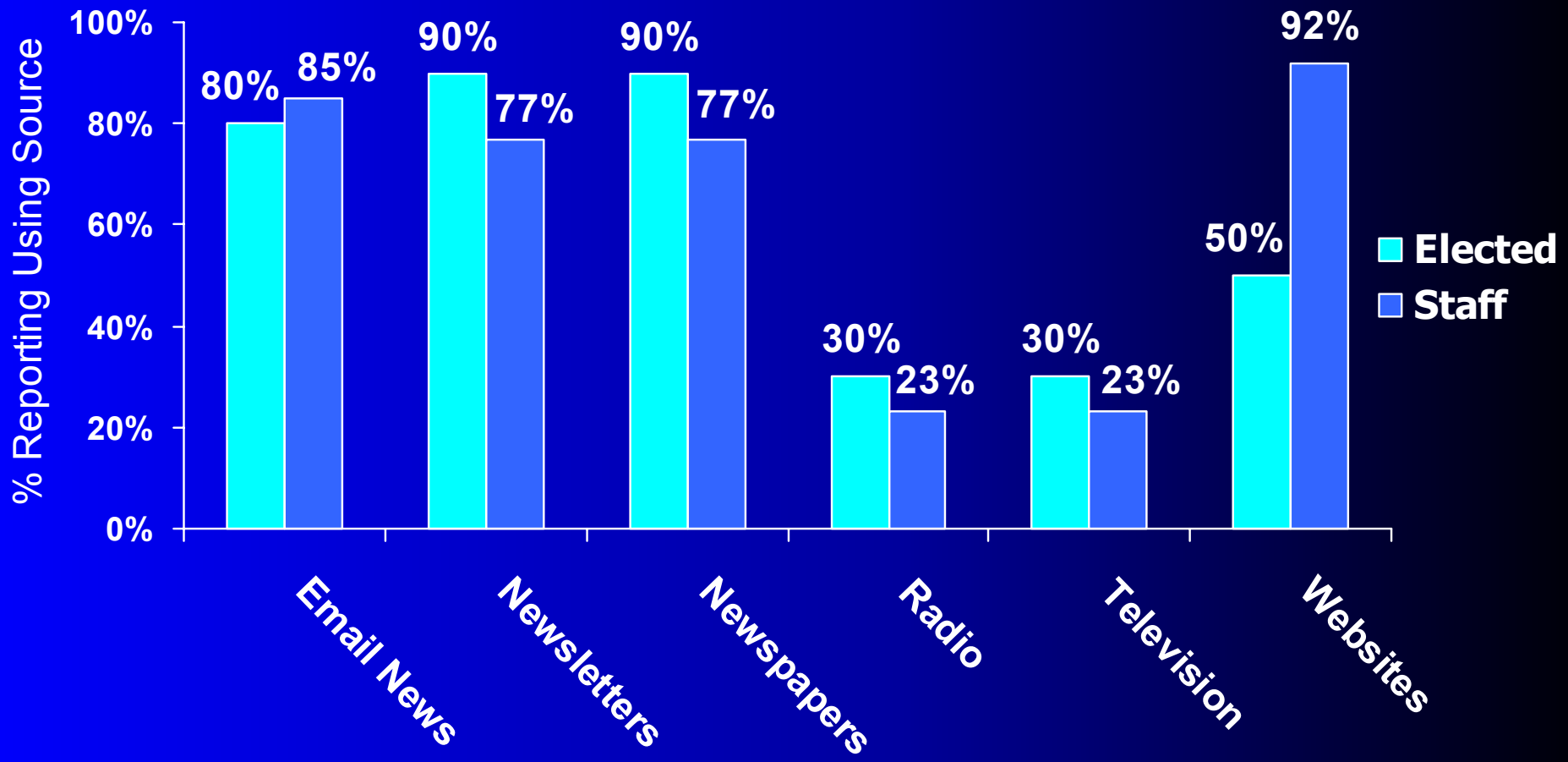
Most respondents don't have a regular set of steps they take when attempting to learn more about a given health policy issue

- 26% - Take regular steps to learn more
  - 10% of elected, 38% of staff
- 74% - Varies by issue
  - 90% of elected, 62% of staff

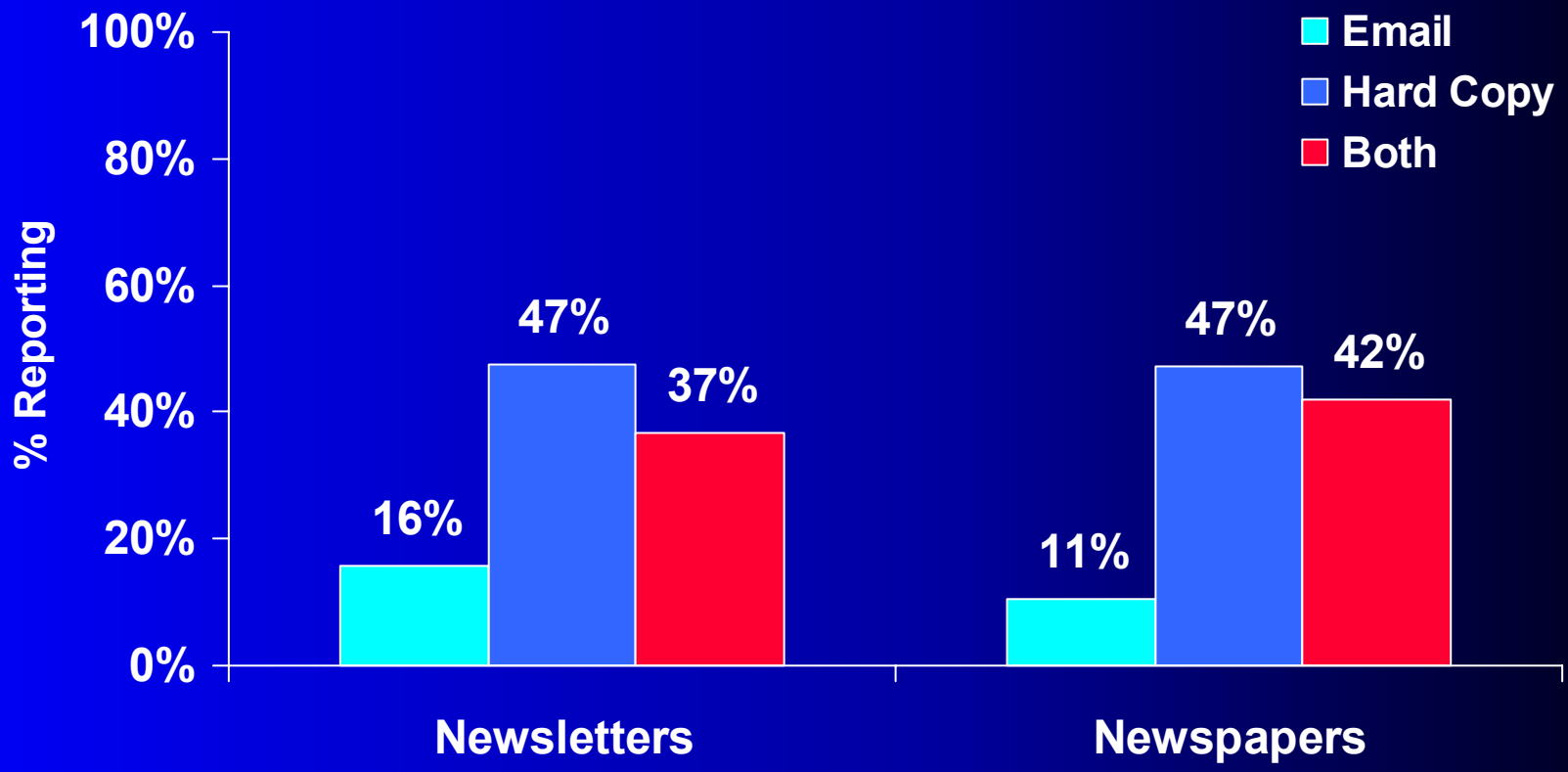
Sources most frequently cited as part of a "regular set of steps" used to learn more about a particular issue:

- 50% - Oregon Health Policy & Research
- 42% - Department of Human Services
- 25% - Lobbyists
- 25% - Staff

Staff more likely to go to websites for information; legislators more likely use newspapers/newsletters



Most legislators and staffers using newsletters or newspapers are reading hard copy versions



Some specific sources mentioned…

- Email news and health care updates
  - 21%: Kaiser Family Foundation
  - 16%: Department of Human Services
  - 11%: National Conference of State Legislatures
  - 11%: Oregon Health Forum
- Newsletters
  - 32%: National Conference of State Legislatures
  - 32%: Oregon Health Forum

Some specific sources mentioned…

- Newspapers:
  - 42% locals or local clipping service
  - 32% NY Times
  - 16% Wall St Journal
  - 11% Washington Post
- Radio
  - 83% National Public Radio/Oregon Public Broadcasting

Some specific sources mentioned…

- TV
  - 67%: KOPB (public television)
  - 33%: Local news
- Websites
  - 35%: Kaiser Family Foundation
  - 24%: National Conference of State Legislatures
  - 18% For each: Department of Human Services, Health Affairs, search engine/Google

Which health related conferences or meetings sponsored by local, state or national associations do you try to regularly attend?

- 30%: None
- 17%: National Conference of State Legislatures
- 13%: Council of State Governments

Other information, services, or help that would be useful

- 17% each:
  - Regular agency briefs/updates, and regular meetings with agencies/analysts
  - Improved ease of access to data, centralized location to locate information, such as a website
- 9% each: Webcasts, interim briefs, hard copy publications with references of research for more information

During the last legislative session, what health related information services would have been useful, that you were unable to obtain?

- 30%: Accurate/reliable/credible data
- 22%: Nothing
- 17%: Fast, easy access to data
- 13%: Details about the Oregon Health Plan

In the next two years, what are the 3 health care issues that you believe Oregon SHOULD address?

- 48%: Affordability/costs
- 35%: Prescription drug issues
- 30%: Service delivery
- 22% each: Access, uninsured, mental health
- 13% each: Long term care, tort reform, new insurance methods

In the next two years, what are the 3 health care issues that you believe Oregon WILL address?

- 43%: Oregon Health Plan
- 26%: Uninsured
- 22% each: Access, mental health, prescription drugs
- 17%: Tort reform

Top issues policymakers report needing more information about:

- Uninsured in general
- Uninsured: Impact/cost shifting to overall system
- Health care finance and delivery in general
- Health care finance and delivery: provider reimbursements
- Access: Safety Nets
- Prescription drug coverage
- Mental health and substance abuse
- Medical liability and tort reform

Oregon Health Policy & Research

- 91% reported having received materials or information from OHPR in the past
- 95% of those found the info helpful

- Reasons cited as to why it was helpful:
  - 30%: Trusted/reliable/credible
  - 25% each: Relevant, concise
  - 15% each: Timely, objective, key people
  - 10%: Included references to research

Suggestions for improvement in Oregon Health Policy & Research materials

- Anticipate questions before they are raised, and have the info available
- Redesign website
- Focus on broad market trends/big picture
- Provide concrete solutions

References

- Sorian R, Baugh T. Power of Information: Closing the Gap Between Research and Policy. *Health Affairs* 2002; 21:264-73.
- Reh D, Taymans C, Andrews E. 2002 Connecticut Health Policymaker Survey. *Conn Med.* 2002; 66(7):415-8.

- Special thanks to both groups for allowing us to view original survey instruments, and to borrow and/or adapt questions for use in this survey.

Moving from Welfare to Work:
Planning for and securing health insurance in the context of welfare reform

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Larger study

AHRQ-funded project entitled:

"The Impact of the Oregon Health Plan on TANF Leavers' Ability to Care for their Families' Health"

Karen Seccombe, PI;

Heather Hartley, Co-Investigator

Research Context

- One year not enough for most TANF leavers to find coverage
- Studies focus on economic struggles; less on health insurance
- Many former TANF recipients can’t rely on new employers for coverage

Purpose

- Identify gaps in respondent knowledge about OHP
- Outline respondent motivations for and approaches to planning for health insurance coverage after expiration of transitional OHP coverage

Methods

- Representative sample of all individuals leaving TANF in Oregon 6-7 months prior to first interview
- Two year panel study
  - quantitative
  - qualitative
- 83 of 551 respondents participated in-depth, semi-structured face-to-face interviews

Insurance Status

- At Wave 2, only 2/3 of respondents and their children are all insured
- Those with insurance tend to be covered by the OHP
- Thus, knowledge of OHP procedures is of paramount importance

Lack of knowledge and information

- Assumptions regarding continuation of OHP coverage
- "Just get a job" mentality as a barrier to planning
- Communication between workers and TANF leavers

Assumptions about OHP coverage

Many respondents did not have sufficient information

- about income cutoffs
- about future coverage options

“Just get a job”

- Pressure exerted on TANF recipients can deflect attention from gathering information for health insurance planning

"Their big push was just finding a job, any job. Don't care if it pays minimum wage, don't care what it does, just get a job. I tried to talk to her because I had been with the state before…saying I really would like to go where I can get the benefits and stuff I need for the family, and it was like, well, you can try, but in the meantime, you're going to have to take anything you can get."

(W1-153)

Communication

- Worker – TANF leaver communication impacts knowledge
- Conflicting information from different relevant offices
- Computer/paperwork glitches

Planning: motivations and actions

- "Day to day" mentality as barrier
- Dire health needs as (potentially) motivating force for planning
- Logistical problems/barriers to applying for OHP
- "Trade offs": Limiting work to keep insurance

“Day to day” mentality

- Lack of active planning was often used as a coping strategy
  - Avoid stressful or depressing processes
  - Push aside worries due to more immediate concerns

"I just take it one day at a time. So if that's my obstacle that I have to overcome tomorrow, then I'll have to overcome [it] tomorrow. Today my obstacle is I got to take a shower, I've got to get to work, and I have to make sure my son practices his cursive..." (W1-286)

Health needs as motivational force

- Seeking out information
- Acquiring a job with adequate health insurance
- Limiting income to stay qualified for assistance

"It sounds terrible to say it this way, but this is reality...I will work a job that makes less for his security."

W1-123

"I know when I was pushing myself to get off of the state, it was my worst fear, not being able to cover my medical costs, and it still is."

W2-380

Problems applying for OHP

- Work schedules and OHP office hours
- Lack of public transportation
- Problems with mailings

Limiting work to keep insurance

- Sacrificing hours to secure or maintain OHP coverage
- Child support
- Discouraging raises from employers

"I barely made it last time. I barely made it and I'm supposed to be getting another raise, and these raises are killing me...You almost want to say 'Don't give me no raise!' you know, because it doesn't even itself out if your job is going to give you fifty cents more an hour and that fifty cents just put you over"

(W2-019)

Policy Implications

- TANF workers should assist recipients in planning
- "OHP specialists"
- Expansion of FHIAP

Fluctuations in Short-term Demand: Implications for Hospital Admission and Discharge Behavior

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Presentation for:

Oregon Health Research & Evaluation Collaborative

Joint work with:

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Outline

I. Background and motivation.

II. What is new in this research?

III. Empirical issues and summary of results.

IV. Elements of theoretical model.

V. Results: Hypotheses from theory and empirical evidence.

VI. Conclusion.

Presentation will focus on intuition and flavor of results.

Background:

- Stochastic demand is a key feature of hospital operations.
- Implications for costs, capacity requirements
- Examples: Cost of empty beds, impact of variance in demand/occupancy on hospital costs.
- Anti-trust Framework: Implications for hospital competition, mergers, acquisitions, closures, expansions.
- Forecasting hospital demand.

Motivation: Fluctuations in demand may have direct implications for hospital behavior.

- Capacity constraints may affect hospital admission and discharge behavior.
- Hospital may have to be selective in which patients it will admit.
- Hospital may have to be selective in which inpatients may remain.
- Existing literature does not deal with these issues and their implications.

What is new in our research?

- First paper to examine impact of short-term fluctuations in demand on hospitals' admission and discharge behavior. Focus on capacity issues.
- Develops theoretical framework that provides testable hypotheses.
- Tests hypotheses using Oregon discharge data from December 1, 1997 to November 30, 1998 (Office of Health Policy and Research).

Key technical innovations:

- Develop a test that permits us to detect discriminatory admissions practices towards patients with different types of insurance.

  -no need to control for underlying differences in health and treatment seeking behavior of patients from different plans.
- Develop a simple proxy measure for the additional hospital resources that would ordinarily be used in the treatment of current inpatients.

Empirical issues:

- How do we detect times when hospitals have insufficient capacity?
- Occupancy rarely exceeds bed capacity (18 times out of more than 20,000 hosp days in our data).
- Capacity constraints apply whenever the quantity of any input necessary in treatment is insufficient for the patients the hospital would like to treat.
- Is capacity a hospital-wide, chain-wide, or market-wide phenomenon?

Solution: Different approaches to identifying days when hospitals may have inadequate capacity.

We use several approaches.

- We report results that arise when:

  -Assume that each hospital serves a market comprising all hospitals within a 15 mile radius.

  -Identify the 20% highest and lowest occupancy days in a hospital's market as, respectively, high and low demand days for that hospital.

  -Postulate that hospital has sufficient capacity on low demand days, but may face capacity constraints on high demand days.

Summary of empirical results:

- Patients admitted on high demand days tend to have greater resource requirements in treatment than those admitted on days when demand is low.
- Patients discharged on high demand days leave earlier than expected when compared to those discharged on days when demand is low.
- Evidence of discrimination in admissions against OHP/Medicaid patients.
- Important differences in discharge patterns of patients with different types of insurance.

Main elements of theoretical model.

- Hospital patients differ in resource requirements in treatment. (LOS and intensity of treatment)

  ->e.g., Medicare's DRG relative weights

- We do not examine issues of appropriateness or efficiency in treatment.

Model– Payment for treatment.

- Hospital treats patients from different insurance plans (plans X and Y).
- Plan X pays more than plan Y.
- Payment hospital receives for treating a patient is proportionate to the patient's resource requirements in treatment.

Model—Hospital preferences.

- Between two patients with same insurance but different resource requirements in treatment, the hospital prefers to treat the one whose requirements are greater.
- Between two patients with same resource requirements but different insurance, the hospital prefers to treat the one with the better paying insurance.

Reality check:

- Hospital behavior arises from a combination of hospital policies and physician decisions.
- Hospital behavior may not be uniform across departments.

Crux of theoretical results regarding the effects capacity constraints have on hospital behavior:

- When the hospital does not have enough capacity to treat all patients, it is forced to restrict admissions of some patients.
- It may also be forced to discharge some patients early.
- When the hospital does not have enough capacity, treatment of patients from low paying plans is affected more than the treatment of patients from high paying plans.

Main hypotheses resulting from theoretical analysis and corresponding empirical evidence.

- For all patients, regardless of insurance type, mean resource requirements will be higher when admissions are affected by insufficient capacity.

  Mean DRG relative-weight of those admitted on:

  High-Demand Days-> 1.143

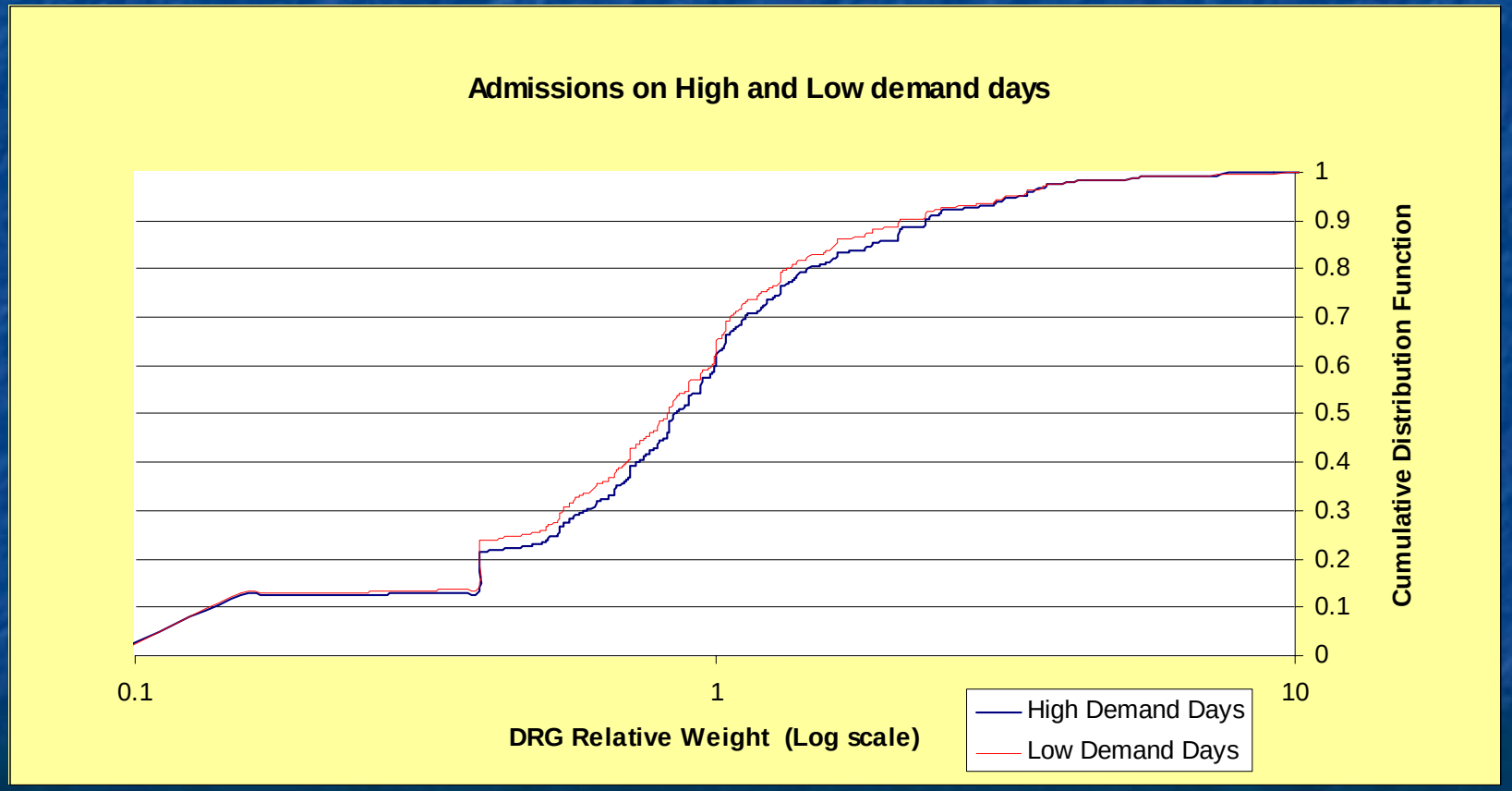
  Low-Demand Days-> 1.087

- For patients with all types of insurance, proportion of patients with low resource requirements will be higher on low demand days.

  -See this by looking at the distribution of hosp admissions over resource requirements (CDF).

  All CDFs have begin value 0 and end value 1.

CDF of admissions on high and low demand days– all patients.



Behavior towards patients with different types of insurance:

Assumption: The hospital values profit. If patients from different plans have identical treatment requirements and care seeking behavior, then

-the hospital will discriminate against patients from plans that do not cover marginal cost of treatment even when hospital has spare capacity.

-the hospital will discriminate against patients from the lower paying plans when capacity is insufficient.

How can we detect such discrimination?

- If patients from different plans have identical treatment requirements and care seeking behavior, then

  -average resource requirement in treatment is higher for admitted patients from lower paying plans.

  Mean DRG relative-weight of those admitted:

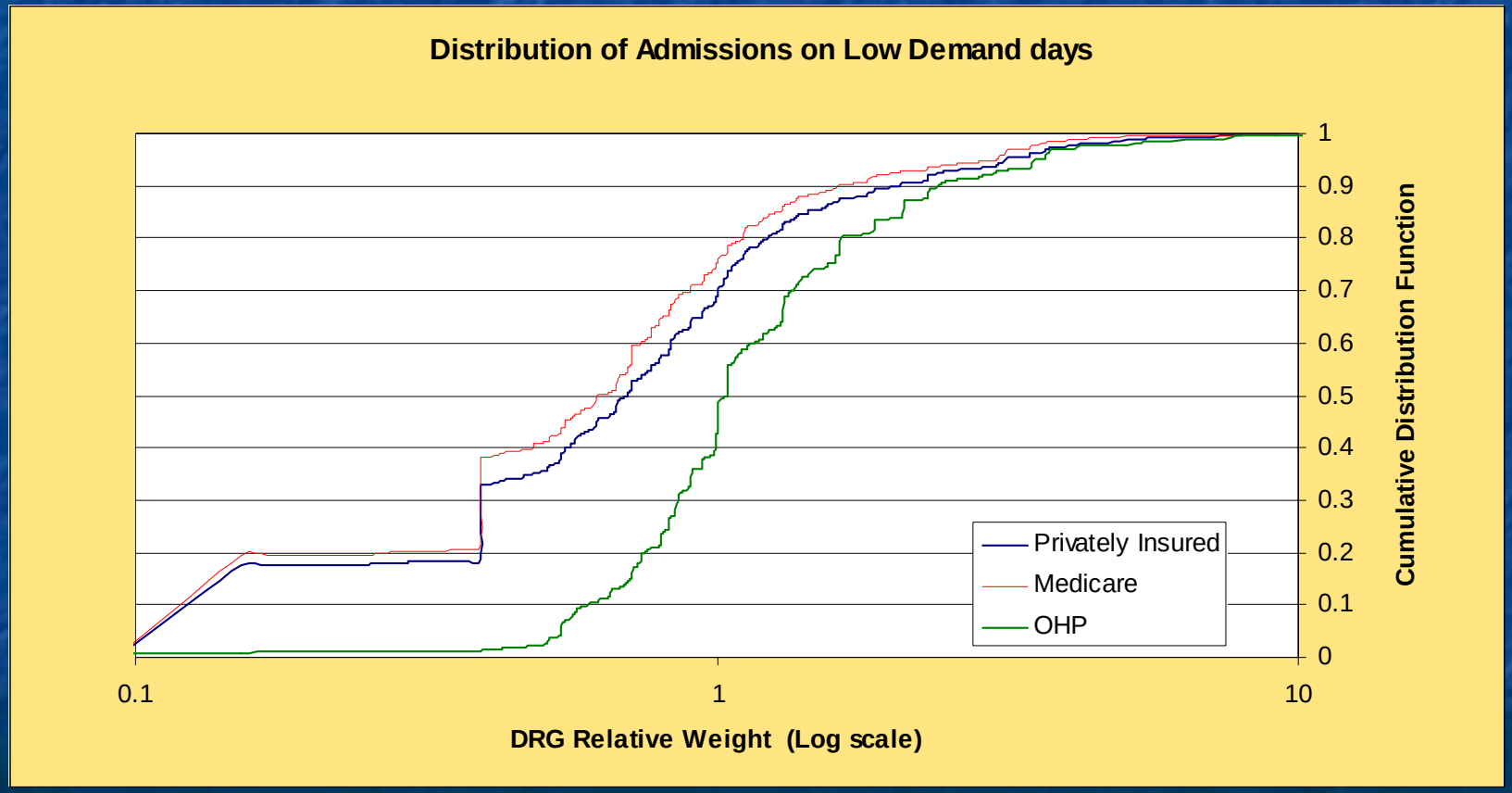
	Private	Medicare	OHP
High-Demand Days->	1.037	0.902	1.464
Low-Demand Days->	0.997	0.866	1.397

Detect discrimination from distribution of admitted patients:

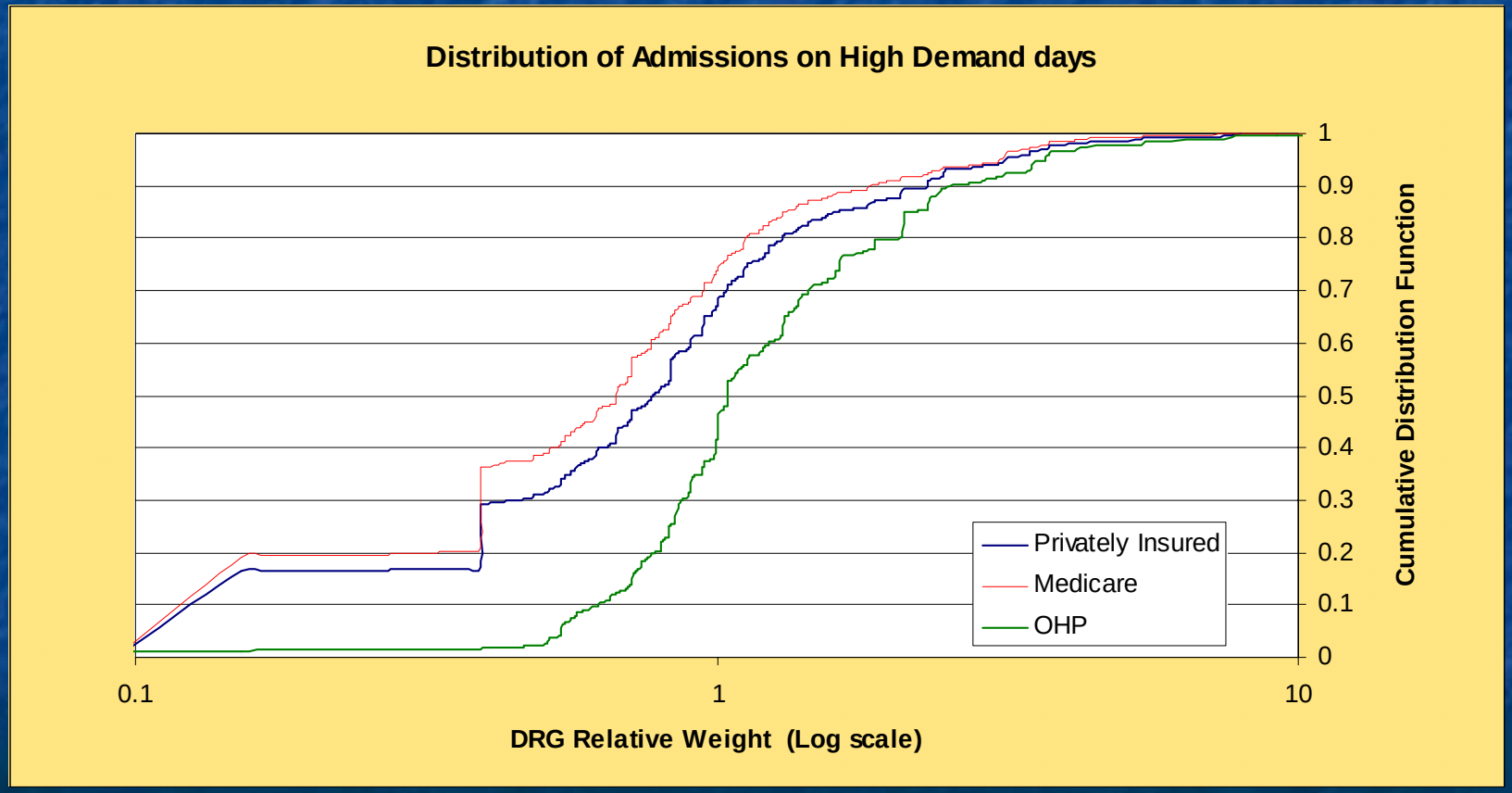
- If patients from different plans have identical treatment requirements and care seeking behavior, then

  -the proportion of admitted patients with low resource requirements in treatment is greater for patients from higher paying plans on both high and low demand days. That is, examine distributions of patients admitted on high and low demand days (CDFs).

CDF of admissions on Low demand days.



CDF of admissions on High demand days.



Do the results so far constitute evidence of discrimination?

- We can’t be sure.
- Patients from different plans may have different treatment requirements and care seeking behavior.

How can we detect discrimination when different plans enroll different types of patients?

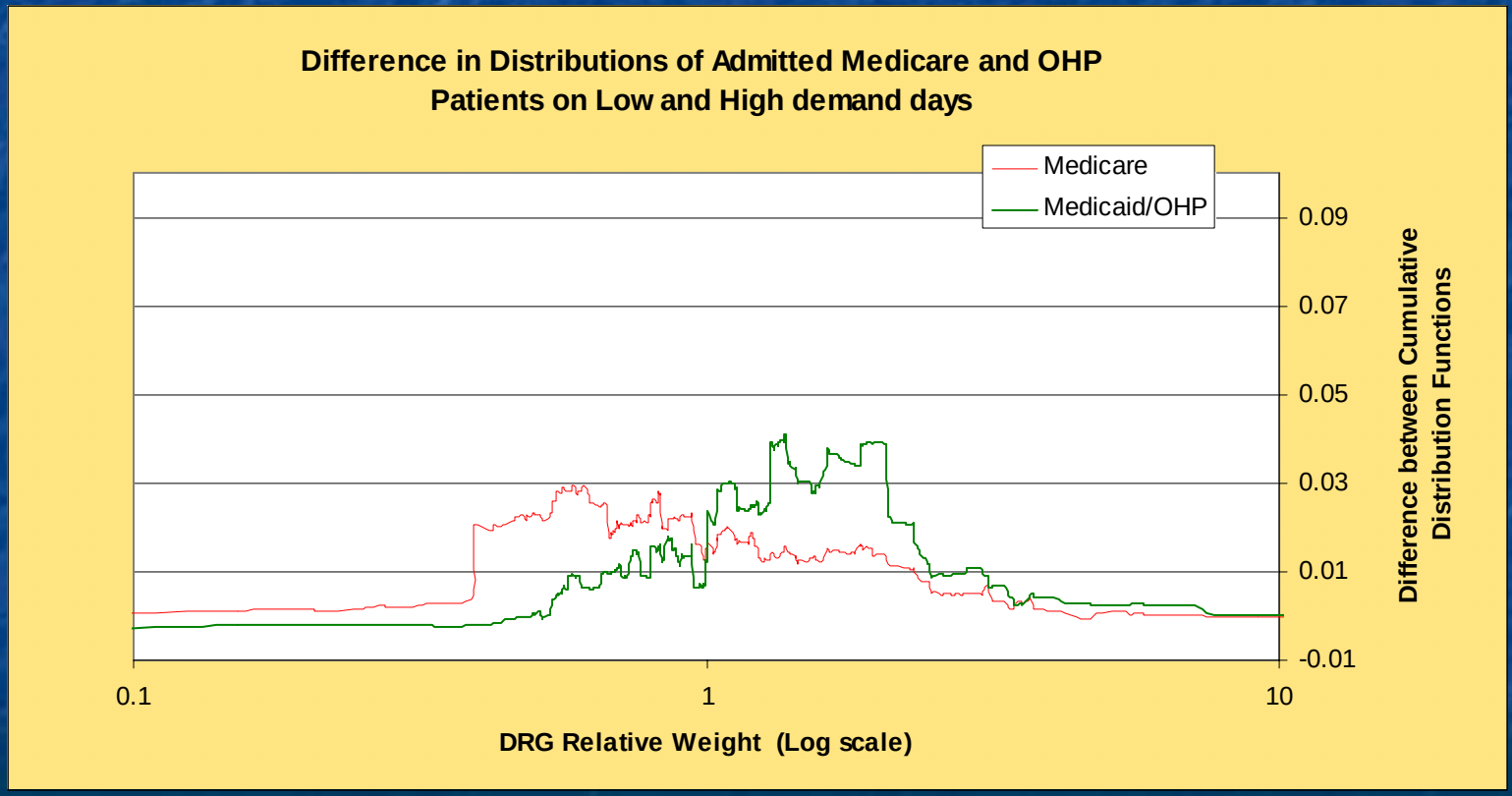
- If the hospital does not discriminate, patients affected by capacity constraints have similar treatment requirements regardless of their health plan.

=>Specifically, maximum impact of capacity constraints is felt at higher level of treatment requirements by patients from lower paying plans.

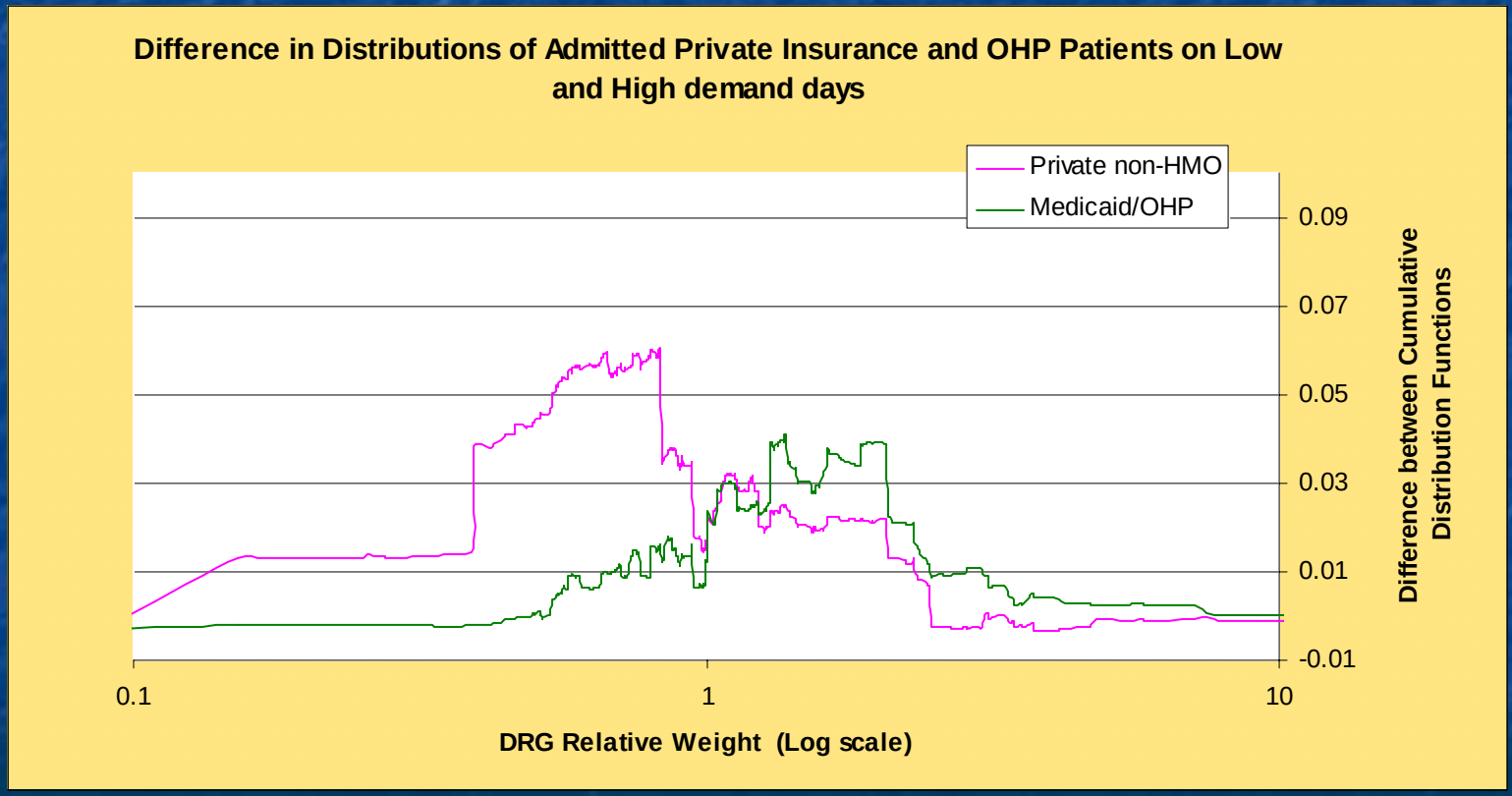
DRG relative-weight where difference between CDFs on high and low demand day is maximized:

	Private	Medicare	OHP
DRG RW where diff max->	0.828	0.584	1.377

Medicare and OHP: Difference in distribution of admissions between high and low demand days.



Private Ins. and OHP: Difference in distribution of admissions between high and low demand days.



Analyzing discharge behavior:

- Expected remaining length of stay (*ERLOS*) based on DRG and elapsed length of stay.
- Large *ERLOS* at discharge implies earlier than expected discharge.

Mean *ERLOS* of those discharged:

	Private	Medicare	OHP
High-Demand Days->	3.022	3.415	4.052
Low-Demand Days->	2.822.	3.044	3.791

Conclusion:

- Examine impact of fluctuations in demand on hospital admission and discharge behavior.
- Patients admitted on high demand days have higher resource requirements than those admitted on low demand days.
- Patients discharged on high demand days are discharged earlier relative to expectations than those discharged on low demand days.
- Differences in treatment of OHP patients.

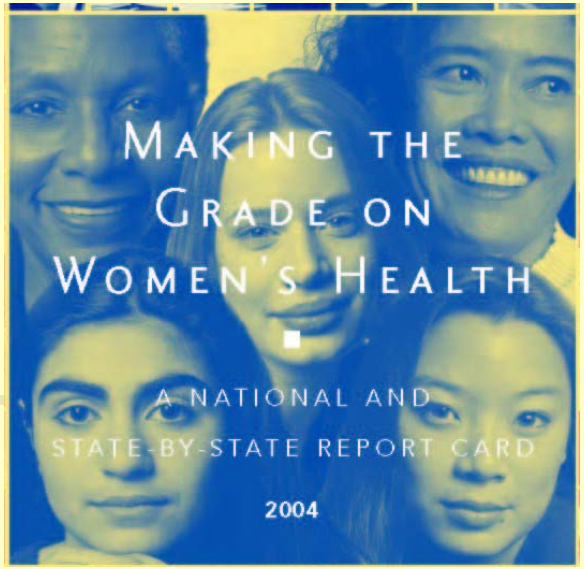
Areas for further research:

- Impact on health/resource use.
- Our technical innovations can be useful in detecting inequity in treatment elsewhere.

  -Women, minorities, lower income.
- Better identification of capacity constraints using more detailed data and observation.
- Our technical advances can have applications in demand forecasting.

Making the Grade on Women's Health:

A National and State-by-State Report Card 2004



This draft is intended for review and comments only. It is not intended for citation, quotation or other use in any form.

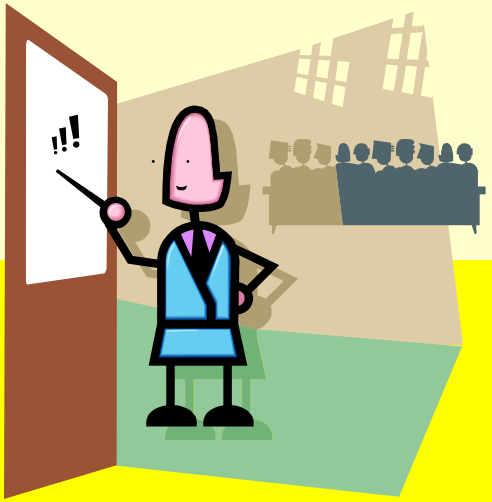
Oregon Health & Science University
National Women's Law Center

Michelle Berlin, MD, MPH
OHREC
September 21, 2004

- **Available electronically**
  - **OHSU Center for Women's Health: www.ohsuwomenshealth.com**
  - **National Women's Law Center: www.nwlc.org**
- **Available in print**

  National Women's Law Center
  (202) 588-5180

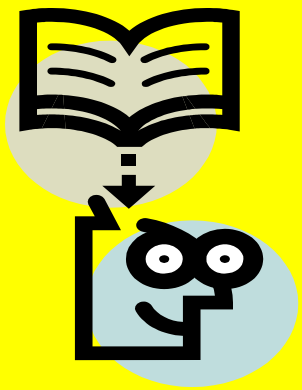
- Overview of *Report Card*
- Grading and Ranking
- Status Indicators
  - Overall
  - Oregon
- Policy Indicators
  - Overall
  - Oregon
- Conclusions/Next Steps



Overview of *Report Card*

Purpose

- Defines women's health broadly
- Provides a state-by-state and national overview of women's health status (status indicators)
- Highlights key policies to adopt to improve women's health status (policy indicators)
- Advocacy tool



Key Findings

- The nation and the states received poor grades for the status of women's health and are far from meeting the *Healthy People 2010* goals.

- No state came close to meeting all the policy indicator goals.

- On the policy indicators, since the previous *Report Card* issued in 2001, states have taken two steps forward and one step back.

Grading and Ranking

Grading and Ranking of Status Indicators

- Benchmarks drawn primarily from HP 2010
- *Grades* indicate how close state is to meeting relevant benchmarks, while *ranks* illustrate how state compares to other states
- Grades take into account that states and nation still have several years to achieve 2010 benchmarks

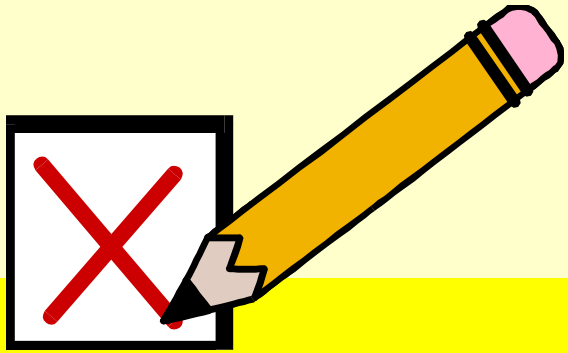
Grading of Status Indicators

- **S**atisfactory – met the benchmark (most based on Healthy People 2010)
- **S**atisfactory **M**inus
- **U**nsatisfactory
- **F**ail

Evaluation of Policy Indicators

States are compared, but not graded, on the policy indicators.

- Meets Policy
- Limited Policy
- Weak Policy
- Minimal/Harmful Policy

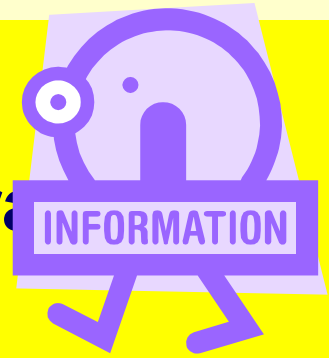


Status Indicators

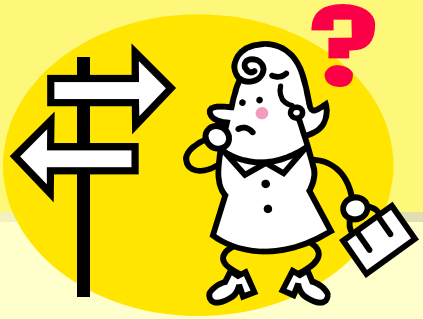
Purpose

To evaluate the state of women's overall health, status indicators measure:

- **women's access to health care services**
- **degree to which women report**
  - **receiving preventive health care**
  - **engaging in health-promoting activities**
- **occurrence of key women's health conditions**
- **extent to which communities encoura women's well-being**



How Status Indicators Selected



- Significant impact on quality of life, well-being
- Affect large numbers of women generally or in a specific population and/or age group
- Amenable to prevention, improvement
- Measurable through consistent reliable data
- Commonly used or broad consensus on use

Status Indicator Findings

- No state received a grade of S
- Six states received an F

- The nation met only 2 indicators and received an overall grade of U
- All states met one benchmark and missed eight

Oregon

- **Access to Health Care Services**
  - **Women without health insurance** **F**
  - **First trimester prenatal care** **U**

- **Screening & Prevention**
  - **Pap smears** **U**
  - **Mammograms** **S**
  - **Cholesterol screening** **F**

Oregon

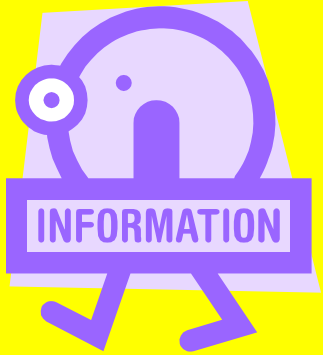
- **Key Conditions**
  - Stroke death rate — F
  - Lung cancer death rate — F
  - High blood pressure — F
  - Diabetes — U

- **Living in Healthy Community**
  - Poverty — F
  - Wage gap — F

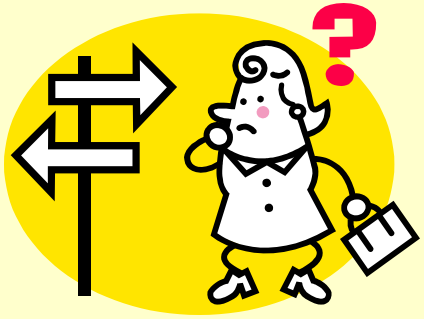
Policy Indicators

Purpose

- To evaluate states' performance in promoting women's health
- Based on state statutes, regulations, and programs addressing problems identified by health status indicators



How Policy Indicators Selected



- Address status indicators
- Measurable through consistent reliable data available for each state
- Comparable across states
- Adopted by one or more states

Policy Indicator Findings

- 25 states improved at least five policies
- Majority of states weakened one to three policies
- Only ONE policy goal was met by all the states

Policies Most Improved/Weakened

Improved

- Tobacco Sales Rates to Minors
- Medicaid Simplified Mail-in Applications
- Linguistic Access

Weakened

- Medicaid Co-payments on Prescription Drugs
- Funding for Tobacco Control Programs
- Clinic Access

Oregon

Women's Access to Health Care Services

Oregon:
Access to Health Insurance & Services

Medicaid eligibility by income

- Pregnant women — Limited
- Working parents — Limited
- Aged and disabled — No/harmful

- **Methods to expand Medicaid enrollment**
  - Presumptive eligibility (preg) — No/harmful
  - Mail-in application — Meets
  - Asset test for parents — No/Harmful

Public insurance for childless adults

Meets

Oregon:
Access to Specific Services

- **Pharmaceutical**
  - **Medicaid Prescription Limits — Meets**
  - **Medicaid Rx Co-Payment — No/Harmful**
- **Breast/Cervical Cancer Treatment**
  - **Medicaid Coverage — Meets**
- **Family Planning**
  - **Medicaid Waiver — Meets**

Oregon

Addressing Wellness & Prevention

Oregon: Prevention

- Nutrition
  - Food Stamp Outreach — Meets
  - Food Stamp Nutrition Ed — Meets
- Smoking
  - Medicaid Smoking Cessation Coverage — Meets

Oregon

Living in a Healthy Community

Oregon:
Economic Security

- Child Support Pass-Through — No/Harmful
- Child Support Collection — Weak
- State Supplement SSI — Meets

Policy: Overall

Systemic Shortcomings Identified by Policy Indicators

- Women need better access to health insurance
- Insufficient access to specific health care providers/services, particularly reproductive health
- Preventive and health promoting measures must be more available
- Disparities and gaps in economic security continue to compromise women's health

Conclusions

- Since the last *Report Card* (2001), states have made more positive changes in their policies than harmful ones.
- But there is still a long way to go.

- Greater commitment to women's health needed at both state and federal levels.

- QUESTIONS?
- COMMENTS?

Maternity Care in Oregon

A 2002 Survey of Providers

Ariel K. Smits, MD, MPH

OHREC Public Forum

October 19, 2004

Maternity Care in Oregon

- Background
- Project goals
- Methods
- Results
- Impact/importance of findings

Background: Prenatal and Delivery Care

- Prenatal care reduces fetal and maternal morbidity and mortality
- Rural women and women with Medicaid are at higher risk for inadequate prenatal care
- Importance of maternity care providers for access to care
- Rumors of loss of maternity care providers in the state

Background: Research in the 1980's

- Large numbers of providers stopped OB care in the 1980's
  - Studies in multiple states, IOM report
  - Cost of professional liability insurance
  - Fear of litigation
  - Time and lifestyle issues
  - Interference with office practice
  - Associations: practice ownership, older age, longer length of practice

Background: Research in the 1980's

- Adequacy of prenatal care fell nationally in the 1980's (Children's Defense Fund 1995)
  - Cuts in federal funding to maternal child health programs (York et al 96)
  - Increased numbers of uninsured women
  - Decreased numbers of practicing obstetricians (Murray and Bernfield 1988).

Background: Oregon as a Model State

- Small size congruent with comprehensive survey
- Low Medicaid reimbursement level
- Sharp rise in malpractice insurance cost after 1999 with loss of caps on non-economic damages

Maternity Care Survey Project

- Cross-sectional descriptive self-administered mail survey of licensed obstetrical providers attempting to better understand obstetrical practice changes in Oregon

Project Goals

- Describe the demographics of current Oregon maternity care providers
- Determine if large numbers are actually quitting
- Determine the important factors relating to the decision to quit maternity care

Methods: Survey Instrument

- 25 questions, 8 pages
- Demographic information
- Types of maternity care included in practice
- Reasons for quitting maternity care if applicable
- Back-up maternity care
- Care of Medicaid patients
- Multiple question types
- Pilot tested

Survey Instrument: Reason for Quitting Choices

- No interest in OB care
- Interference with lifestyle
- Interference with family
- Conflicts with office practice
- Cost of professional liability insurance
- Fear of lawsuits
- Personal experience with lawsuits
- Hospital privileging issues
- Low OB patient volume in practice
- Concern with skill level
- Professional change
- Low reimbursement
- Back-up issues
- Other

Methods: Subjects

- All OB/Gyns, FPs, GPs, and CNMs with active Oregon licenses with mailing addresses in Oregon or close areas of surrounding states
  - Mailing list:
    - Oregon Board of Medical Examiners
    - Oregon State Board of Nursing
  - Comprehensive survey rather than sample
  - Includes many non-OB providers
    - Liability insurance survey: approx. 850 OB providers
    - Mailing: over 2000 providers
  - Excluded: lay midwives, LDEMs, other providers

Methods Continued

- First mailing: October, 2002
- Second mailing: November, 2002
- Data entry in ACCESS
- Analysis with SPSS (11.0)
  - Chi square
  - Logistic regression

Results

- Mailed: 2158
- Returned: 1232 (58% response rate)
  - 63% of OB/Gyns
  - 64% of CNMs
  - 53% of FPs
  - 39% of GPs
- 163 exclusions
- 1069 total surveys analyzed

Results: Demographics

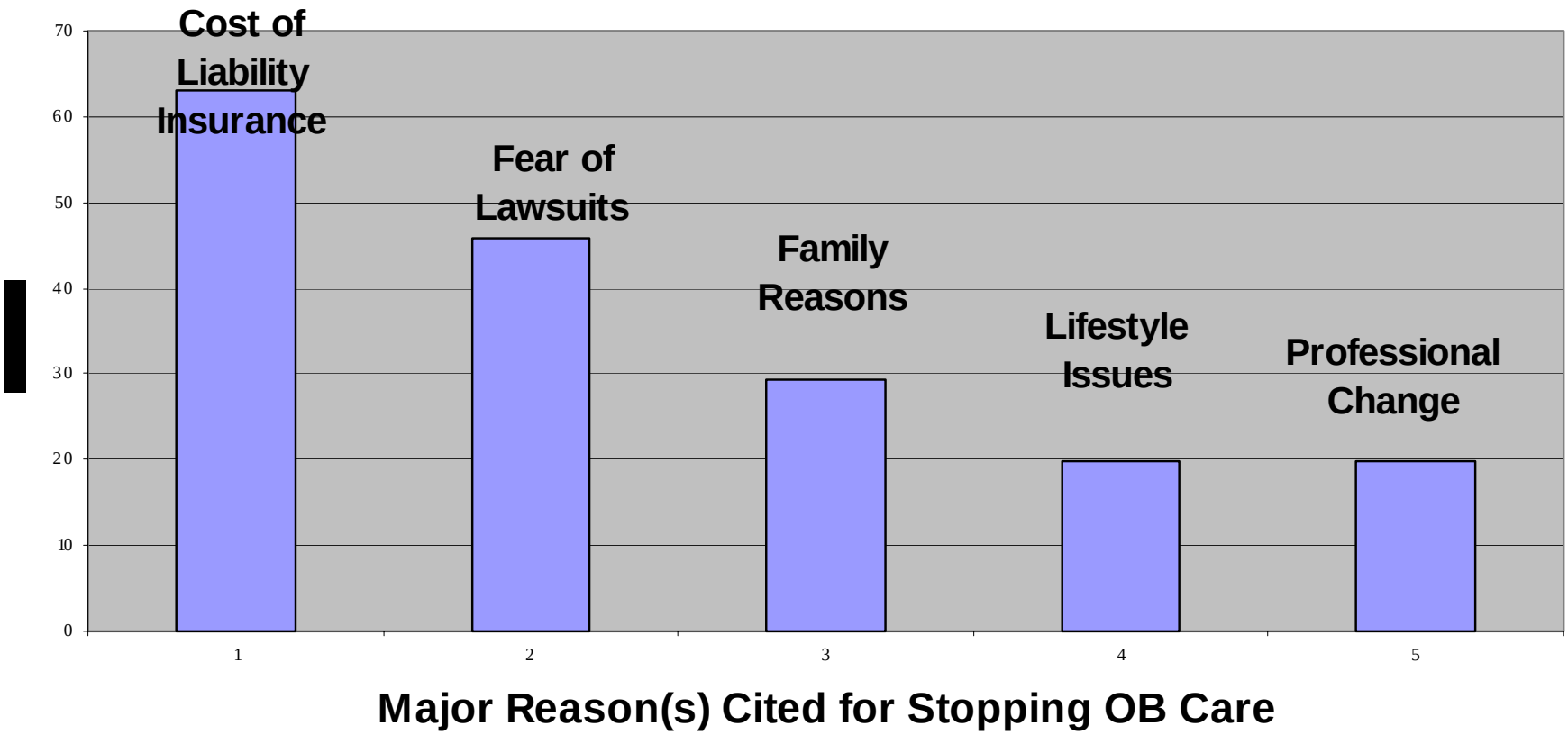
Table 1. Demographics of included respondents (N=1069)

	No. (%)
Specialty	
Obstetrics/gynecology	261 (24.4)
Family physician	650 (60.8)
General practitioner	52 (4.9)
Certified nurse midwife	106 (9.9)
Female	435 (40.7)
Practice outside Portland metro area	683 (63.9)
Solo practice	188 (17.6)
Ave. pt care hours per wk (hrs)	37.7
Ave. on call hours per wk (hrs)	39.5
Ave. age (yrs)	46.6

Results: Status of Maternity Care Practice

Status of Pregnancy Care Practice	Number (%)
Total sample	1069 (100)
Undetermined pregnancy care status	15 (1.4%)
Never delivered babies	176 (16.5)
Previously delivered babies **Stopped prior to 1999** **Stopped 1999-2002**	367 (34.3) 242 (65.4) 127 (34.6)
Currently delivering babies **Plan to stop in 1 yr** **Plan to stop in 2-3 yrs** **Plan to stop in 4-5 yrs** **No plans to stop**	511 (47.8) 56 (11.0) 40 (7.8) 61 (11.9) 354 (69.3)

Current OB Providers: Major Reasons for Quitting



Current OB Providers

- **Significant Associations with Stopping Maternity Care:**
  - Male
  - Practice ownership
  - Pay own liability insurance
  - Rural
  - Work longer hours
  - Older age

Current OB Providers

- **Medicaid**:
  - 384 (75.1%) see unlimited Medicaid
  - 220 (45%) of these plan to limit or stop accepting Medicaid
- **Back up:**
  - 236 (46.2%) currently
  - 45 (19%) plan to stop
  - 34 of these are outside of Portland

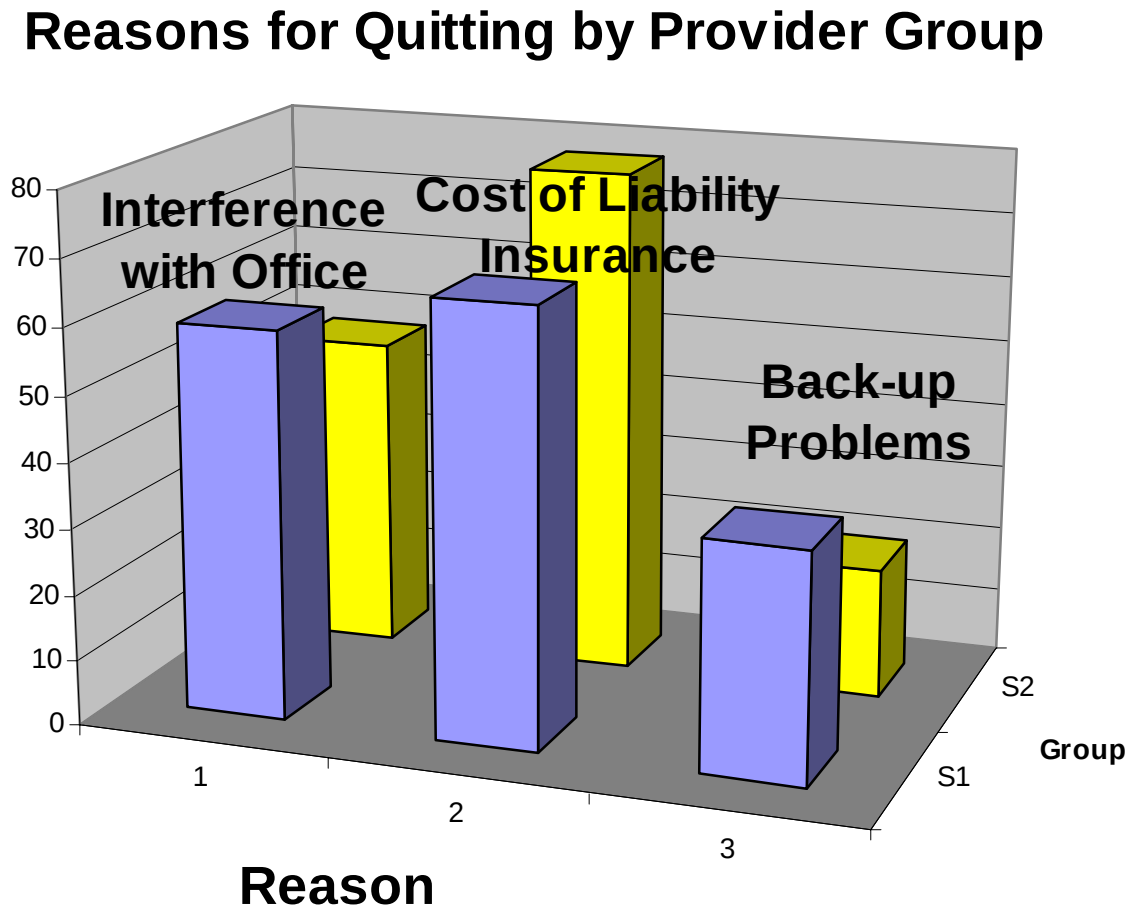
Providers Who Have Already Stopped Maternity Care

- 366 providers had at one time included OB in their practice
- Most common major reasons for quitting:
  - Interference with family (51.9%)
  - Cost of professional liability premium (47.5%)
  - Interference with lifestyle (47.1%)
  - Fear of lawsuits (41.3%)
- 125 (34%) quit 1999-2002

Comparison of Providers Who Have Stopped OB Care pre- and post-1999

- Pre-1999 group
  - Significantly more likely to cite interference with office or back-up difficulties
- Post –1999 group
  - Significantly more likely to cite cost of liability insurance as reason for quitting

1999-2002 Group Compared to Pre-1999 Group



Study Limitations

- Self report
- Respondent bias
- Exclusion of non-licensed providers
- Lack of data on incoming providers

Discussion

- Liability premium increases 99-02:
  - OB: 280%
  - FP w/OB: 375%
- Large proportion (up to 70%) of patients are Medicaid
  - Low reimbursement

Rural issues:

- Medical practice as a small business
- Large distances between providers
- Dependence on surgical back-up for continued maternity care

Comparison of Premium Costs, 1999-2003

Cost of Professional Liability Insurance Premiums

Specialty	1999	2003	Percent Increase
OB/Gyn	$21,900	$61,200	280%
FP with OB	$8,550	$32,100	375%
FP without OB	$4,200	$9,900	236%

Northwest Physicians Mutual, January 2003

Implications

- Access to care issues
  - Rural and Medicaid
  - Future studies needed
- Physician retention and recruitment issues
- Policy issues
  - Health care system reform
  - Insurance reform
  - Tort reform

Questions?

- Acknowledgements:
  - Oregon Medical Association
  - Oregon Academy of Family Physicians
  - Oregon Chapter of American College of Obstetrics and Gynecology
  - Oregon Health & Science University Department of Family Medicine

Welfare Reform and Access to Health Care

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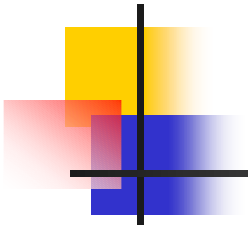
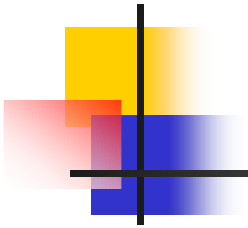
Kim Hoffman, A.B.D. kimh@pdx.edu

School of Community Health

Portland State University



“You can always get a place to stay by shacking up if you have to, and you can get food at a soup kitchen. But how am I supposed to pay for all those high price fancy doctor bills?”



- Health problems, fear of losing insurance, and access to care are major concerns among welfare recipients
- Medicaid was ranked as the most important benefit

National data indicate that poor women have greater health problems:

- self reports
- disability
- ADL

- Poor children are more likely to suffer from chronic and acute ailments
- iron deficiency, diarrhea, asthma, lead paint poisoning...

Transitional Medicaid

When families leave TANF they receive 1 year of transitional Medicaid coverage

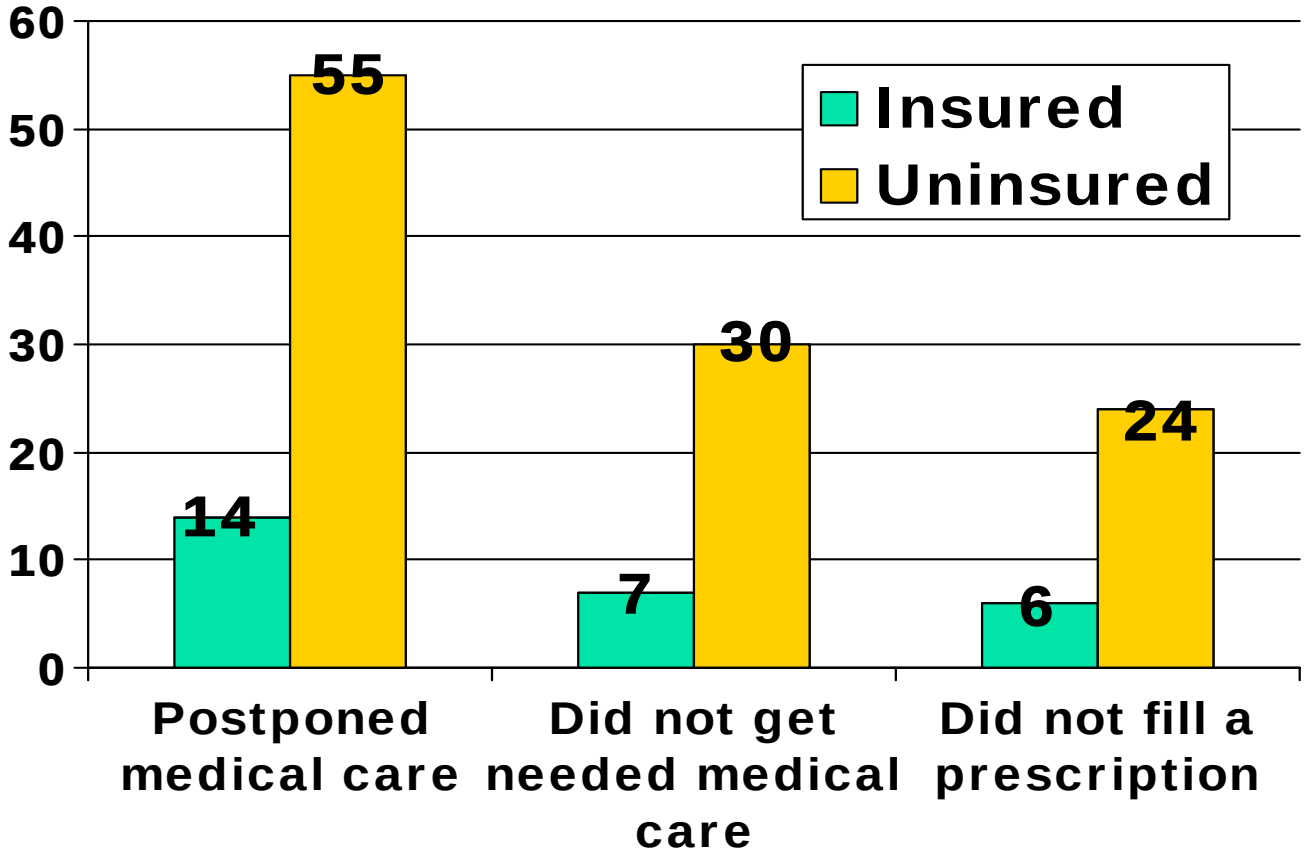
After that, where do they get coverage?

Are they able to get the health care that they need?

National and State Research Findings

Studies commonly report that 25-35% of adults and 15% of children are completely uninsured after leaving welfare.

Consequences of Being Uninsured



Kaiser Family Foundation

Research Questions

- Do families lose their health insurance after transitional Medicaid?
- If so, with what consequences?
- Are welfare recipients concerned about this?

Oregon Health Plan

- Unique expanded Medicaid program
- Watched around the country
- Successfully reduced uninsured in Oregon from 18% to 11%

Agency for Healthcare Research and Quality (AHRQ)

- Telephone Survey in Oregon
  - Wave 1 N = 637
  - Wave 2 N= 552
- In-depth Qualitative Interviews
  - Wave 1 N = 90
  - Wave 2 N= 83

English and Spanish

Retention

- Quarterly phone “check-ups”
- National on-line directory
- Mailings
- Home visits

Sample Characteristics

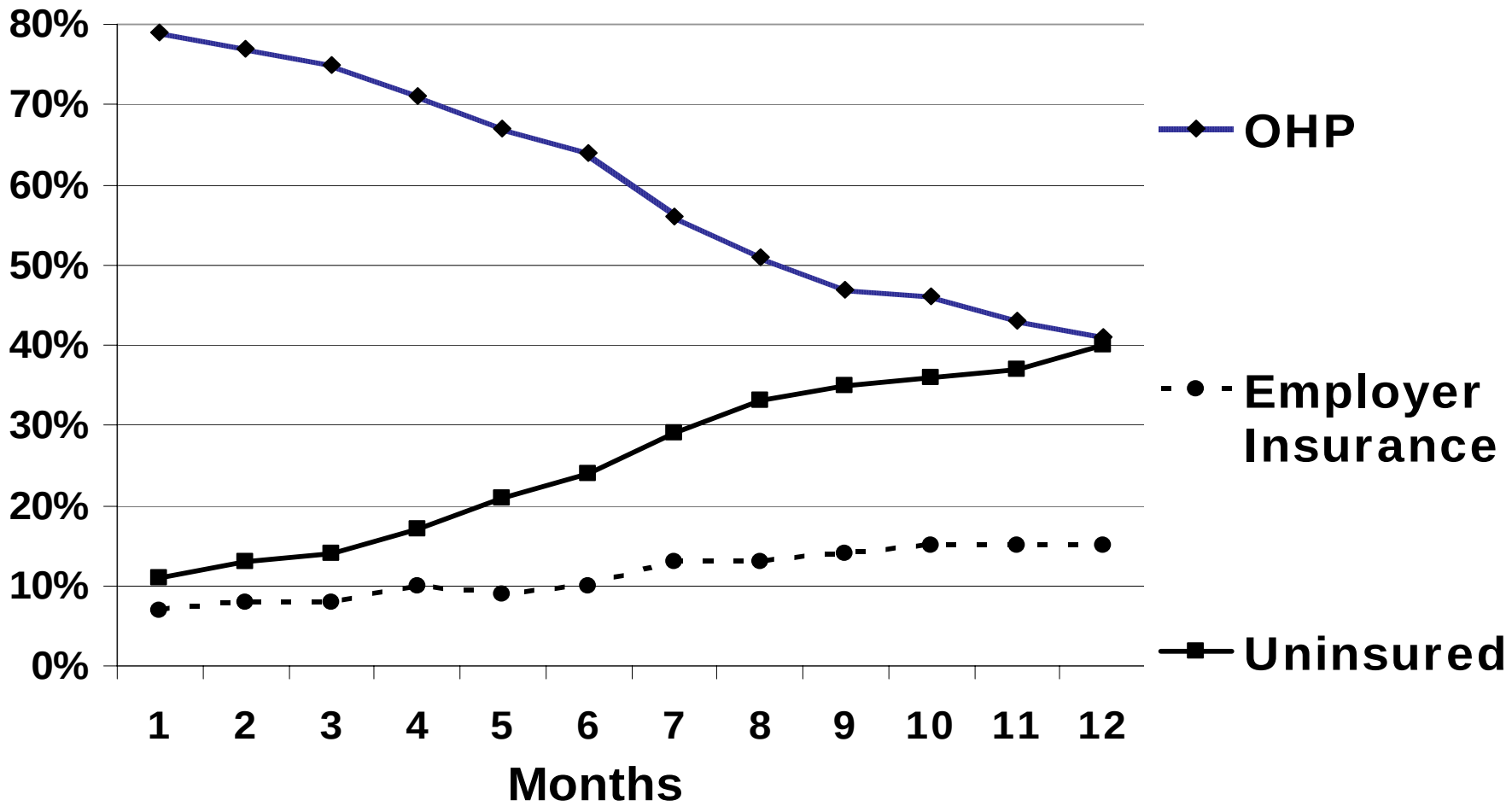
- Female 90%
- Male 10%

- African American 6%
- Hispanic 18%
- White and Other 76%

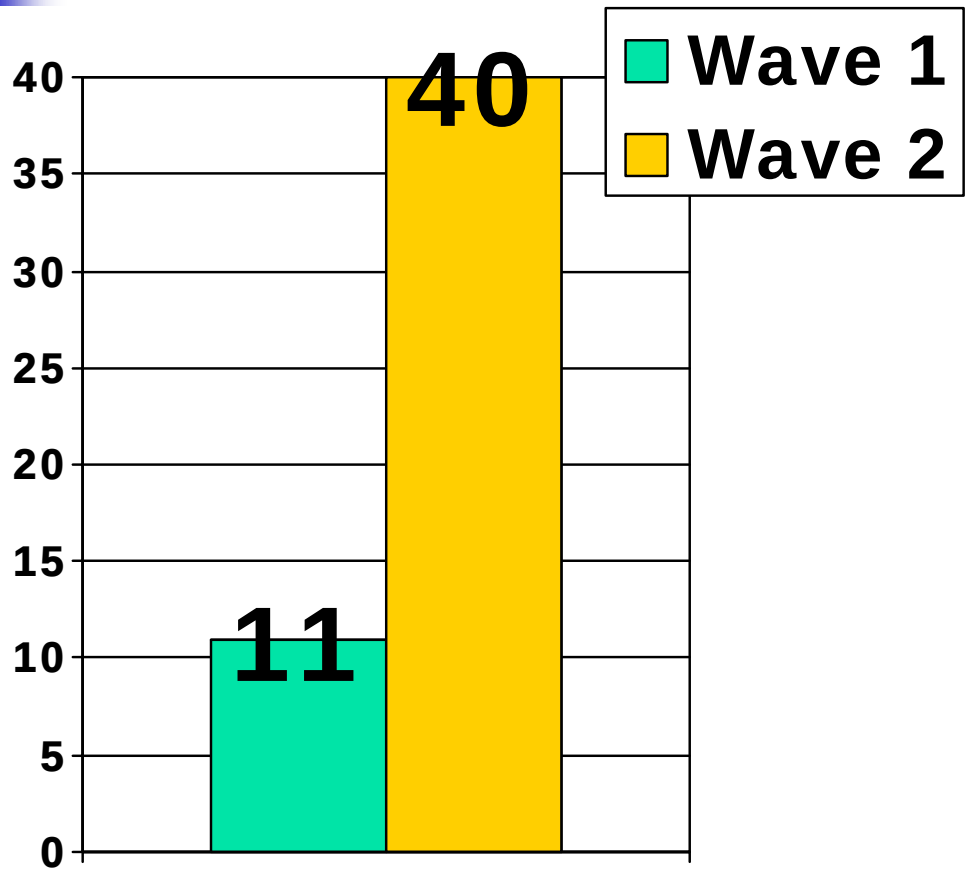
- English speaking 89%
- Spanish speaking 11%

Very close to statewide averages

Insurance Trends Over Year Following Wave 1 Interview

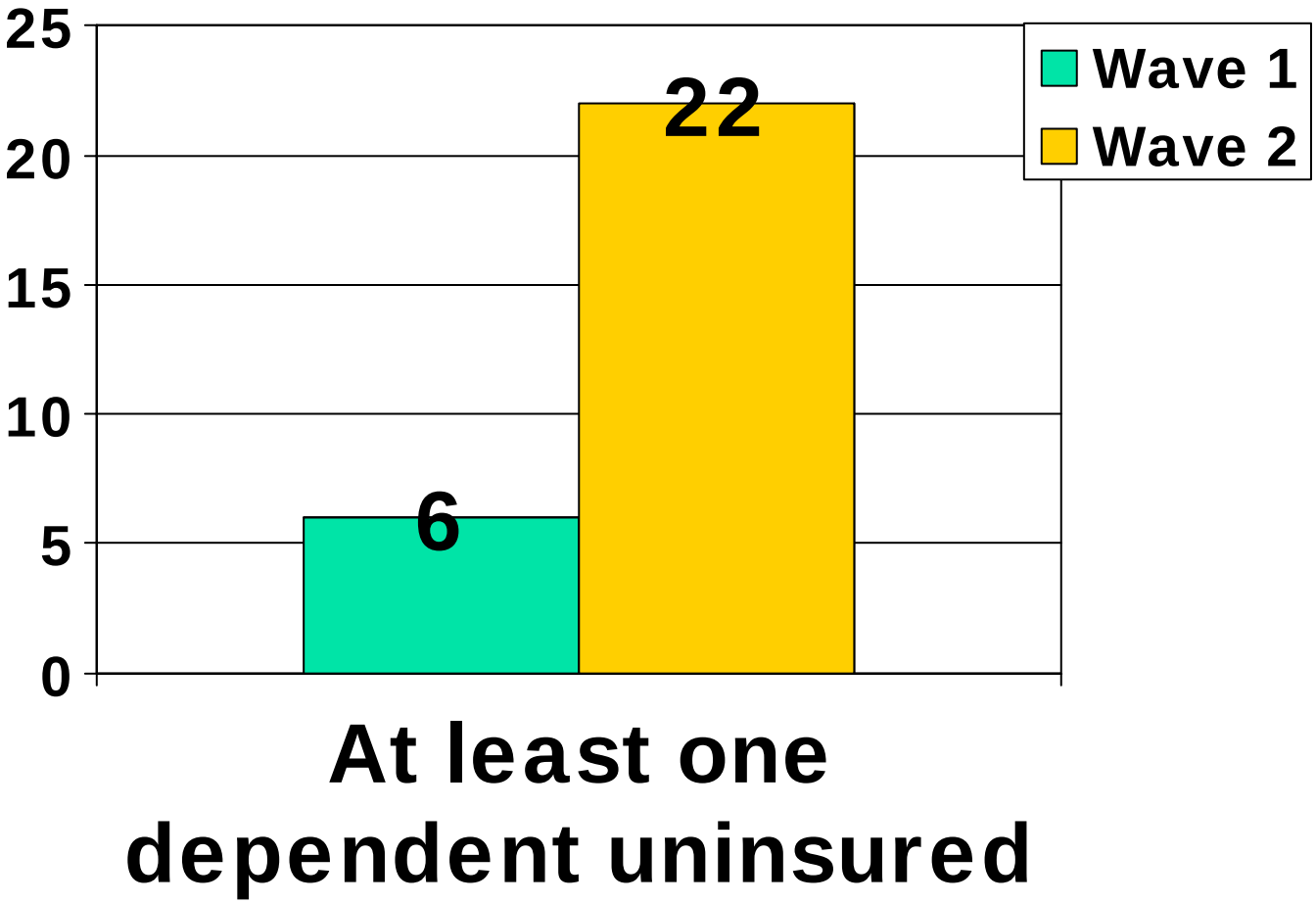


Adults Currently Uninsured



57% were without dental insurance at Wave 2

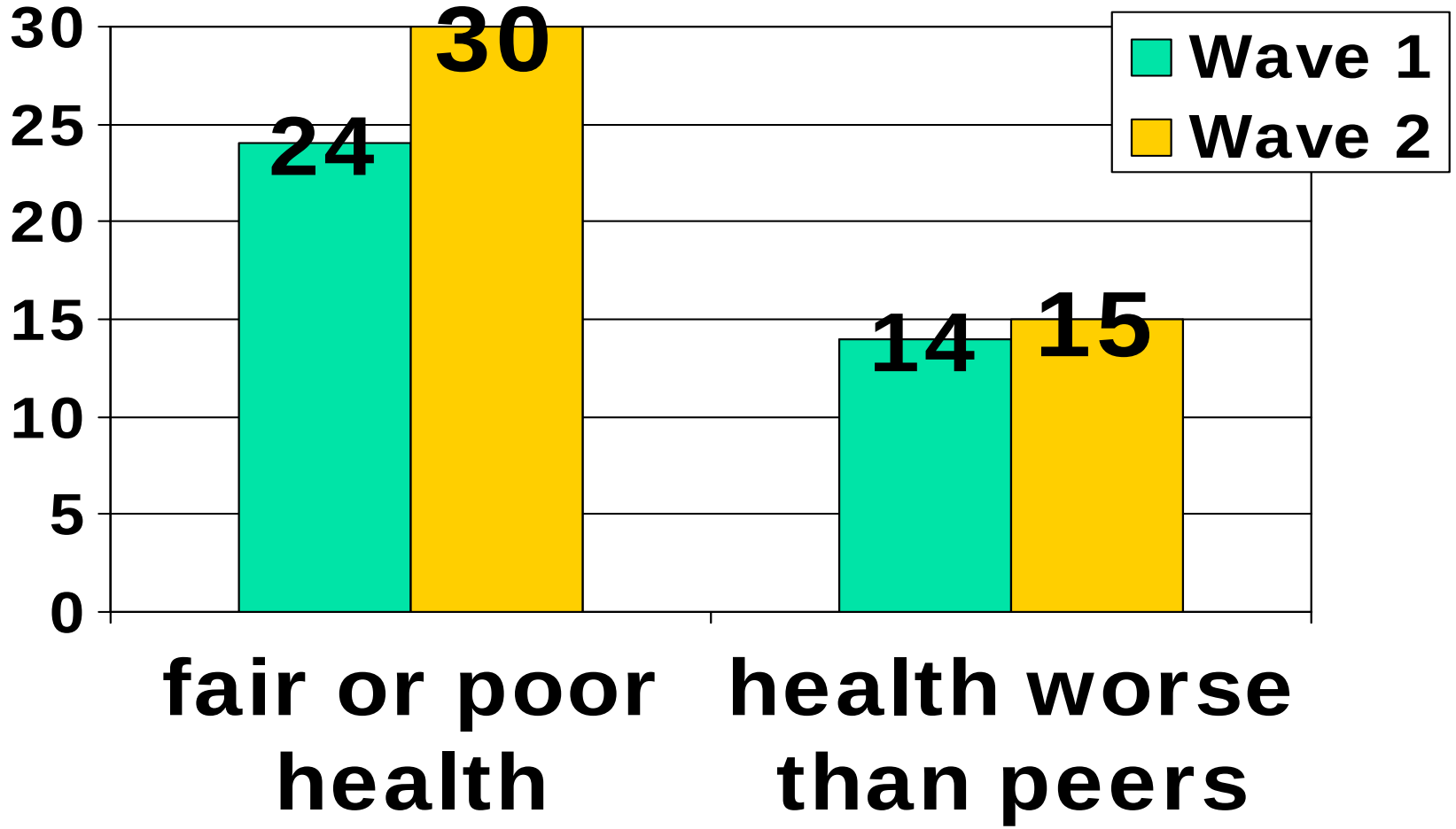
Children Currently Uninsured



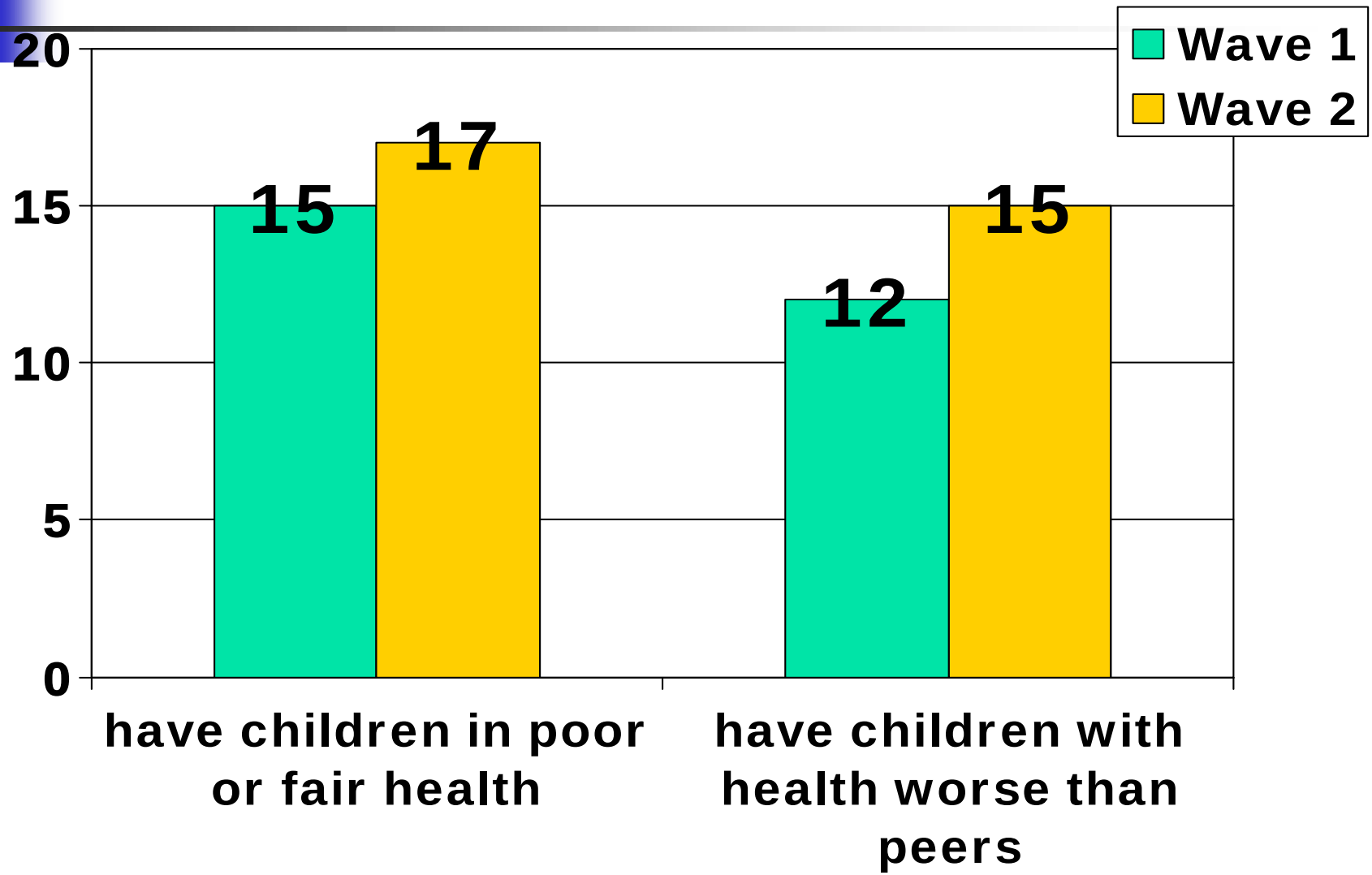
Health Status, Wave 2

- 30% of adults have fair or poor health
- 20% say health interferes with job
- 22% limited in activity due to health
- 39% have chronic problem or pain
- 14% less healthy than 6 months ago
- 17% have child with fair or poor health

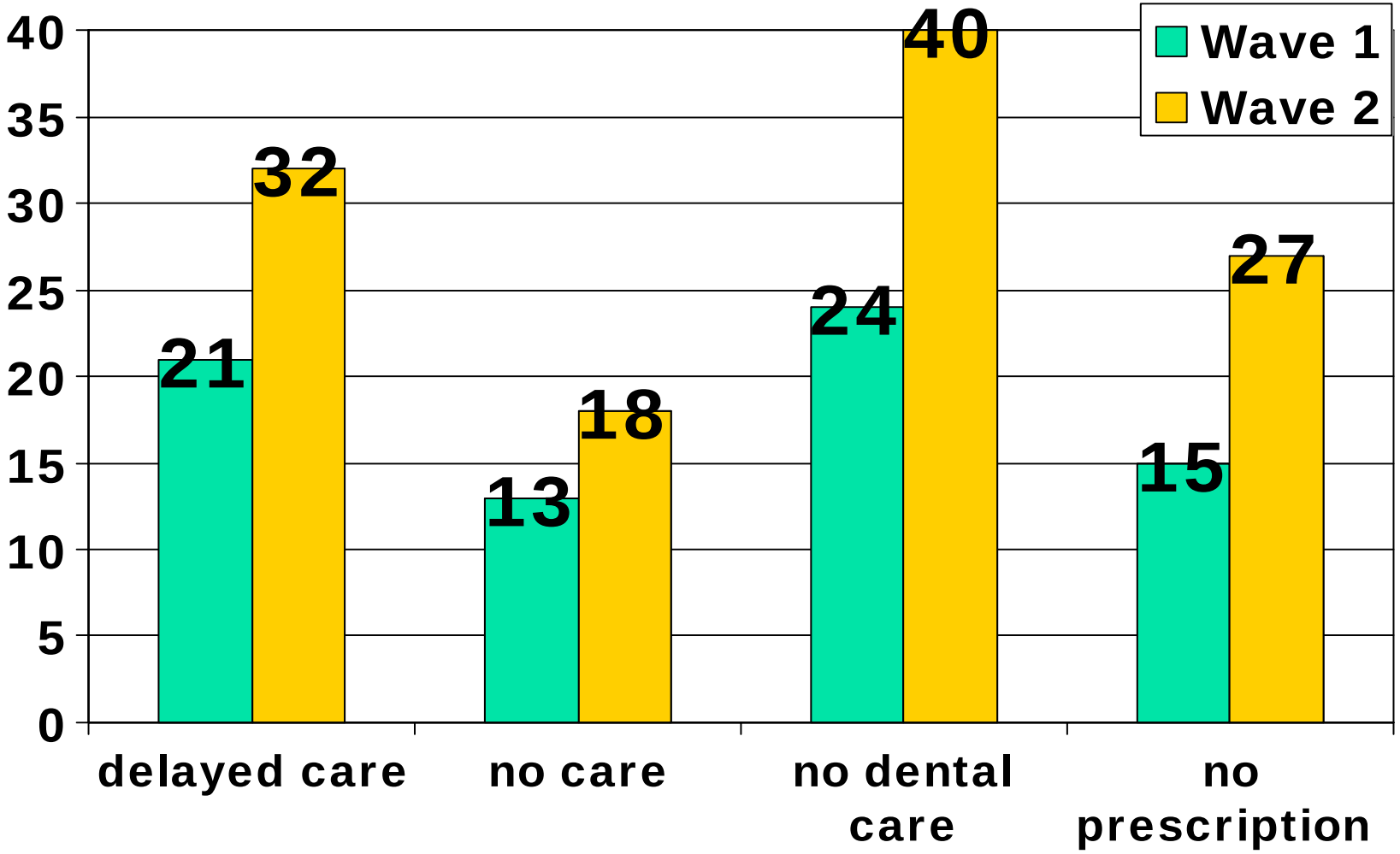
Adult: Changes in Health



Children: Changes in Health



Are They Getting Care?

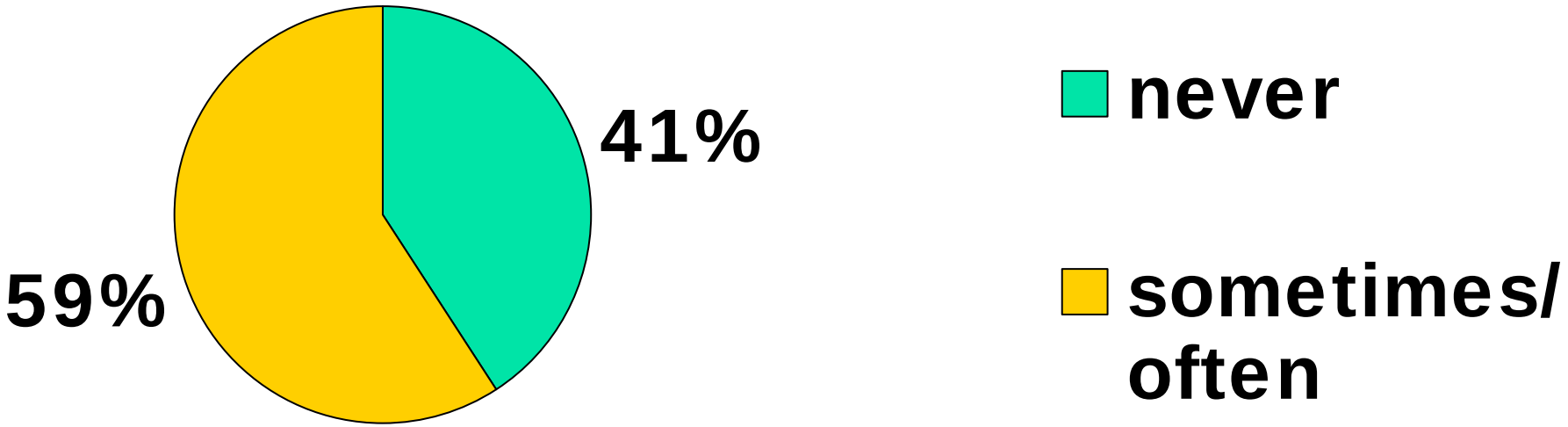


- *“I can’t tell you where my diabetes is right now….”*

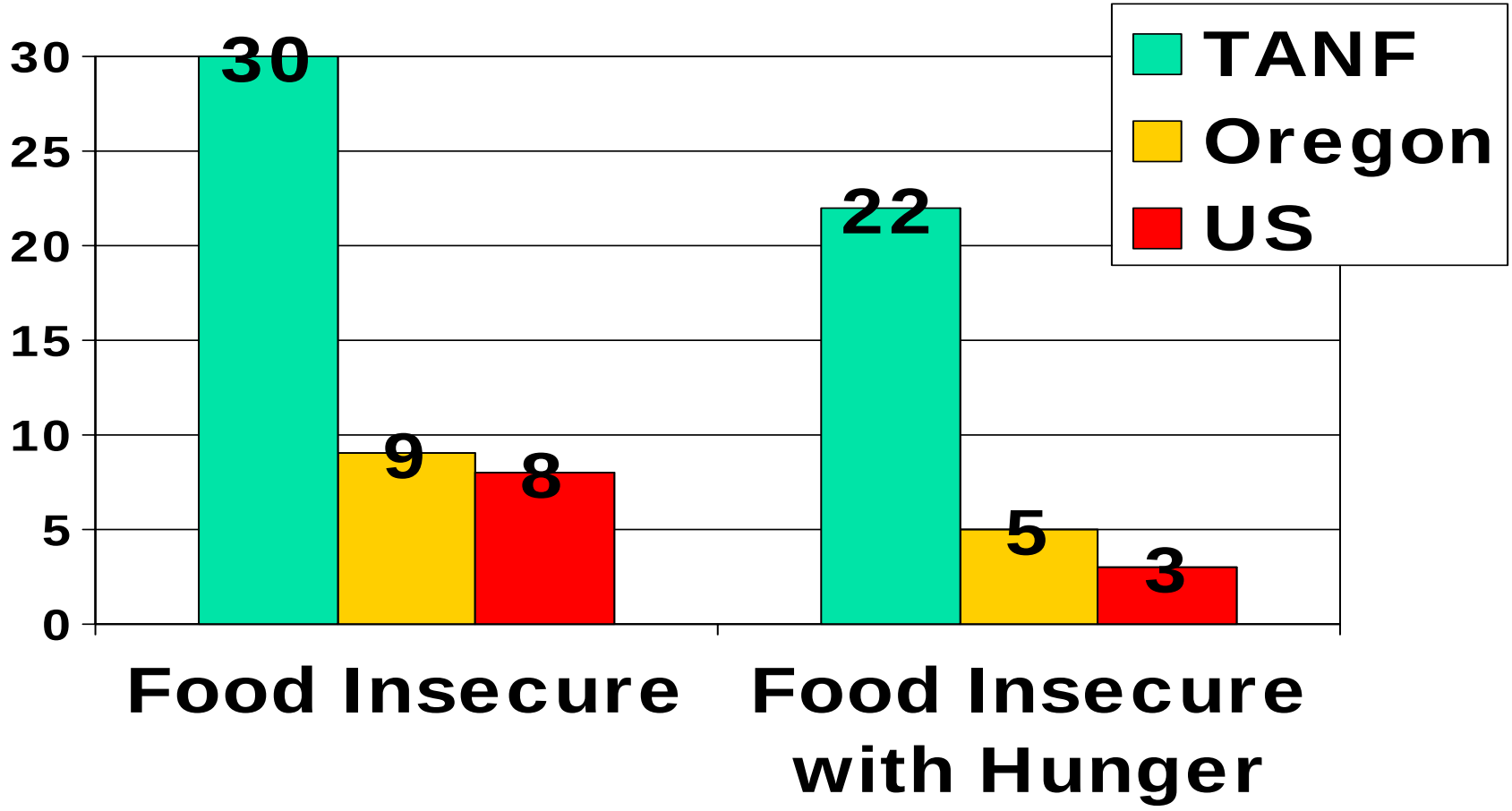
- *“I’m down to my last bottle of insulin…”*

Food Insecurity

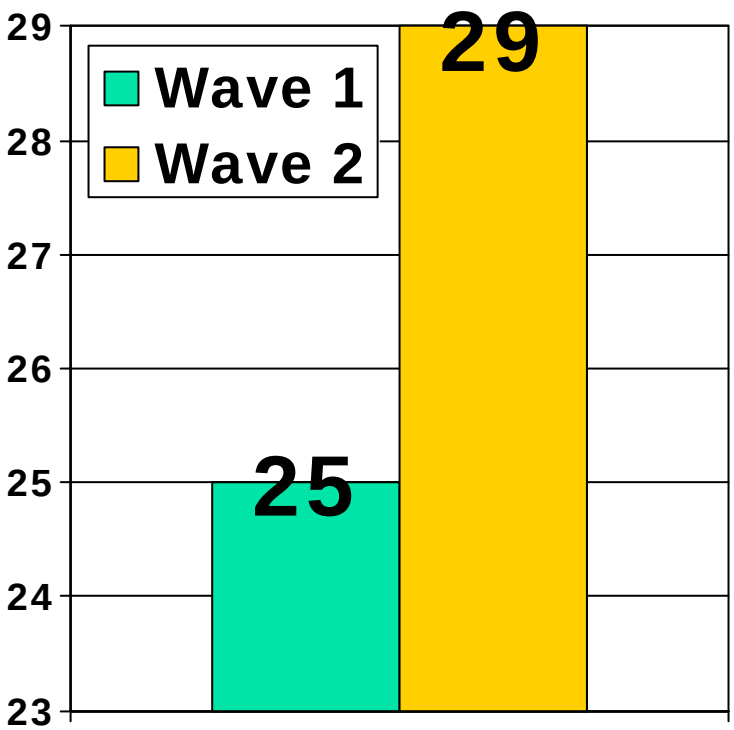
Please consider this statement: the food that I bought didn't last; I didn't have money to get more



Food insecurity; state and national levels

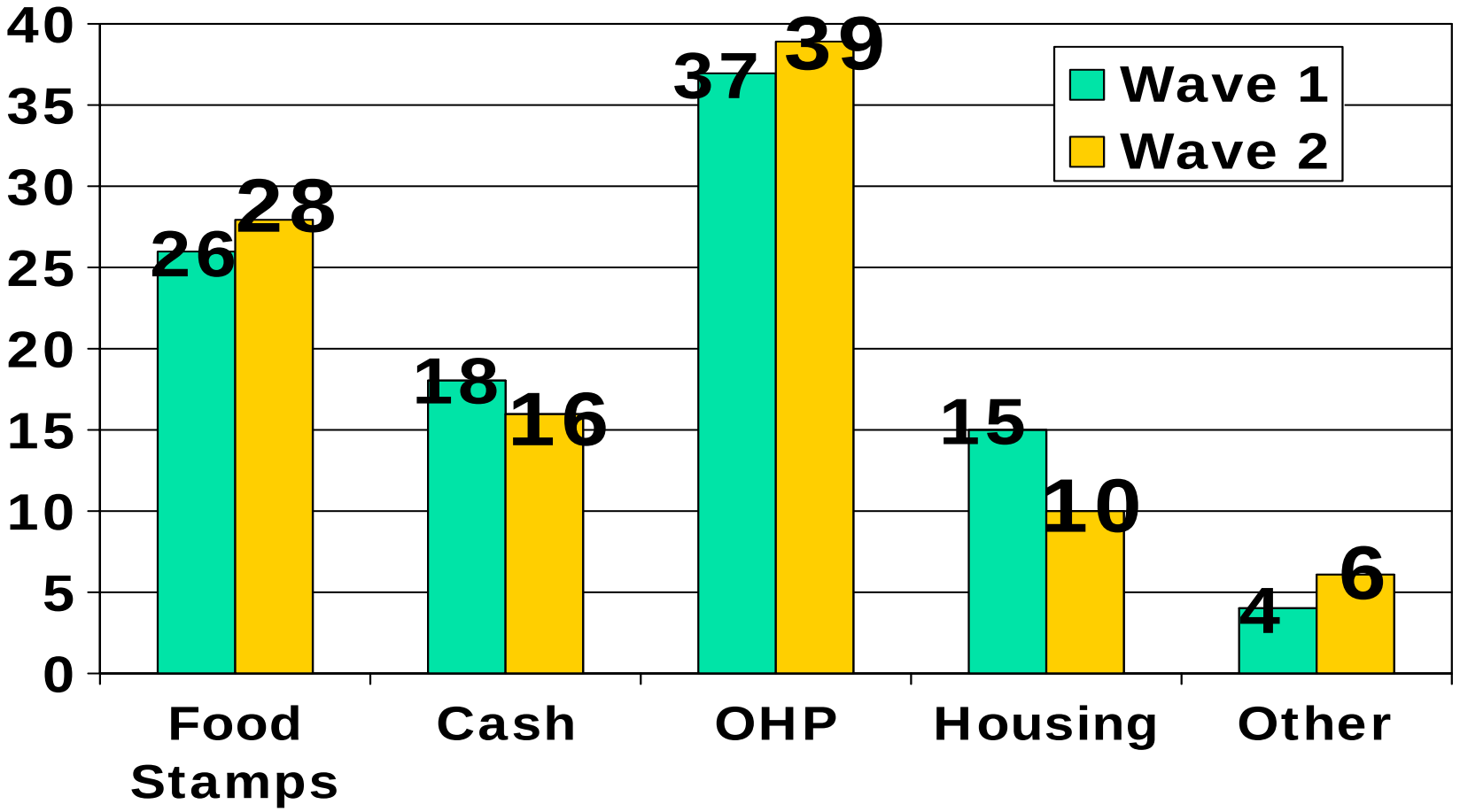


Clinically Depressed



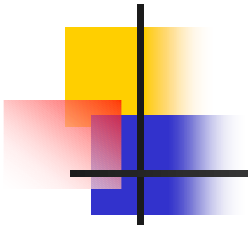
"I think that's part of my depression..."

Most Important Benefit



Importance of Health Insurance

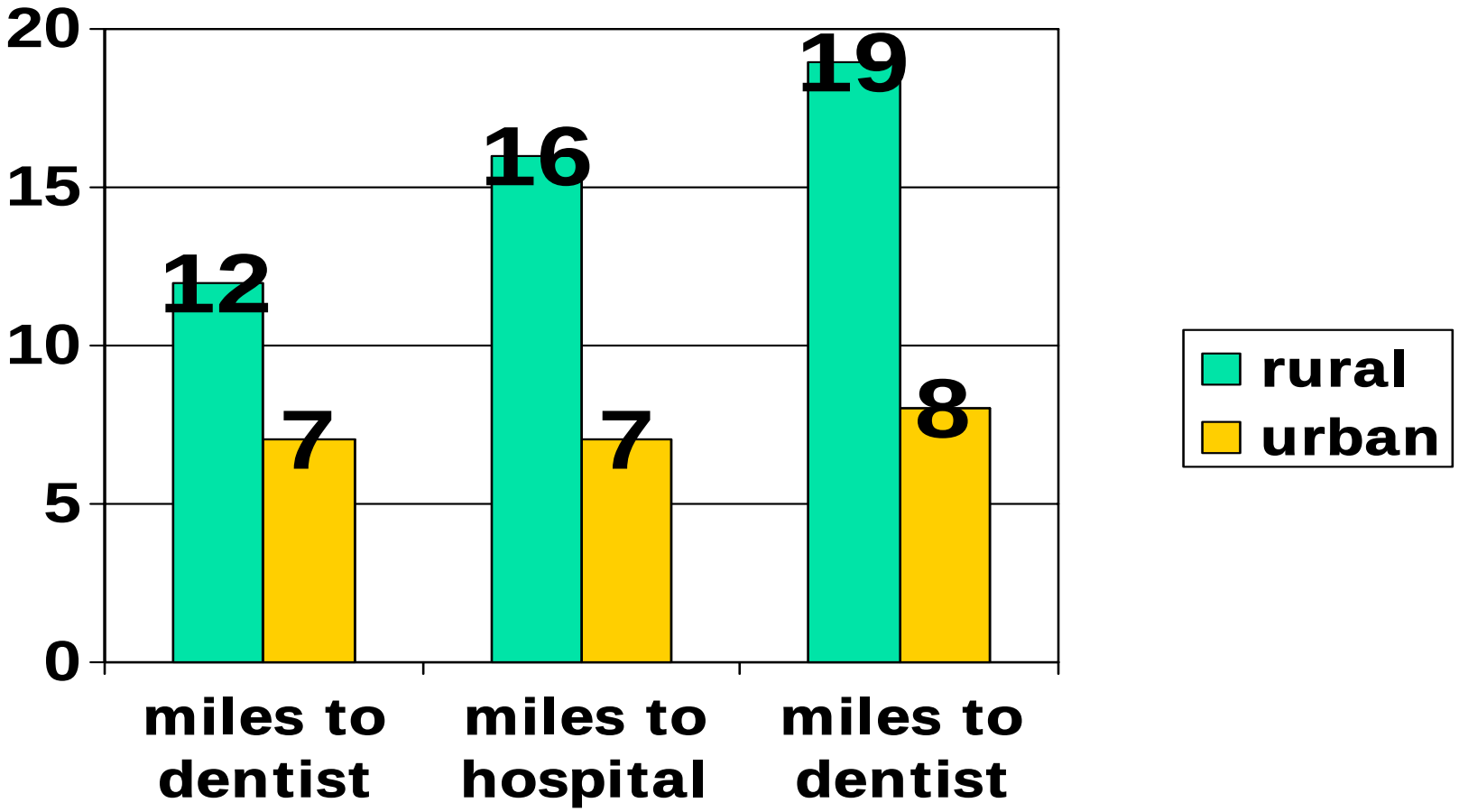
- 40% claim OHP (Medicaid) is most valuable benefit
- 94% report that health insurance is of great importance to their family
- 40% worry more about getting health care since leaving TANF



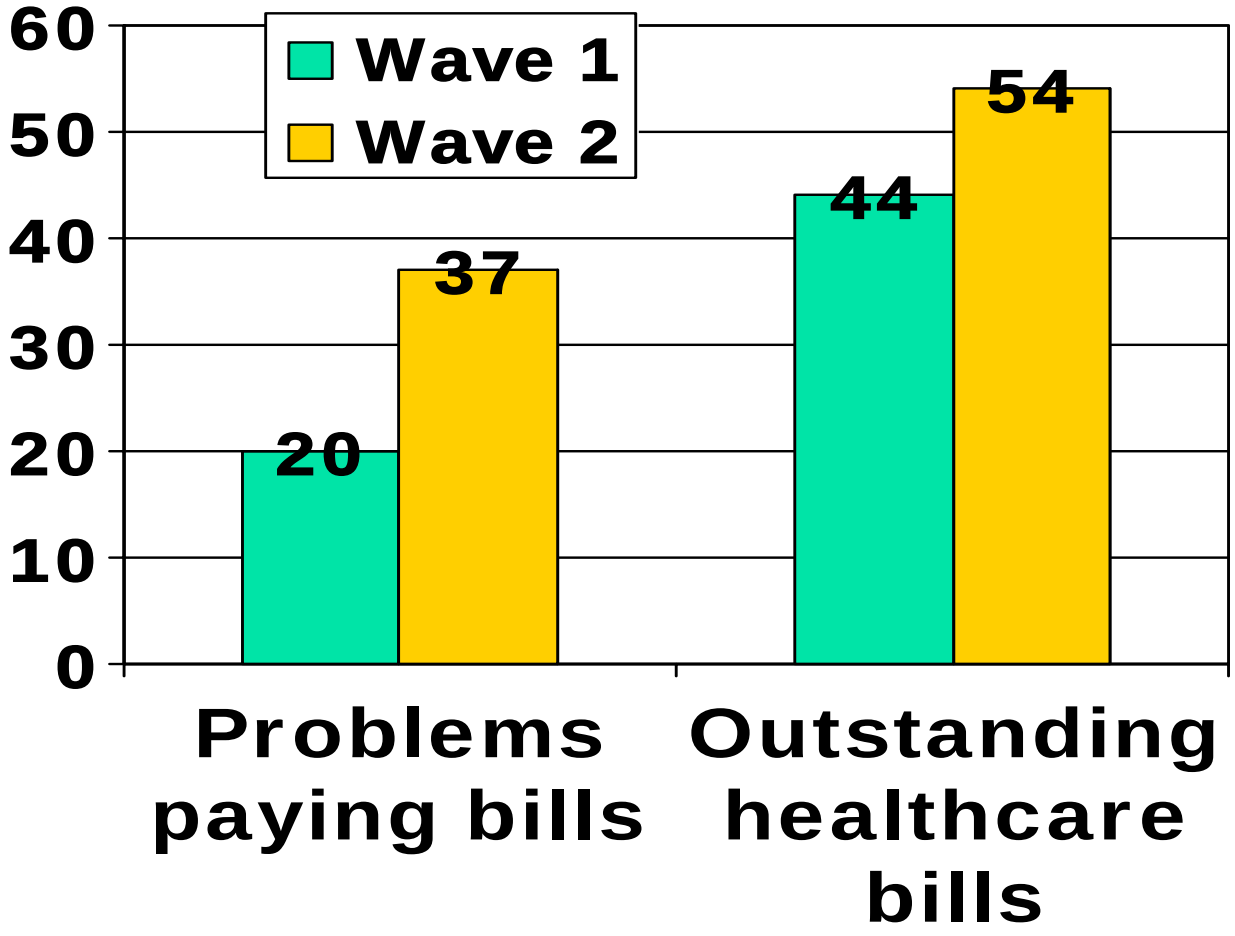
"I've never had to use it myself, but my daughter couldn't do without it…."

"He has lead paint poisoning…The medical benefits—definitely it's the medical benefits that are the most important"

Rural/Urban Differences in Access to Care



Financial Concerns



"I'm just going to dig a grave..."

Health insurance is a pressing social policy problem

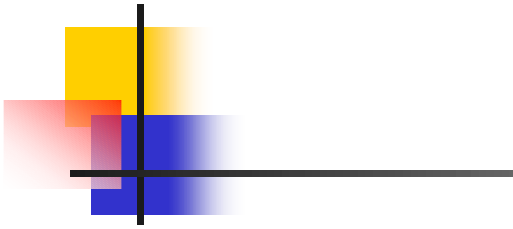
The magnitude of the problem is immense, and will only intensify over time as the single year of transitional Medicaid continues to expire for the welfare-to-work families.

Recommendations:

- Welfare workers should assist TANF recipients in not only job seeking but also health insurance planning.

- OHP (and other state Medicaid programs) must engage in increased outreach and provision of information.

- Federal or state governments must provide greater incentives for businesses to provide insurance to their workers if the U.S. plans to continue to rely upon employer-sponsored insurance as the foundation for coverage.



- Expand OHP and other state Medicaid funding

- Establish incentives so that more providers would be willing to serve OHP clients.

- Acknowledge personal barriers and develop policies and work with TANF-leavers to overcome them

It's been terrible… They need their shots, Scotty missed his shot, and we never got our dental work done. We had appointments. … I've got letters saying you have to finish your appointments, yet I don't have the coverage. …. I'm asking for help.

The Drug Effectiveness Review Project

JOHN SANTA MD
Center for Evidence-based Policy
Oregon Health & Science University

The Drug Effectiveness Review Project

- What it is
- How it works
- The results, with examples
- Implications and opportunities

CENTER FOR EVIDENCE BASED POLICY
Globalizing Evidence, Localizing Decisions

Objectives

- Provide you information
- Get and give constructive feedback
- Establish a “science” relationship
- Improve how the health care system works for all of us

CENTER FOR EVIDENCE BASED POLICY
Globalizing Evidence, Localizing Decisions

"We are drowning in information but starved for knowledge."

John Naisbitt

Megatrends, 1982

The Ethics of Pharmaceutical Benefit Management

Burton S.L. et al, Health Affairs, 20, #5, Sept/Oct 2001

- Accept resource constraints
- Help the sick
- Protect the worst off
- Respect autonomy
- Sustain trust
- Promote inclusive decision making

CENTER FOR EVIDENCE BASED POLICY
Globalizing Evidence, Localizing Decisions

The Drug Effectiveness Review Project

- **Systematic evidence-based drug class reviews focusing on comparative effectiveness to support preferred drug list, formulary, disease management or patient information activities**.
- Focus on the most important 25 drug classes
- Update every 6-12 months
- Each participant uses local decision makers to draw conclusions from the evidence for their use. Globalize evidence, localize decisions.
- Process and products available to the public

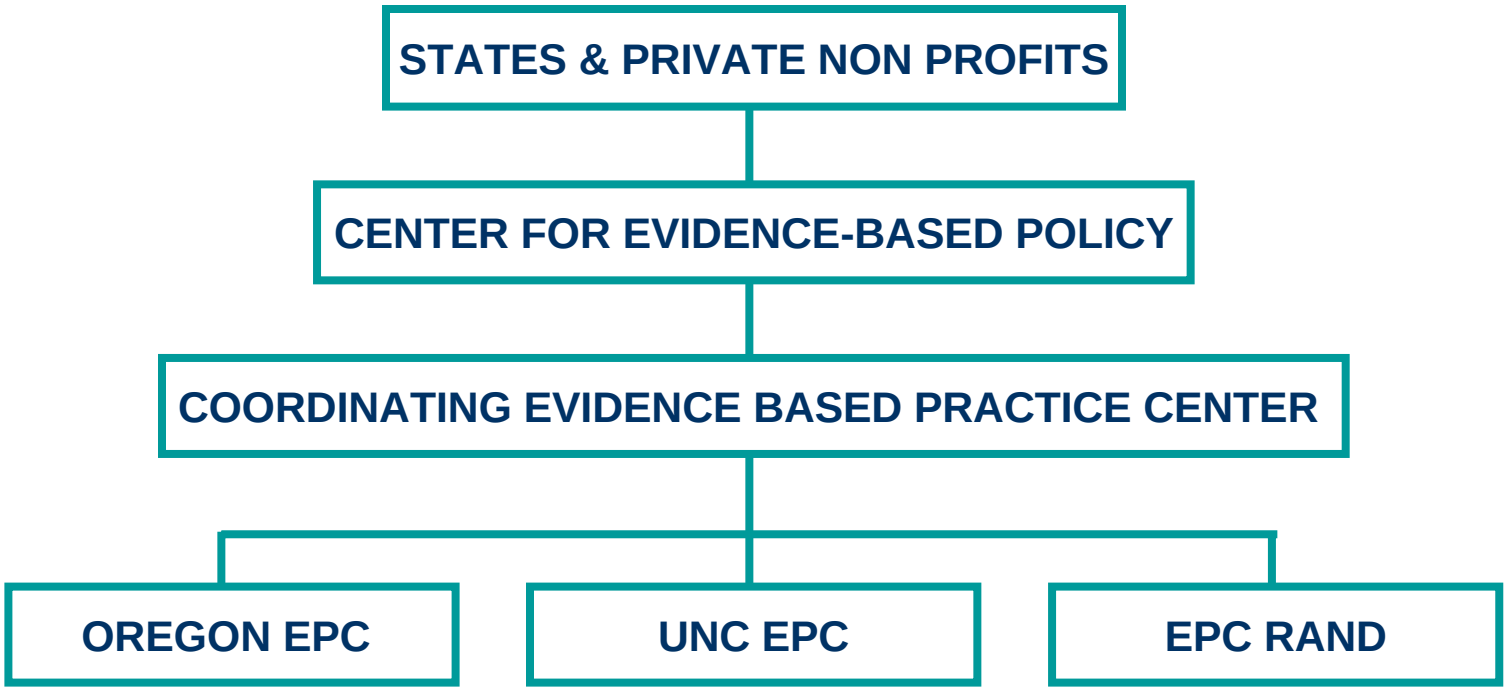
CENTER FOR EVIDENCE BASED POLICY
Globalizing Evidence, Localizing Decisions

Topics

1. PPIs
2. Long-acting opioids
3. Statins
4. NSAIDs
5. Estrogens
6. Triptans
7. Muscle Relaxants
8. Oral Hypoglycemics
9. Incontinence Drugs
10. ACE Inhibitors
11. Beta Blockers
12. Calcium Channel Blockers
13. ARBs
14. 2nd Generation Antidepressants
15. Atypical Anti-psychotics
16. 2nd Generation Antihistamines
17. Anticonvulsants with Mood Stabilizing Properties
18. Inhaled Corticosteroids
19. ADHD Drugs
20. Alzheimer's Drugs
21. Anti-platelet Drugs
22. Osteoporosis Drugs

CENTER FOR EVIDENCE BASED POLICY
Globalizing Evidence, Localizing Decisions

Organization Chart



Center for Evidence-based Policy

- MISSION: To address policy challenges by applying the best available evidence through self-governing communities of interest.
- Department of Public Health and Preventive Medicine, Oregon Health & Sciences University
- Supports collaboration, facilitates communication

CENTER FOR EVIDENCE BASED POLICY
Globalizing Evidence, Localizing Decisions

OHSU Evidence Based Practice Center

- AHRQ designated EPC. Department of Medical Informatics and Clinical Epidemiology, OHSU School of Medicine
- Agreement with Center for drug class reviews.
- Credible, responsive source of comprehensive information.
- Reports provided to local decision making bodies.

CENTER FOR EVIDENCE BASED POLICY
Globalizing Evidence, Localizing Decisions

Governance Group

- 15 Organizations
  - State Medicaid organizations
  - State employee plans
  - Private organizations
- Decisions to be made
  - Key policy decisions
  - Drug classes to be reviewed
  - Key questions
  - Timelines

CENTER FOR EVIDENCE BASED POLICY
Globalizing Evidence, Localizing Decisions

Current Announced Participants

- Alaska
- Arkansas
- California Healthcare Foundation (CalPERS and several advocacy groups collaborating)
- Canadian Coordinating Office of Health Technology Assessment (CCOHTA)
- Idaho
- Kansas
- Michigan
- Minnesota
- Missouri
- North Carolina
- Oregon
- Washington
- Wisconsin
- Wyoming

Rx Policy Process

- Need/Reason
- Politics
- Information
- Purchasing/Pricing
- Incentives/Disincentives
- Litigation

The Drug Effectiveness Review Project is a collaborative information project

CENTER FOR EVIDENCE BASED POLICY
Globalizing Evidence, Localizing Decisions

Evidence-based Systematic Review Process

- Problem formulation/key questions
- Find evidence
- Select evidence
- Synthesize and present
- Peer review and revision
- Maintain and update

CENTER FOR EVIDENCE BASED POLICY
Globalizing Evidence, Localizing Decisions

Expert Information Process

- Experts may underplay controversy or select only supportive evidence
- Without systematic approach bias may be introduced
- Experts may ask good research questions but the wrong questions for patients and providers
- Experts may not be aware of all evidence
- Experts may or may not disclose conflicts

Conflict of Interest

- Center and EPC staff have no direct conflict of interest, disclosure process
- Participating organization representatives have no direct conflict of interest.
- Policy posted on web site
- Participating organizations each have conflict of interest policy

CENTER FOR EVIDENCE BASED POLICY
Globalizing Evidence, Localizing Decisions

Relevant Examples

- Heartburn/Proton pump inhibitors
- Chronic pain/Long acting opioids
- Arthritis/NSAIDs and COX2s
- Heart Failure/BetaBlockers
- High cholesterol/Statins

Relevant Examples

- Second generation antidepressants
  - Comparative effectiveness—number needed to treat
  - SSRIs vs SSNIs
  - Adverse effects
- Atypical antipsychotics
  - Comparative effectiveness
  - Adverse effects
- Mood stabilizers
  - Bipolar—comparative effectiveness, ?? Effectiveness for some drugs

Implications and Opportunities

- Gain the stage
- Stabilize the process
- Promote market competition
- Reallocate resources
- Improve outcomes
  - Safety
  - Expectations

CENTER FOR EVIDENCE BASED POLICY
Globalizing Evidence, Localizing Decisions

Local Decision Makers

- All participants commit to conflict of interest process
- All the participants have public processes as part of their decision making process
- Participants use information in a variety of ways
  - Several use as primary preferred drug list information
  - Several use as a secondary confirmation of internal or PBM information
  - Several use for information/education to consumers

Consumer Groups

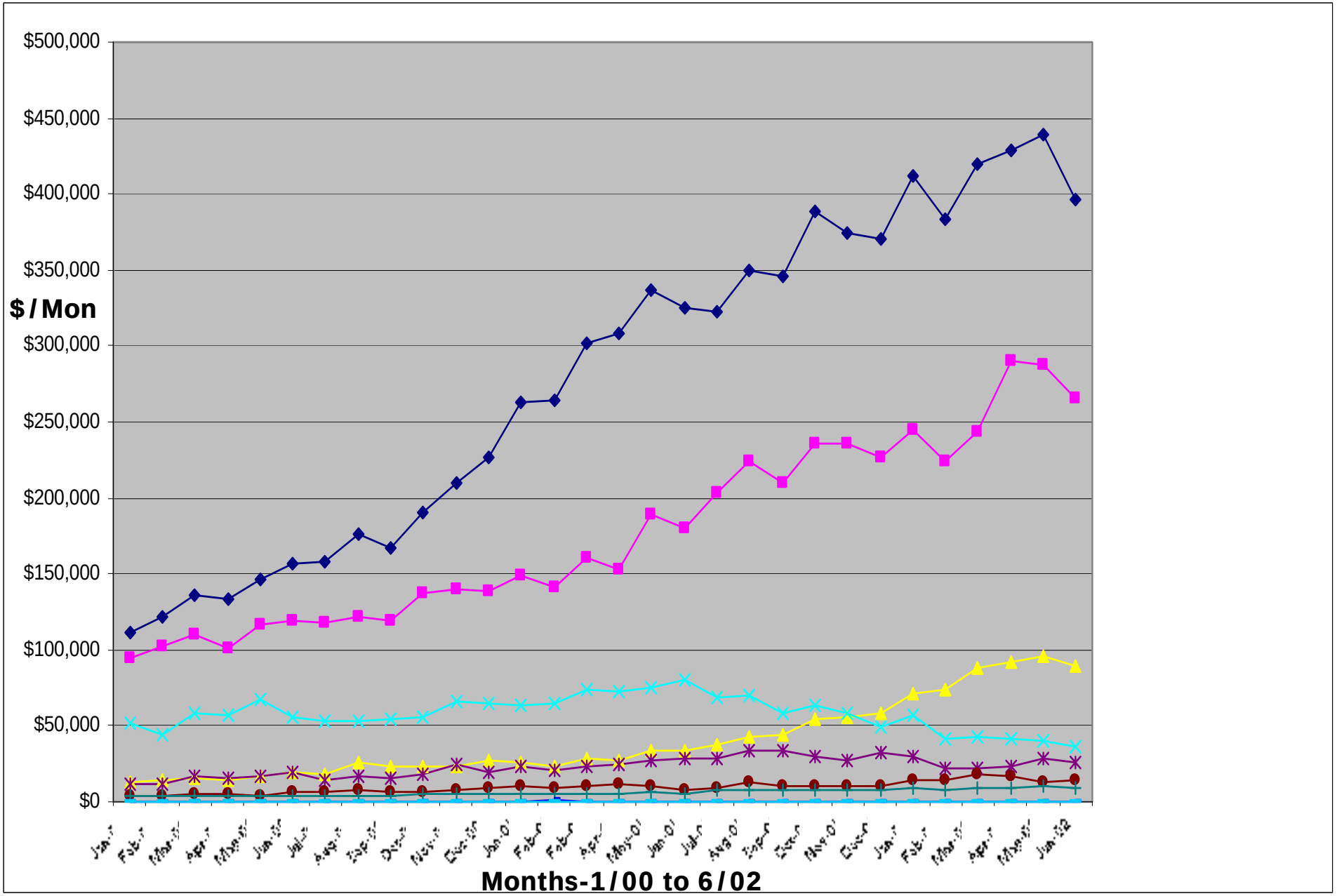
- Information to consumers.
  - Easily accessible
  - Just in time
  - Transparent
- Accountability.
  - Where are our $$$ going?
  - Safety
- Influence the research agenda.
  - If we don't insist on good information can we ever expect to get it?
- Access for the uninsured

“Perfect Competition”

- Homogeneity of product
- Perfect information
- Freedom of entry and exit
- Numerous small firms and customers

Microeconomics Principles and Policy, Baumol, W.J., and Binder A.S.

$$ Market share over 24 months—single Rx class



Opportunities

- Commonwealth
- Kaiser Family Foundation
- University of Washington

CENTER FOR EVIDENCE BASED POLICY
Globalizing Evidence, Localizing Decisions

Web Site

- Information, timelines, draft and final key questions, draft and final reports.
- **Public can comment on key questions and draft reports.**
- Contact information **www.ohsu.edu/drugeffectiveness**

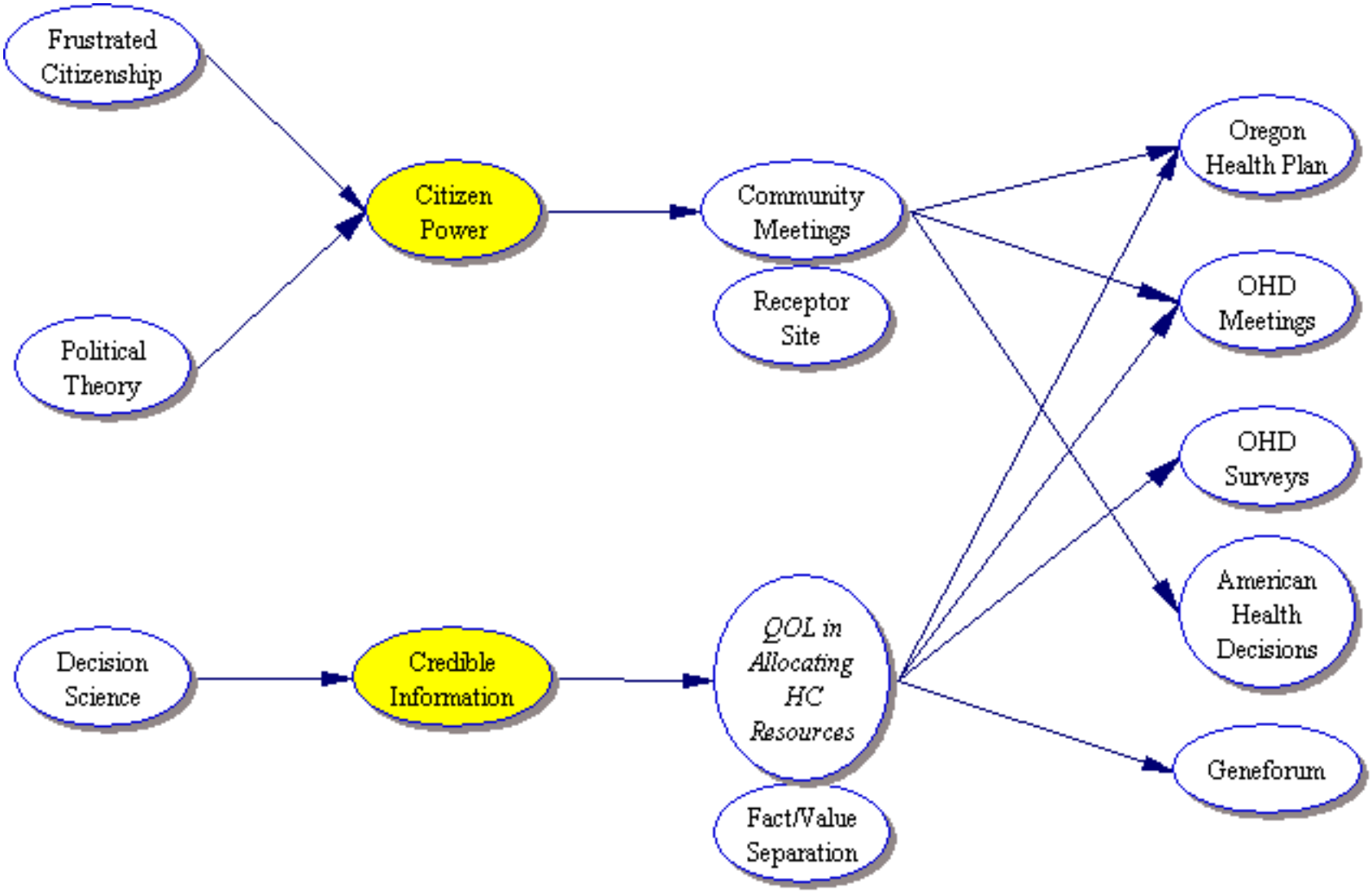
CENTER FOR EVIDENCE BASED POLICY
Globalizing Evidence, Localizing Decisions

More Information

- Project website at www.ohsu.edu/drugeffectiveness
- Email comments/questions regarding the Center to santaj@ohsu.edu
- Call John Santa at 503-494-2691 if questions regarding the Center or Project
- Follow local decision-makers websites
- Contact local decision-makers regarding information about their decision-making process

CENTER FOR EVIDENCE BASED POLICY
Globalizing Evidence, Localizing Decisions

The
OREGON HEALTH DECISIONS STORY


Frustrated Citizenship
Political Theory
Citizen Power
Community Meetings
Receptor Site
Oregon Health Plan
OHD Meetings
OHD Surveys
American Health Decisions
Geneforum
Decision Science
Credible Information
QOL in Allocating HC Resources
Fact/Value Separation

Frustrated Citizenship

1982. Soon after Ralph Crawshaw had been appointed head of the Oregon Statewide Health Coordinating Council, it became clear that the Council alone could do little against entrenched interests about high health care costs and *de facto* rationing. The Council turned to the public.

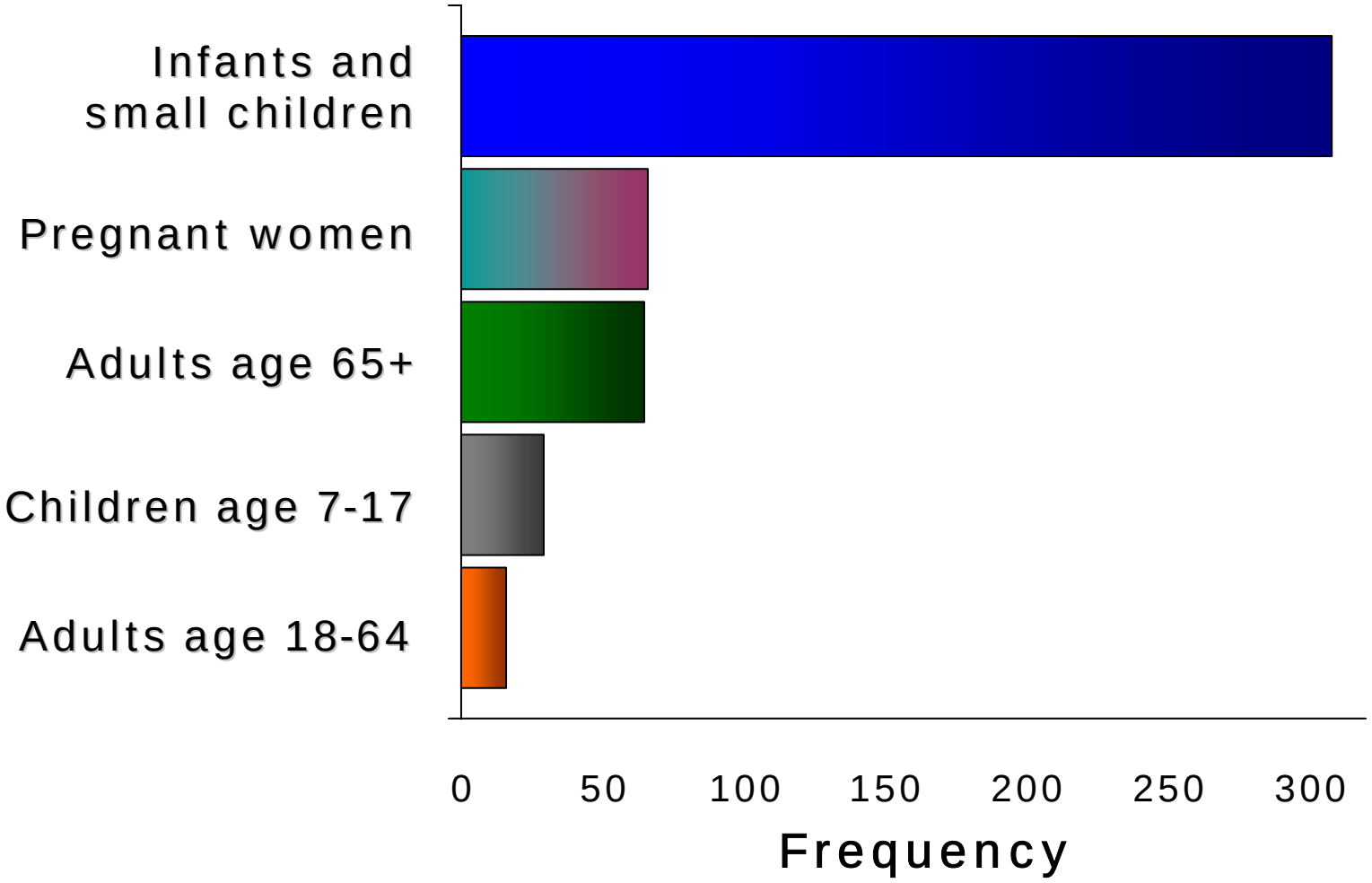
Political Theory

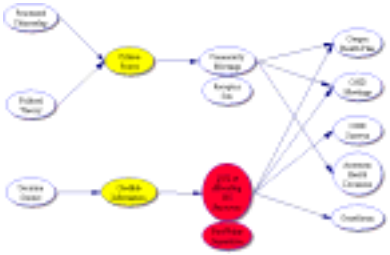
Mike Garland added to Crawshaw's experience an ethical foundation based in part on Benjamin Barber's theory of strong democracy.

Decision Science

Barry Anderson introduced fact-value separation and other decision science concepts to help define the proper roles of public values and scientific expertise.

Which group should be first priority?





QOL in Allocating Health Care Resources

1988. These strands were brought together at a Health Care Parliament, chaired by Mitch Greenlick, and published as a booklet of principles (copies available after the presentation).

The Oregon Health Plan

1989. John Kitzhaber saw these principles incorporated into law as the requirement to prioritize health services on the basis of values obtained from community meetings.

American Health Decisions

OHD was an Oregon first. Soon, similar organizations sprang up in other states and in other countries, and the various state organizations came together as AHD.

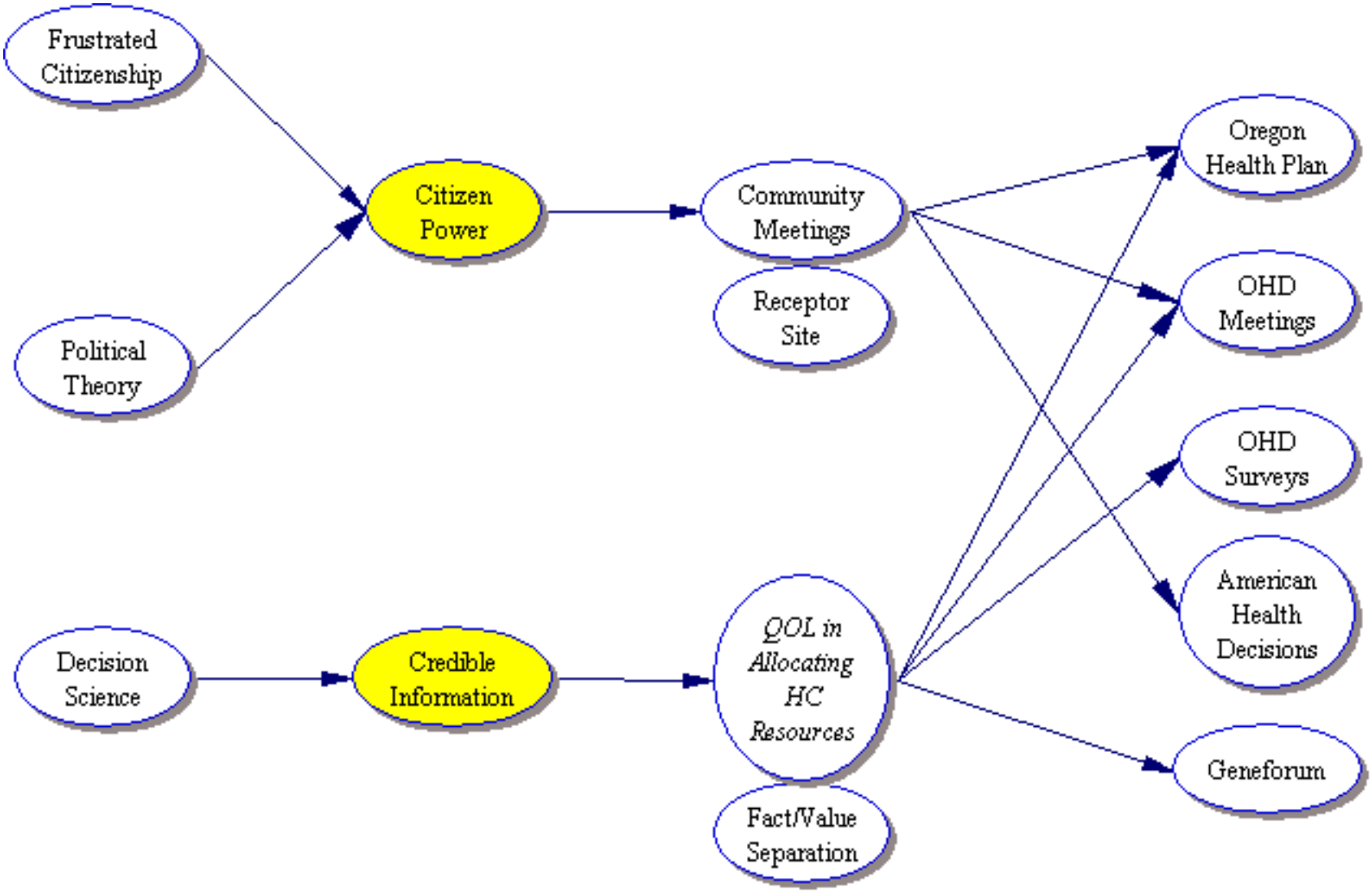
OHD
Meetings & Surveys

The ideal OHD meeting involves:

- A prepared *"receptor site"*
- *Hosting* by a respected local leader
- *Assurance* that what is said at the meeting will be transmitted to the "receptor site" for use in decision making.
- *Fact-value* separation.
- A *"graffiti wall"* to help participants keep track of the questions and their ideas and to edit what will be forwarded to the "receptor site".

Geneforum

Greg Fowler established Geneforum, an OHD spin-off dedicated to informing the public and its representatives about genetic science and obtaining public value judgments for use in decision making. Geneforum employs Web site interactives, surveys, and talks more than community meetings.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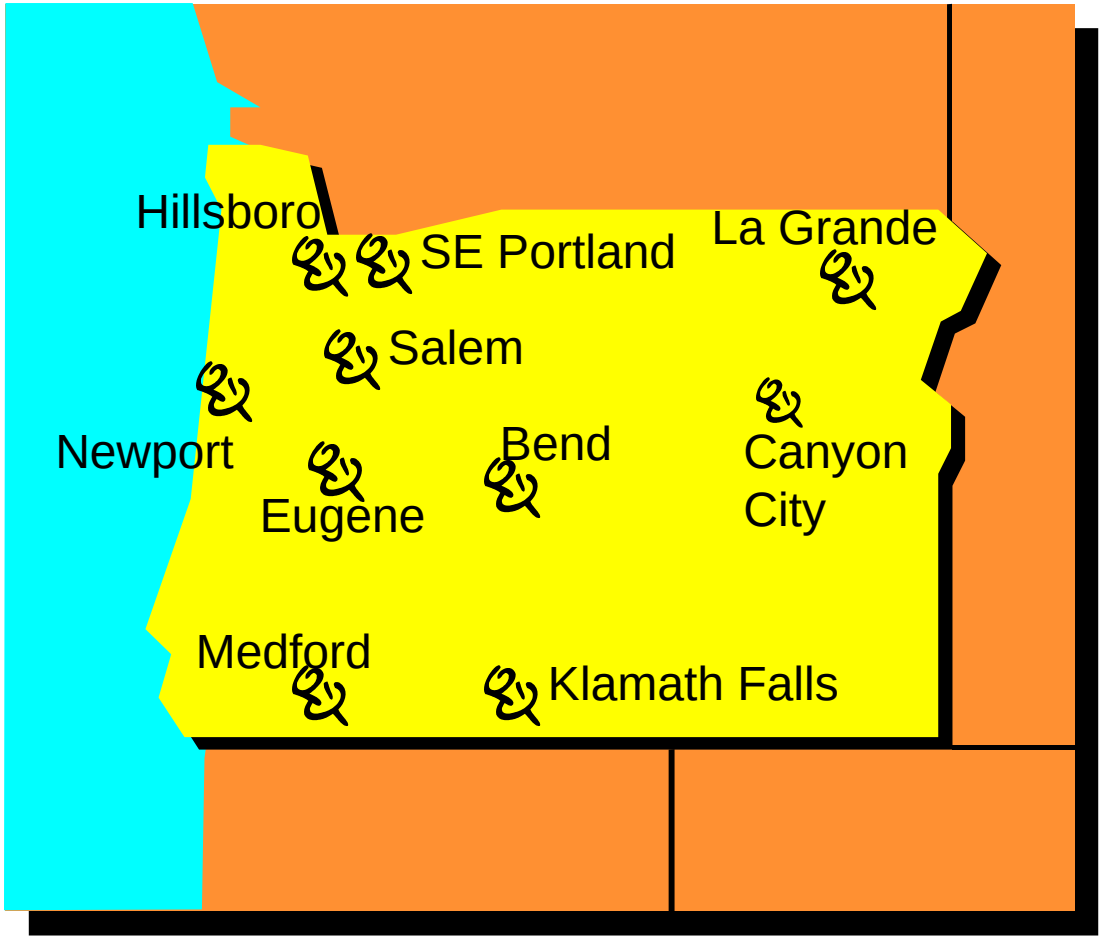
Oregon Health Policy Commission:

Community Forums, Sept. 2004

Elizabeth Baxter

OHREC, November 16, 2004

Sites



Participants came from these counties:

Benton	Lincoln
Clackamas	Malheur
Deschutes	Marion
Gilliam	Multnomah
Grant	Polk
Harney	Umatilla
Lane	Union
Klamath	Wallowa
Jackson	Washington
Josephine	Yamhill

Health Care Costs:

In 2003:

- 20 million American families had problems paying medical bills
- Two-thirds of those families had health insurance coverage.

Tough Trade-offs: Medical Bills, Family Finances and Access to Care; Issue Brief No. 85; June 2004; Jessica H. May, Peter J. Cunningham

Discussion: Controlling Cost

CONCERNS

- The ‘System’ (administrative cost, cost-shift, reimbursement constraints, ‘defensive medicine’)
- Services (drugs, technology)
- Changes in populations (aging, chronic conditions)

SOLUTIONS

- Control drug costs/advertising
- Regulate insurer rate increases
- Tort reform
- Fund/reimburse prevention and health education

Access

- Of those without insurance:
  - Almost half postpone seeking care because of costs
  - More than a third need care but did not get it
- Challenges –
  - Geography
  - Workforce shortages
  - Less populated areas

Kaiser Commission on Medicaid and the Uninsured; Access to Care for the Uninsured: An Update, Sept. 2003

Discussion: Ensuring Access

CONCERNS

- Workforce shortages
- Barriers to access (geographic, transportation, uninsurance, language, culture, immigration status)
- Changes to OHP

SOLUTIONS

- Broaden scopes of practice
- Improve reimbursement
- Provide incentives for providers to practice in rural areas

Quality

"just because outstanding care is available does not mean that it is always provided or that everyone has access to that care"

Institute of Medicine, Crossing the Quality Chasm: A New Health System for the 21st Century. (2001)

Discussion: Increasing Quality

CONCERNS

- The ‘System’ (Accountability, inefficiencies, inconsistent definitions of quality, inadequate workforce to ensure quality)

SOLUTIONS

- Public information about quality measures
- Communication tools – technology and team
- Publicly available Information on cost
- Reduce administrative burdens
- Increase use of evidence-based practices

Health Status

- One third of deaths in Oregon can be attributed to these 3 behaviors:
  - Tobacco use
  - Lack of physical activity
  - Poor eating habits

Discussion: Improving Health

CONCERNS

- Education
- Nutrition
- Tobacco
- Individual responsibility

SOLUTIONS

- Schools to provide physical education, health education
- Eliminate or regulate vending machines / fast food in schools
- Reimbursement for prevention/health education

Lessons Learned:

- Know what you want to learn – focus.
- Only ask for information that you will use.
- Give feedback about what happens with their input
- Build on credibility; continue the dialogue.

Health Values Survey 2004

Oregon Health Decisions

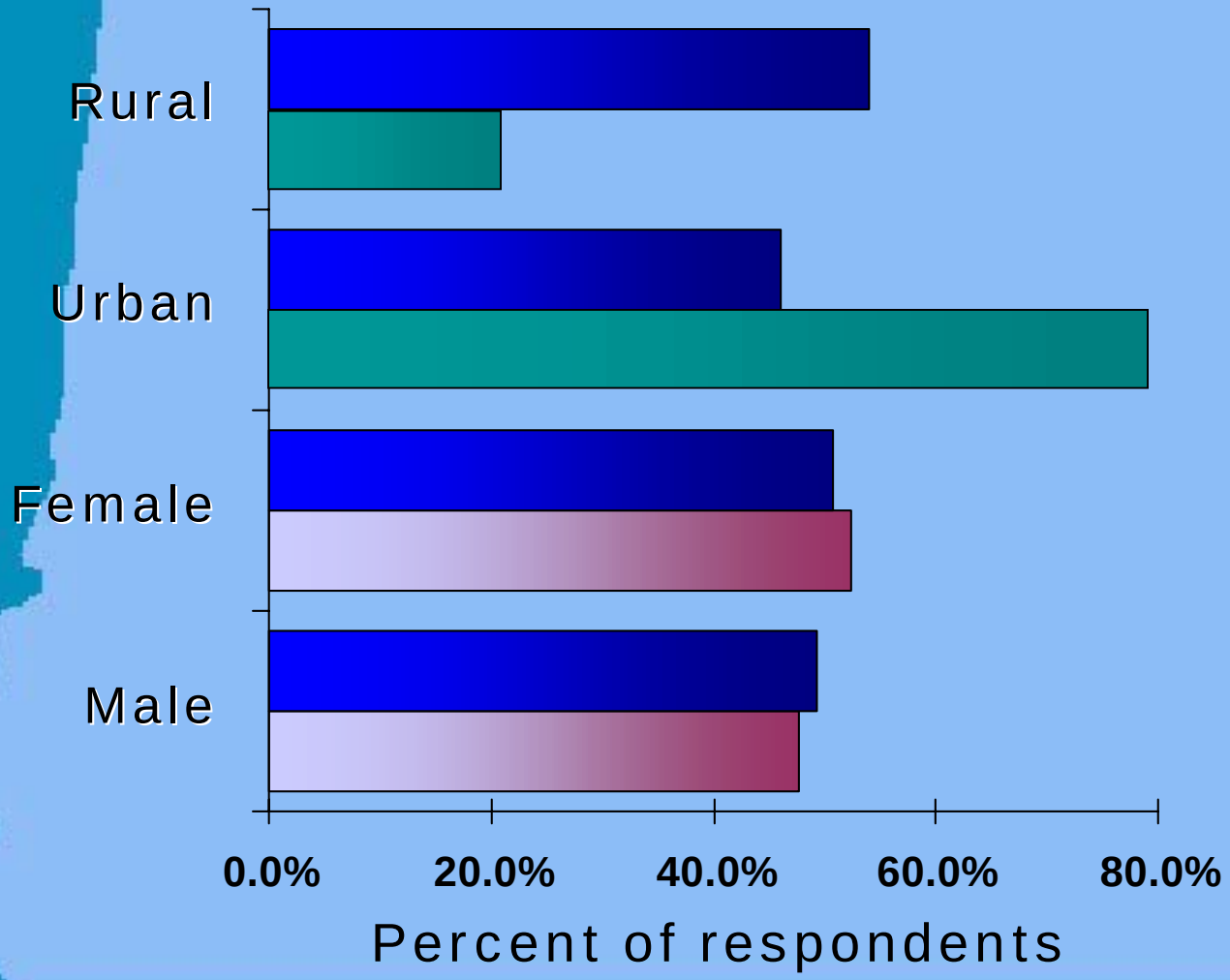
Survey FAQs

- What type of survey?
  - Computer-assisted telephone interview (randomly dialed)
- How many people?
  - 531
- Is that enough people?
  - Representative sample of the entire state
  - Maximum standard error: ± 2.17% (1.96*SE= ± 4.25%)
  - Maximum pooled SE for 2000 and 2004: ± 2.73% (1.96*SE= ± 5.35%)

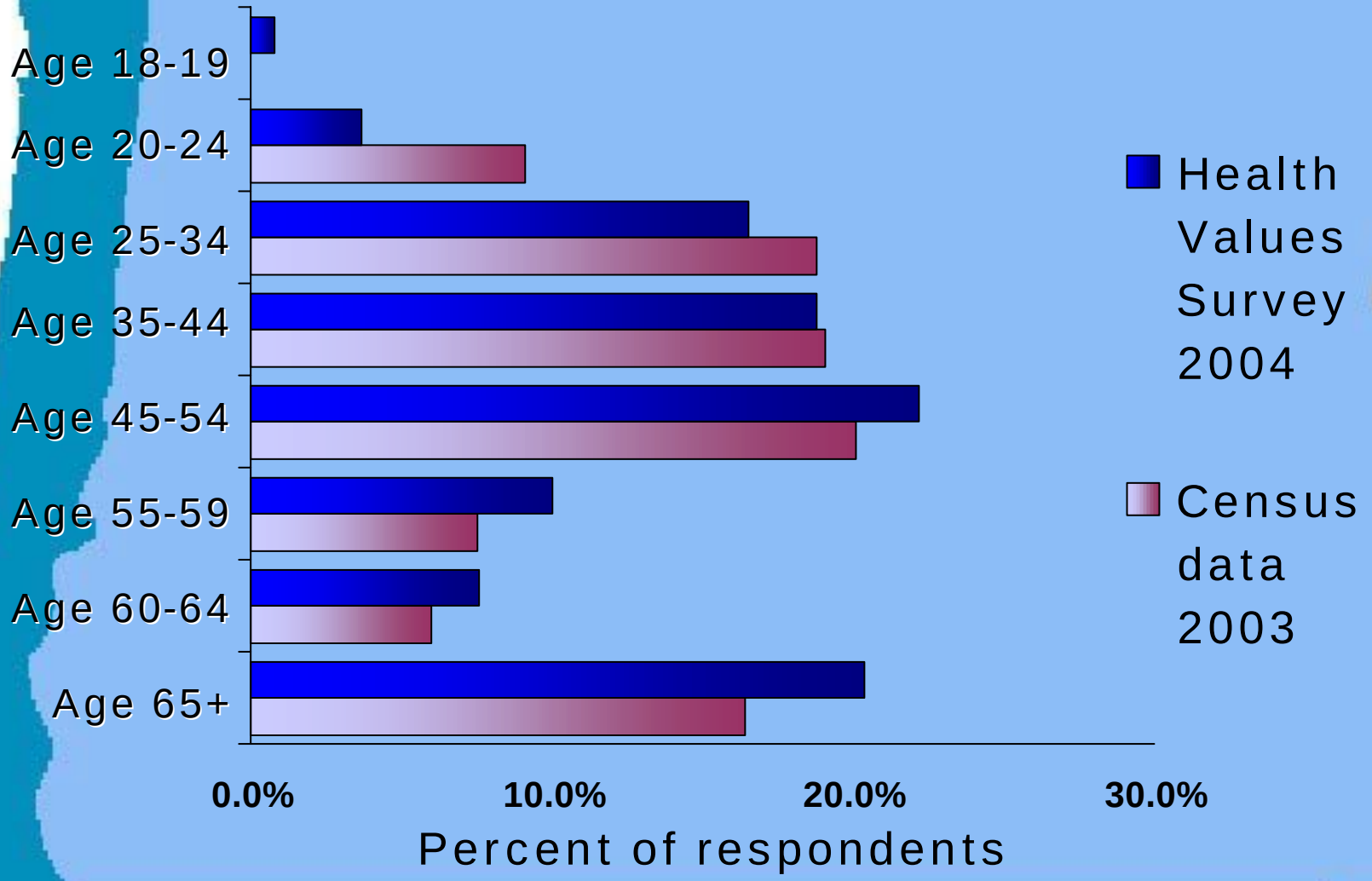
Data analysis

- SAS 9.1
  - Survey Frequencies procedure (aka "proc surveyfreq")
    - Incorporates 9 strata (region)
    - Applies survey weights
    - Calculates chi-square statistics
      - SE is weighted by stratum
    - Does not calculate exact tests
- SPSS 12.0.0
  - Non-parametric tests
    - P-values may be slightly higher
    - Not enough to alter conclusions

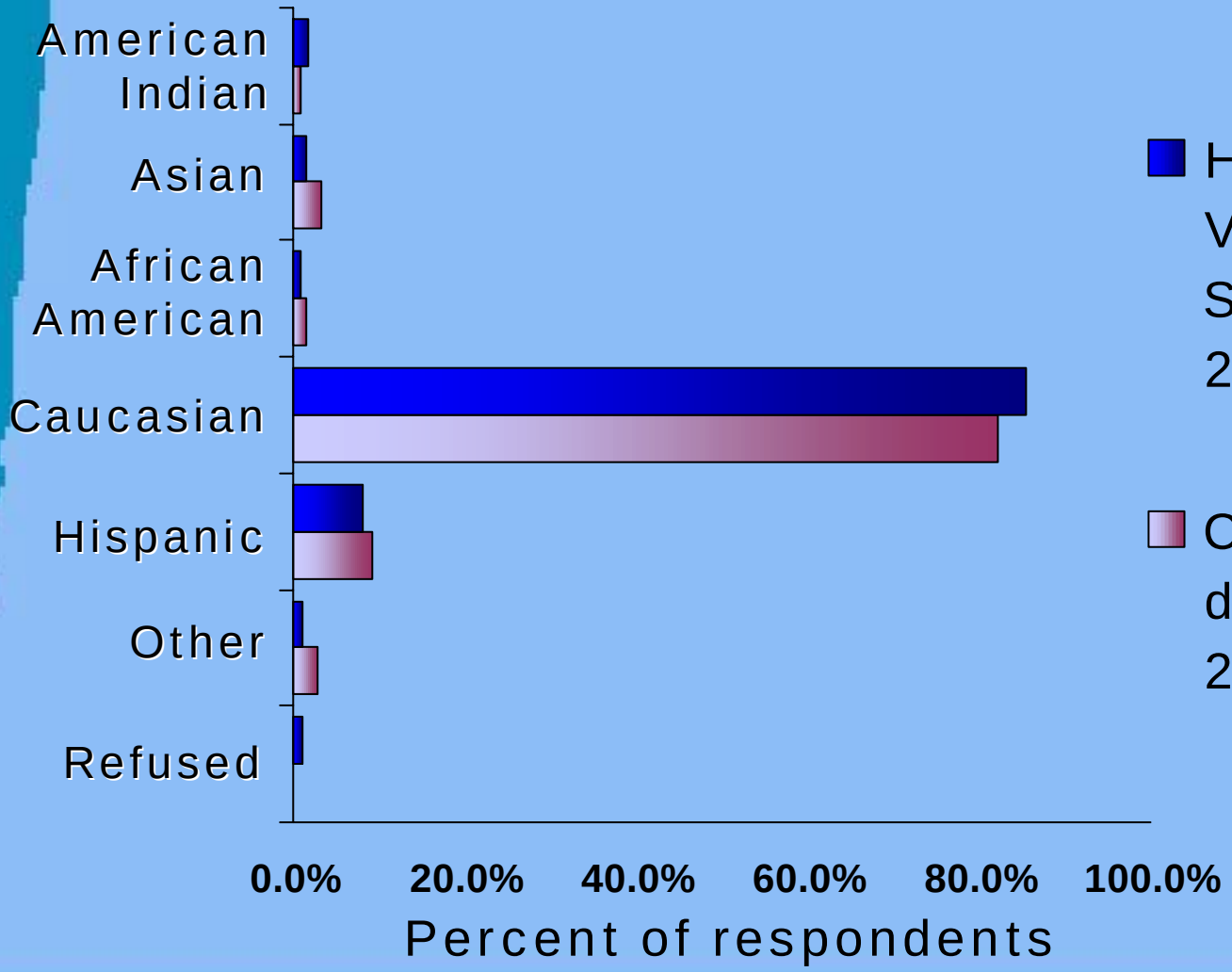
Demographics



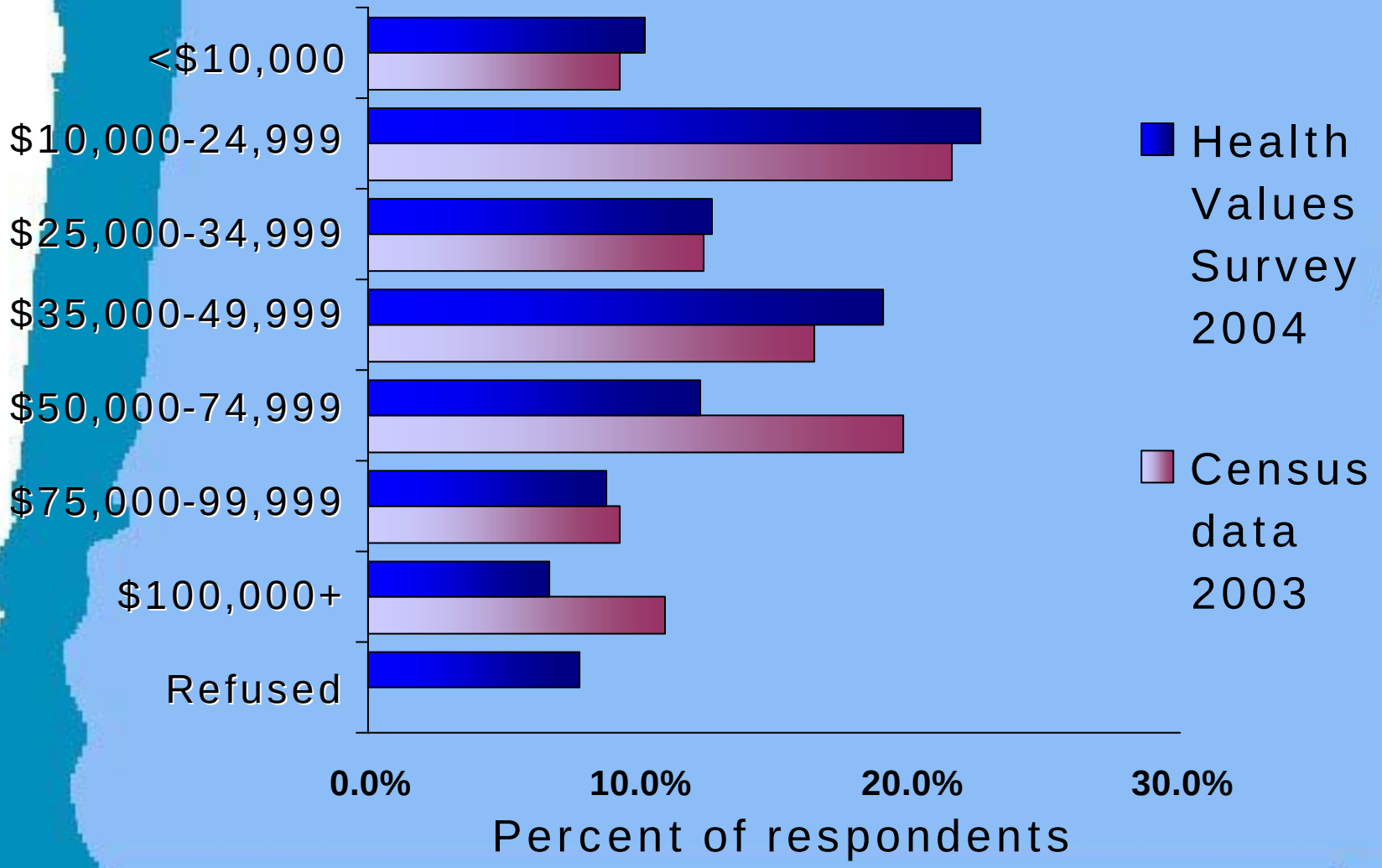
Age group


Age 18-19
Age 20-24
Age 25-34
Age 35-44
Age 45-54
Age 55-59
Age 60-64
Age 65+
0.0%
10.0%
20.0%
30.0%
Percent of respondents
Health Values Survey 2004
Census data 2003

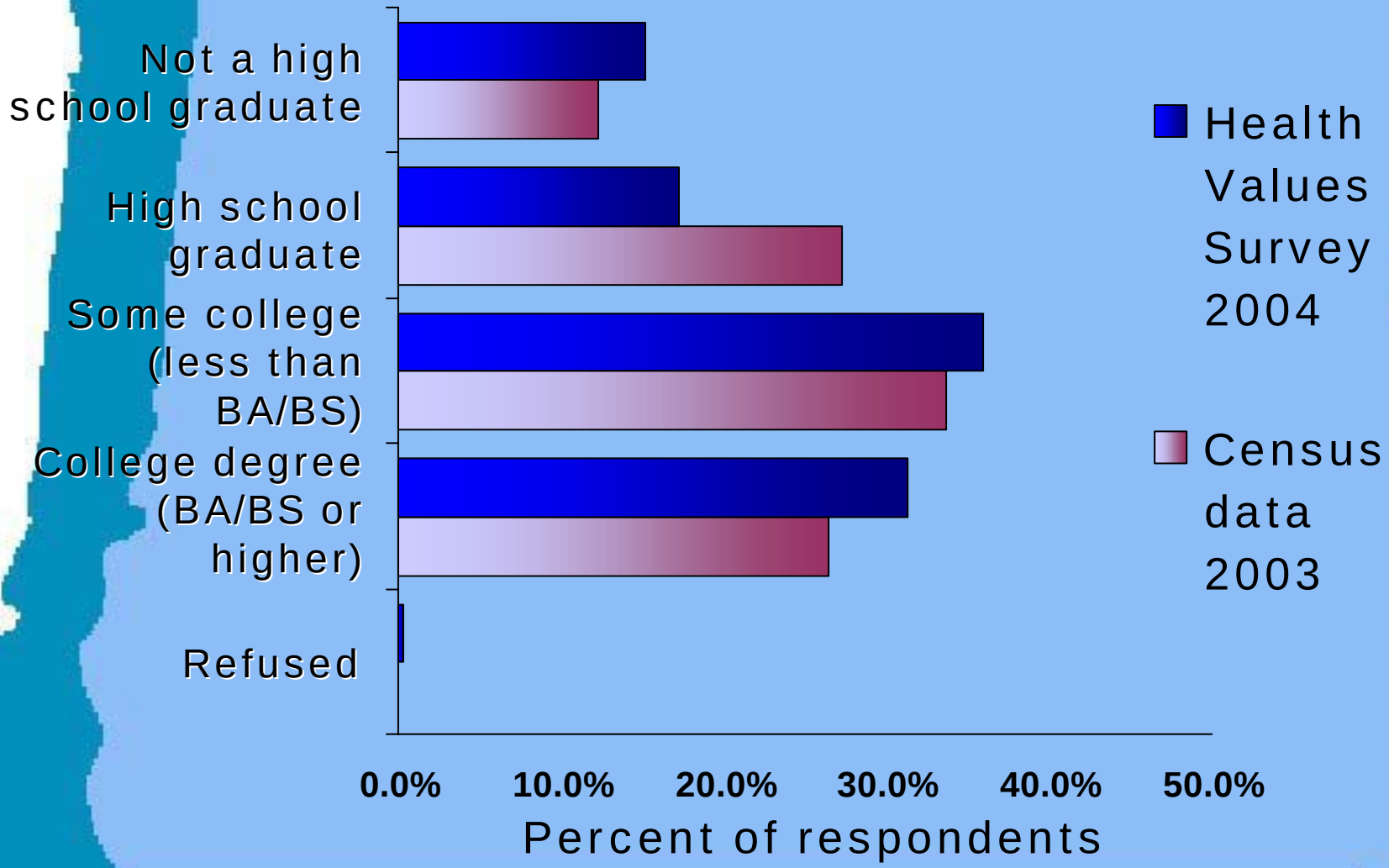
Ethnicity


American Indian
Asian
African American
Caucasian
Hispanic
Other
Refused
Health Values Survey 2004
Census data 2003
0.0%
20.0%
40.0%
60.0%
80.0%
100.0%
Percent of respondents

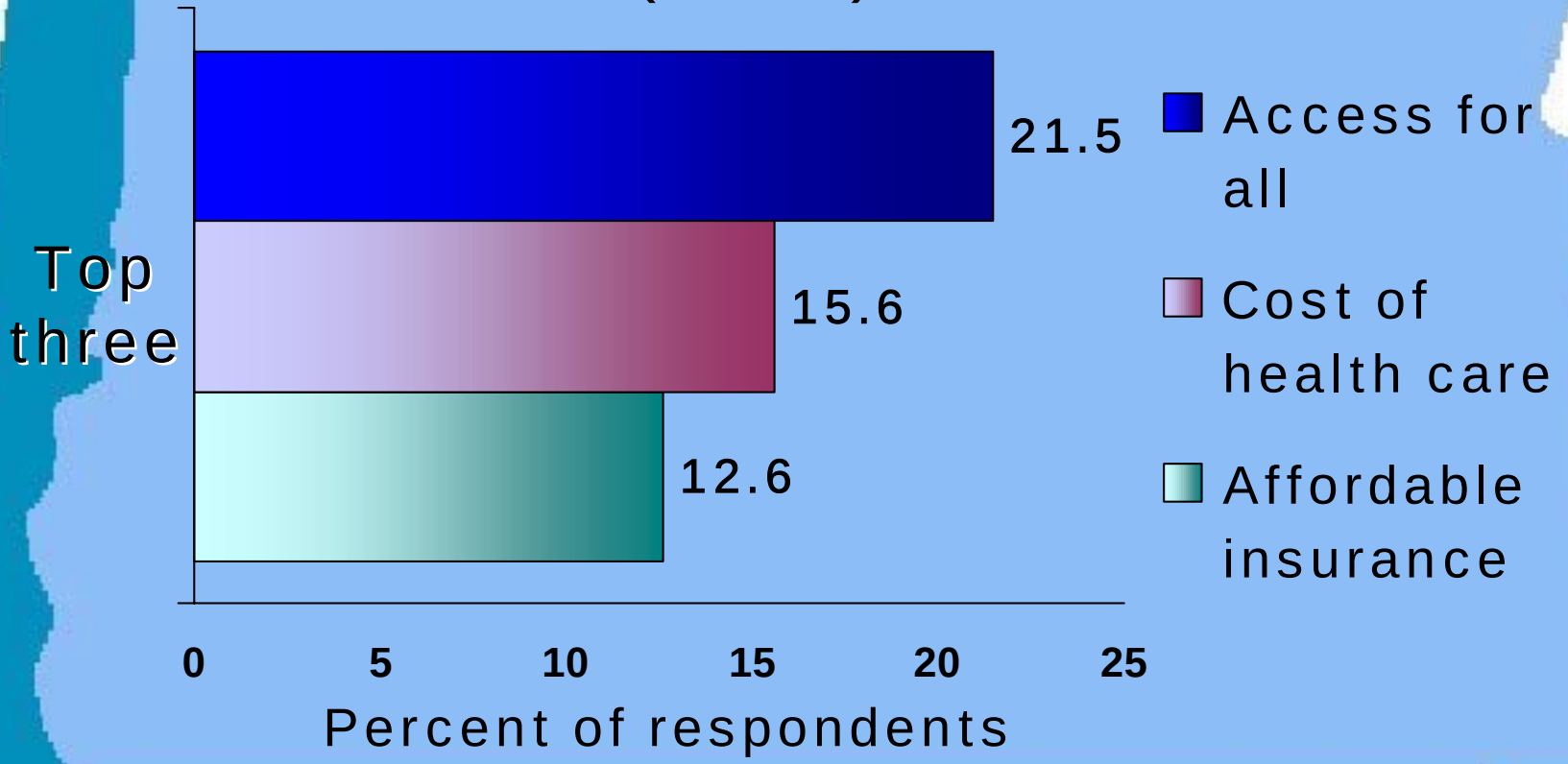
Household income



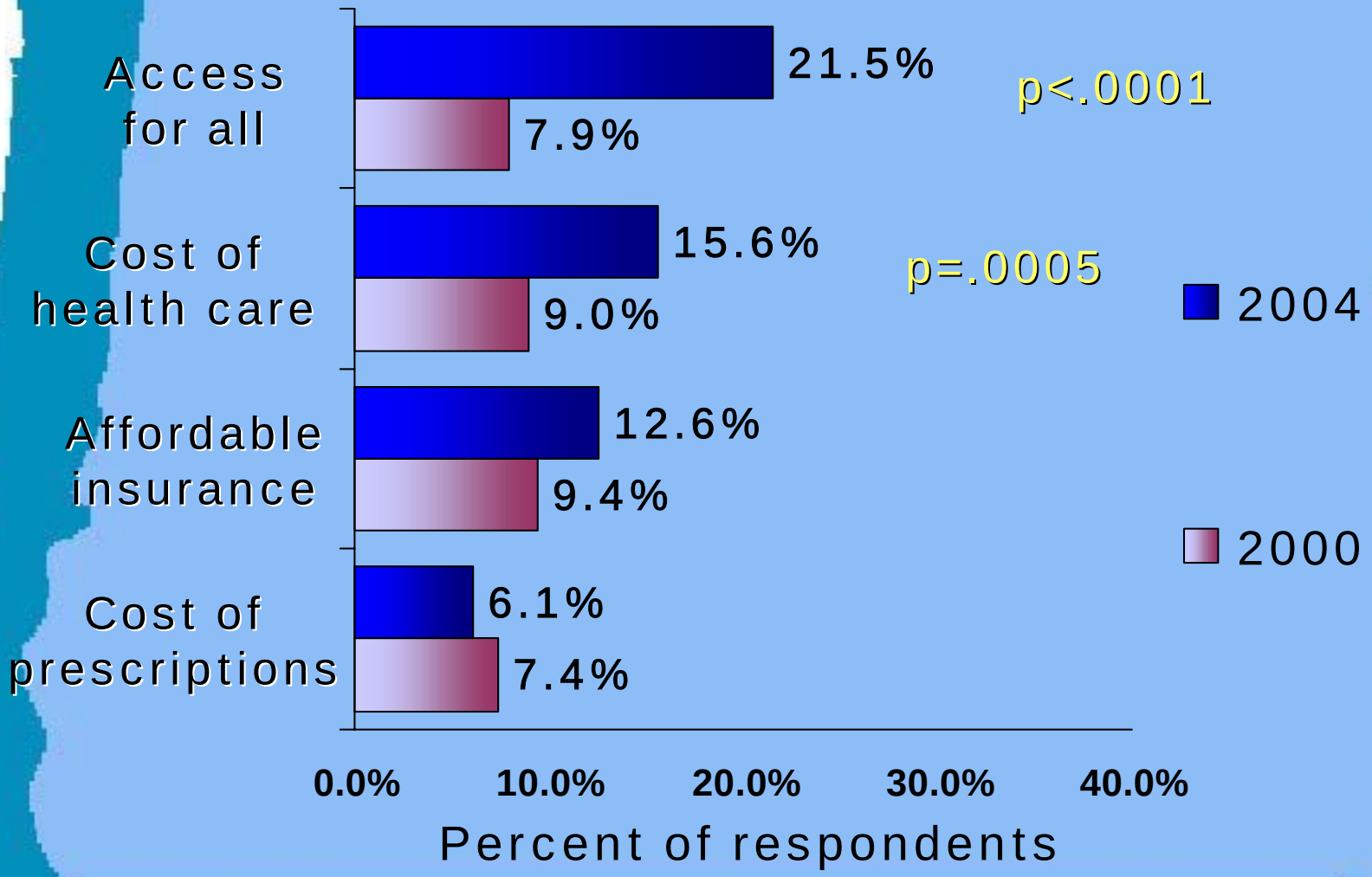
Education


Not a high school graduate
High school graduate
Some college (less than BA/BS)
College degree (BA/BS or higher)
Refused
Health Values Survey 2004
Census data 2003
0.0%
10.0%
20.0%
30.0%
40.0%
50.0%
Percent of respondents

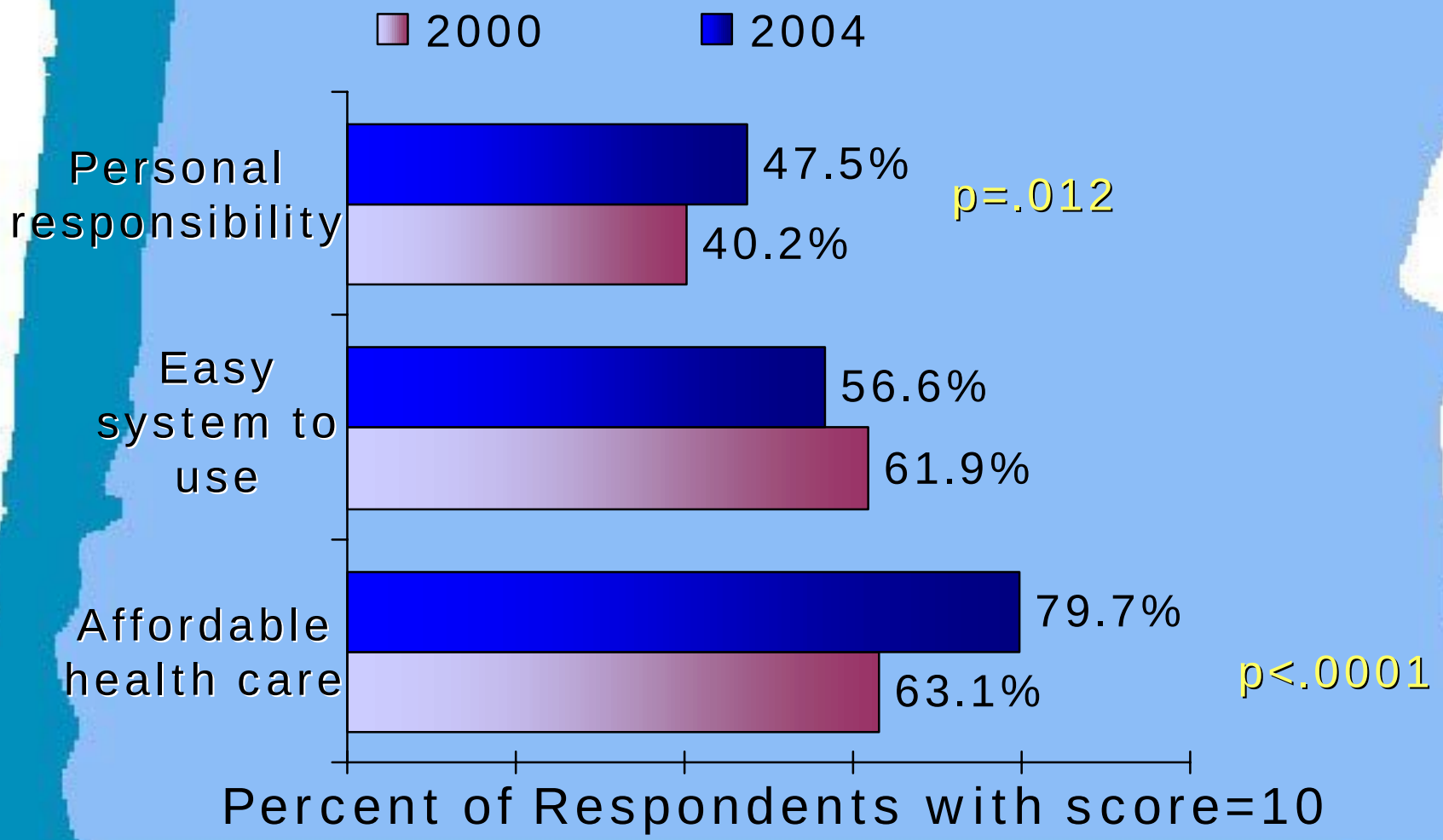
In general, when you think about health care in Oregon, what is the number one problem that needs to be solved? (2004)



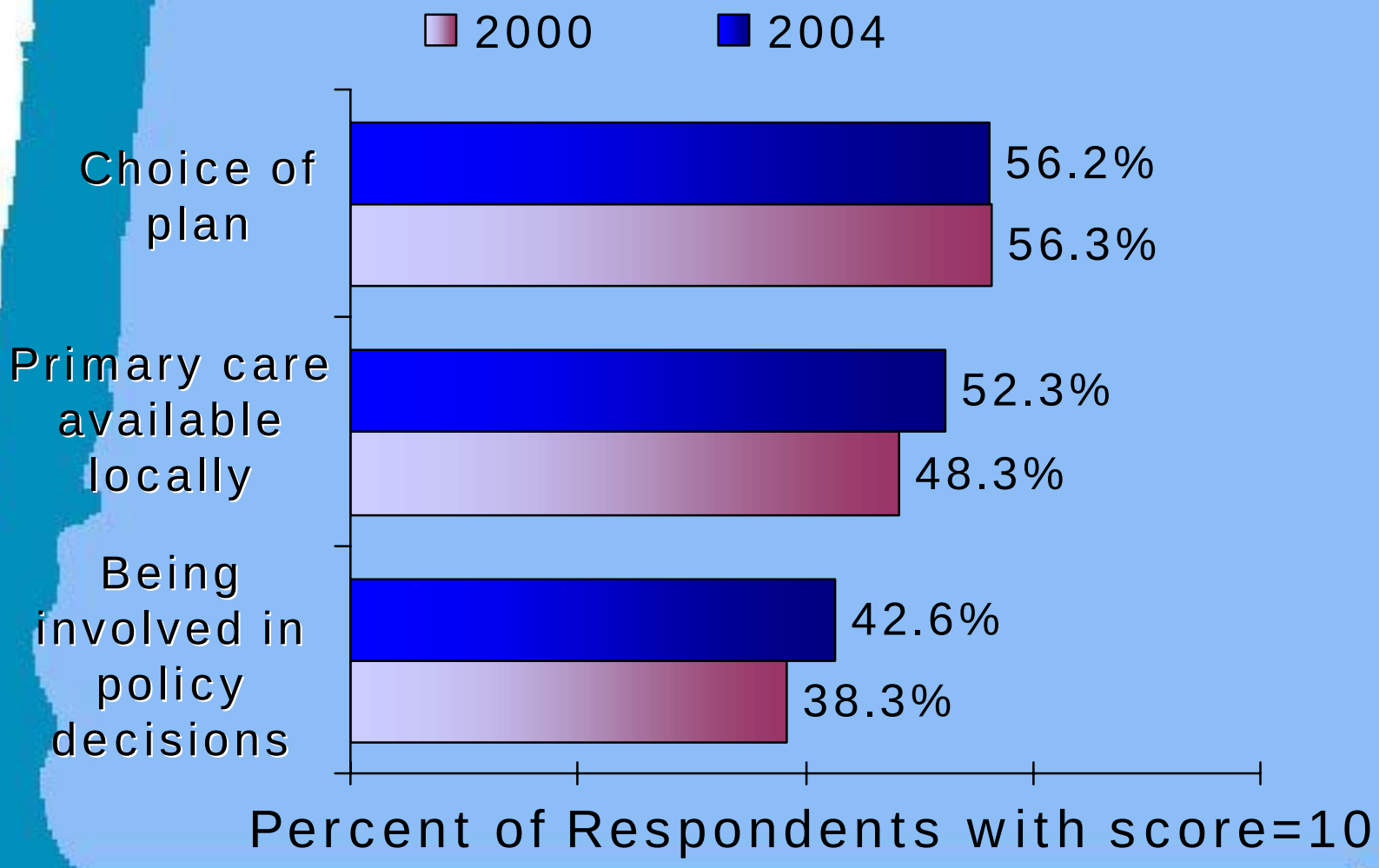
2000 vs. 2004


Access for all
21.5%
7.9%
p<.0001
Cost of health care
15.6%
9.0%
p=.0005
Affordable insurance
12.6%
9.4%
Cost of prescriptions
6.1%
7.4%
2004
2000
0.0%
10.0%
20.0%
30.0%
40.0%
Percent of respondents

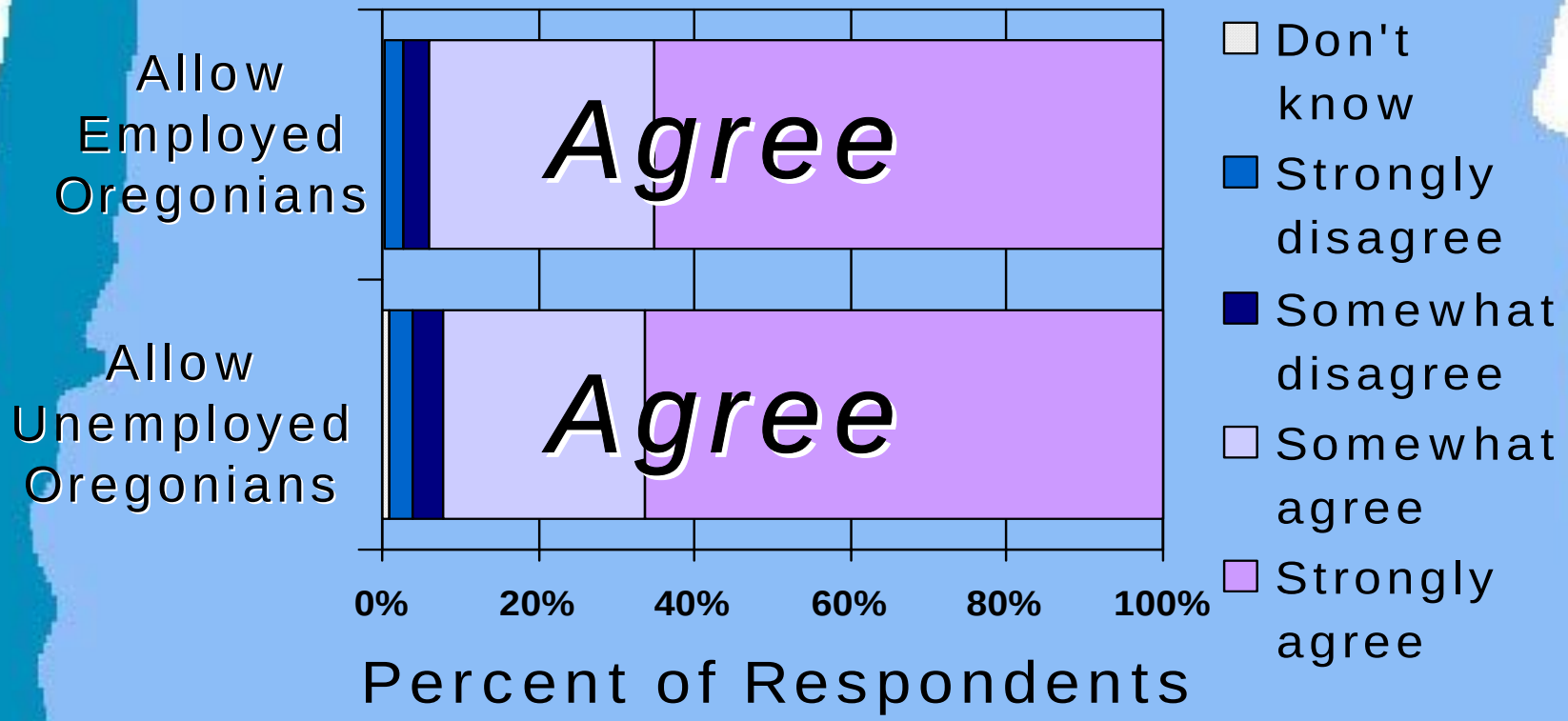
Importance (10 pt scale)



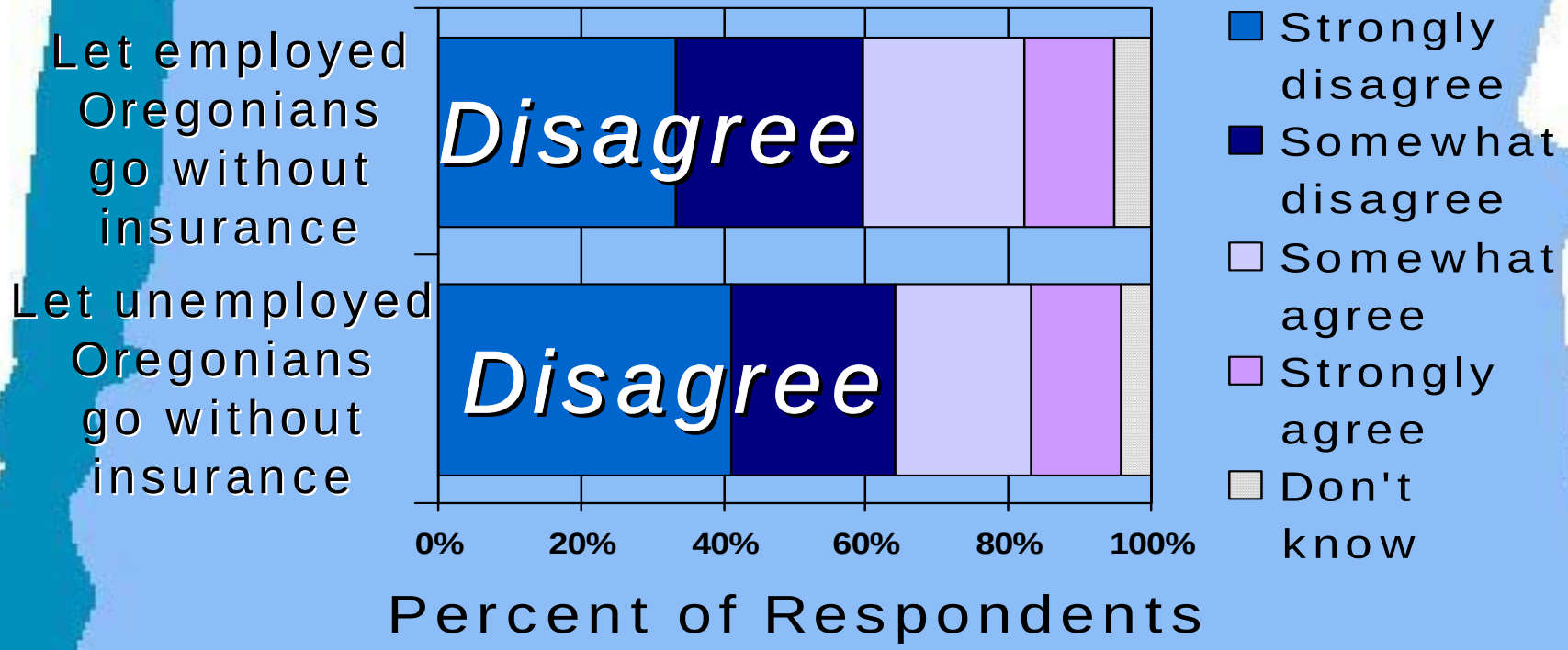
Importance (10 pt scale)



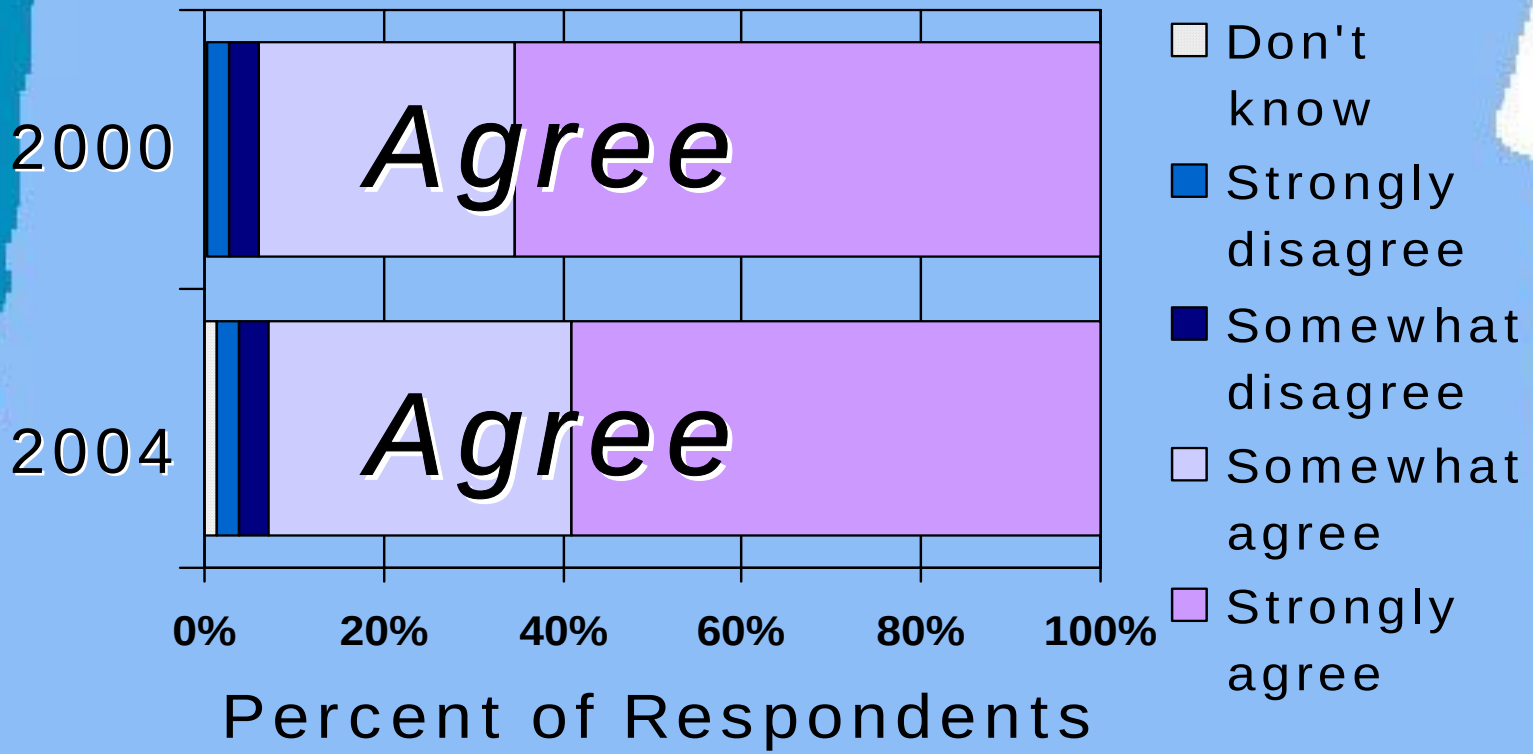
Let uninsured Oregonians use public health care plans with sliding scale payment (2004)



Let uninsured Oregonians go without health insurance-- use ER if needed (2004)



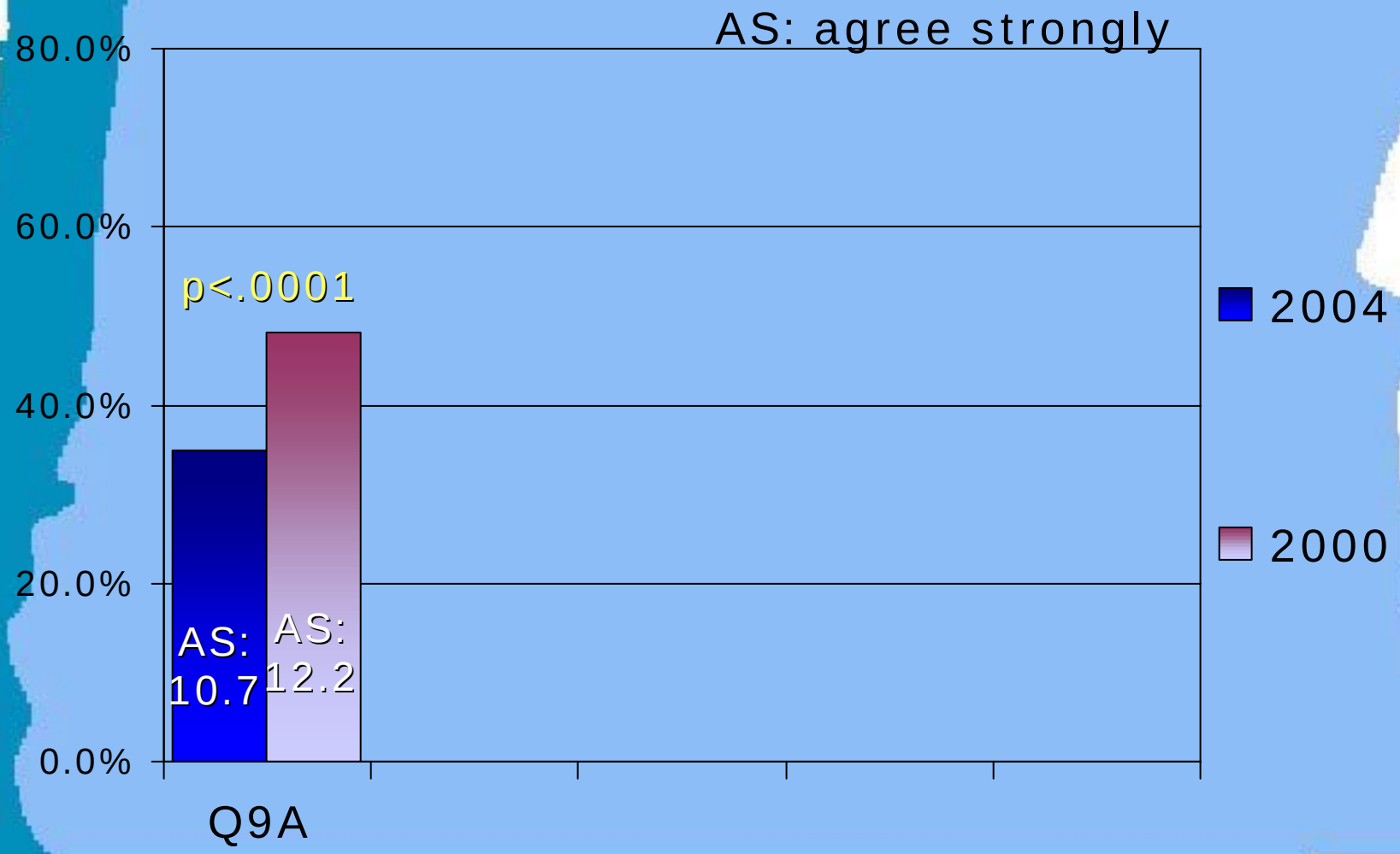
Let employed Oregonians use public health care plans with sliding scale payment



2000 vs. 2004

Q9A: The Oregon Health Plan should pay for experimental treatments that seem promising even though they have not been proven to be effective.

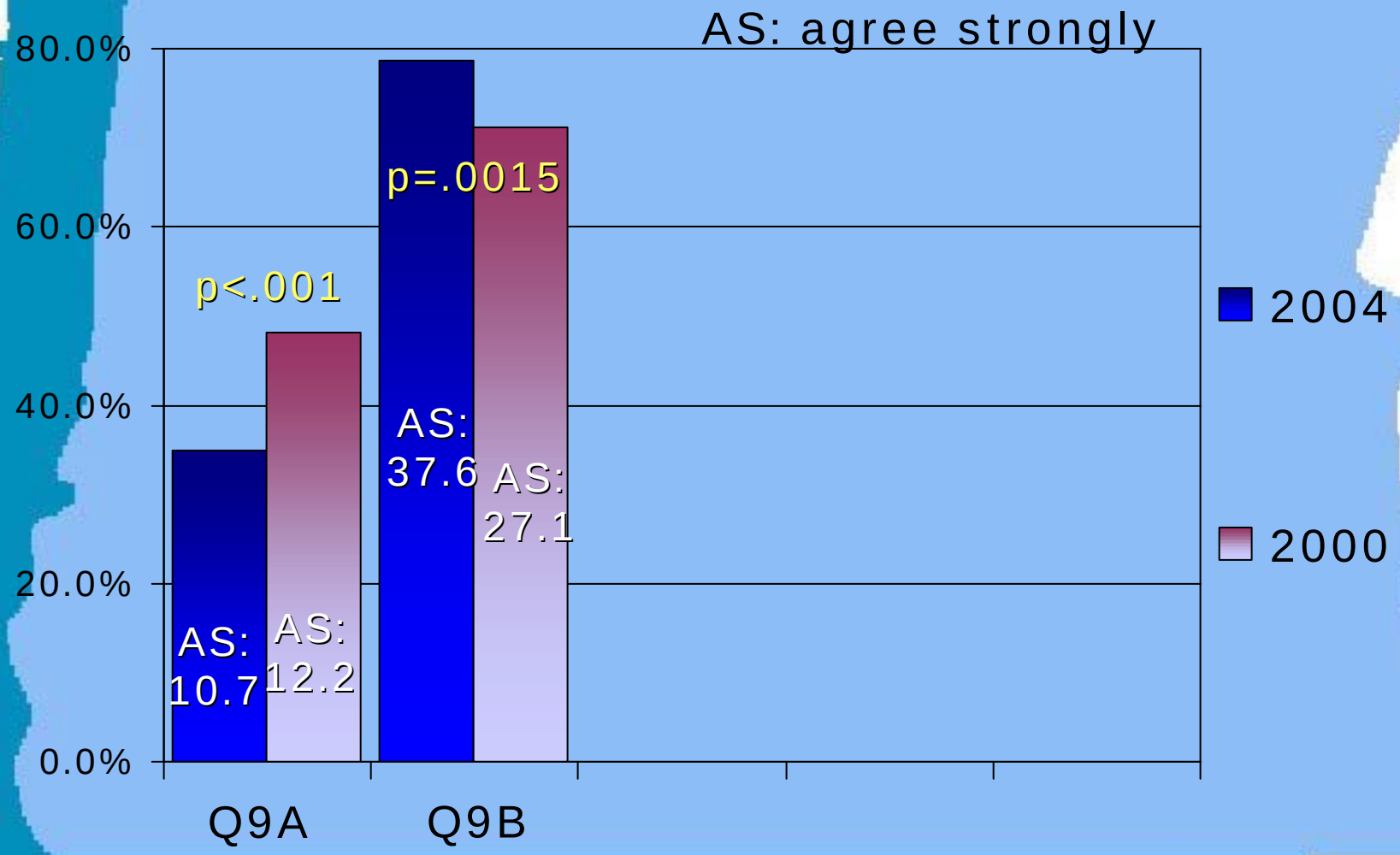
2000 vs. 2004


AS: agree strongly
80.0%
60.0%
40.0%
20.0%
0.0%
p<.0001
AS: 10.7
AS: 12.2
Q9A
2004
2000

2000 vs. 2004

Q9B: When money is limited for the Oregon Health Plan, leaders should reduce services but keep as many people as possible in the program.

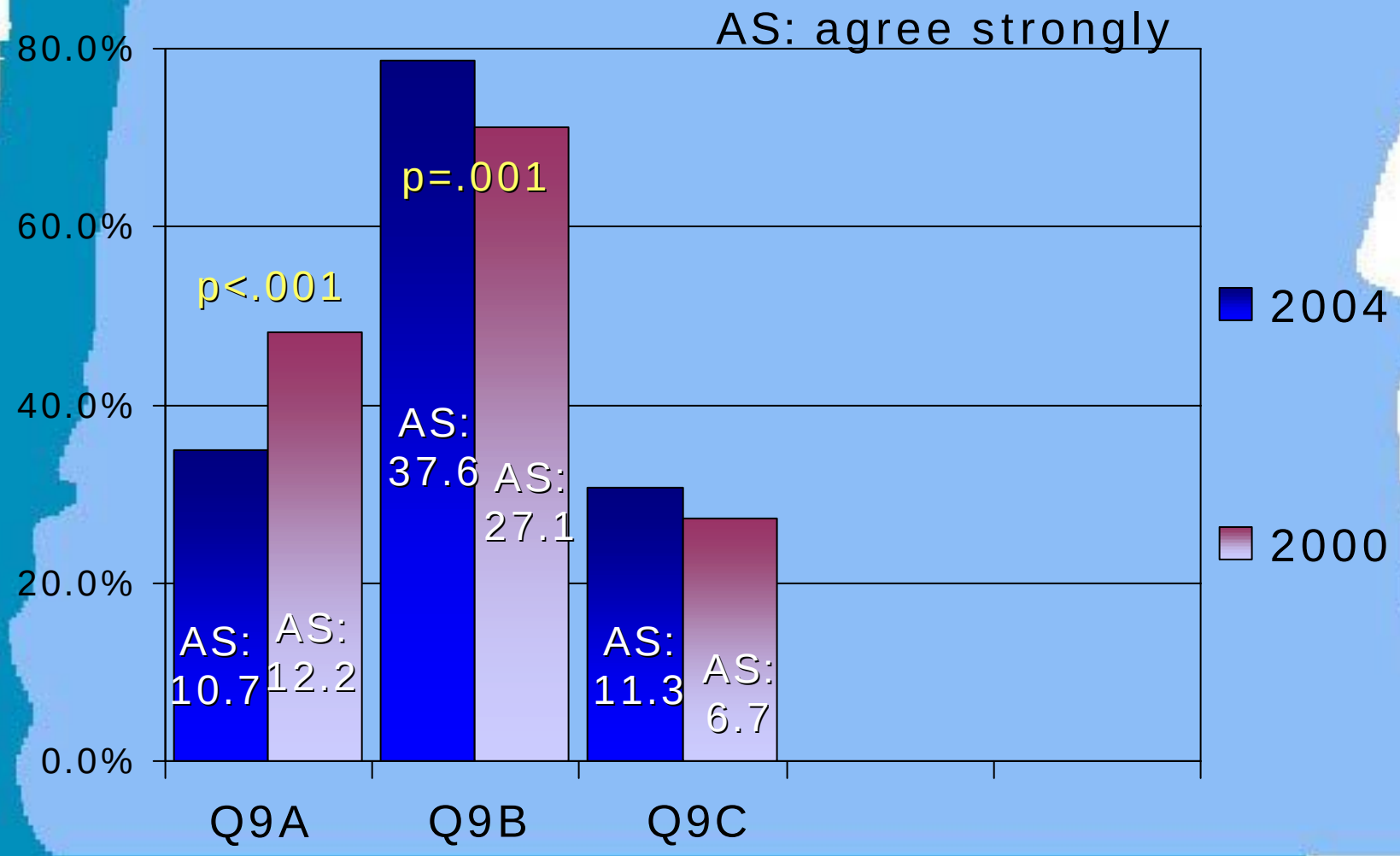
2000 vs. 2004


AS: agree strongly
80.0%
60.0%
40.0%
20.0%
0.0%
p<.001
p=.0015
AS: 10.7
AS: 12.2
AS: 37.6
AS: 27.1
Q9A
Q9B
2004
2000

2000 vs. 2004

Q9C: When money is limited for the Oregon Health Plan, leaders should keep the full set of services and reduce the number of people in the program.

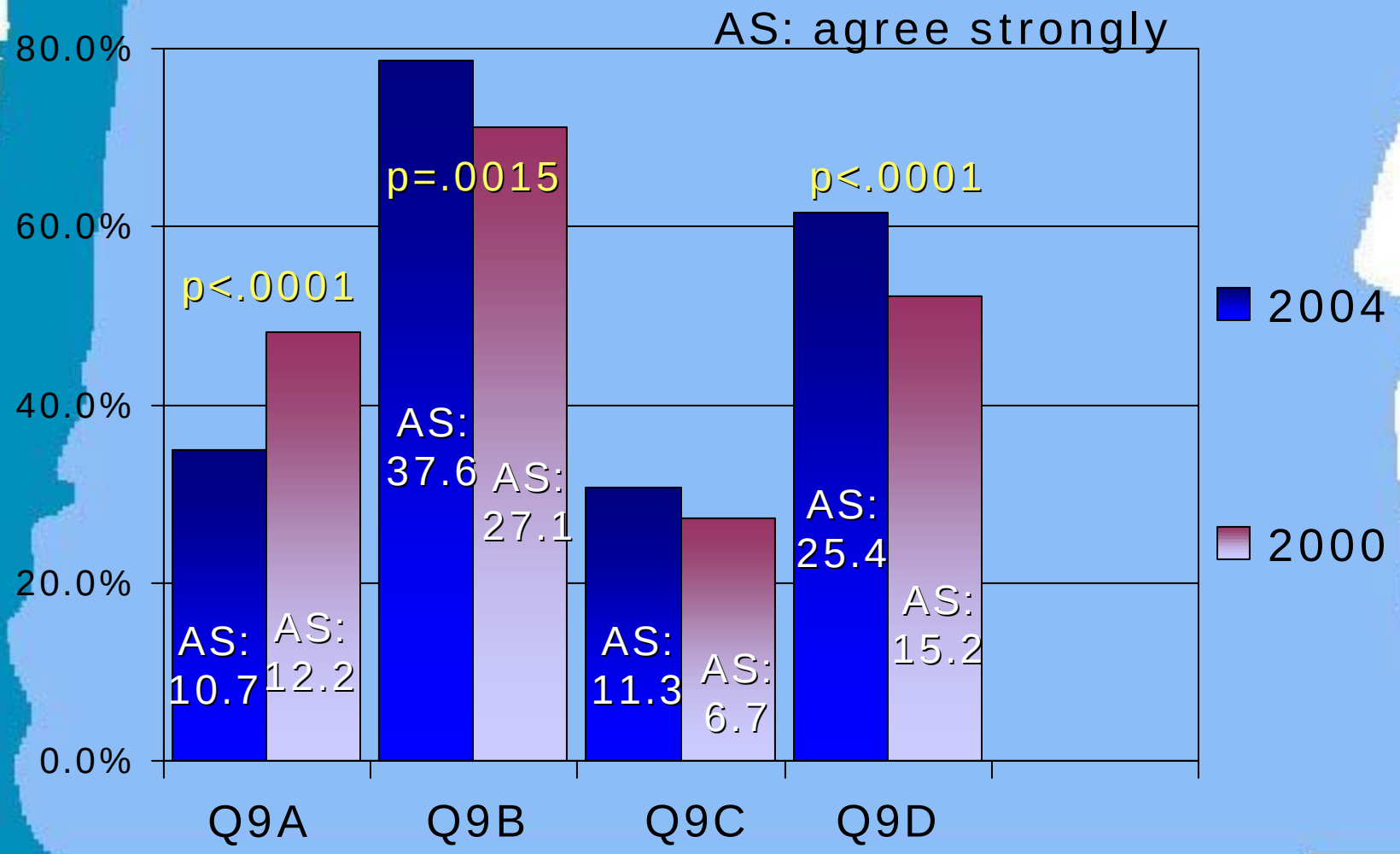
2000 vs. 2004


AS: agree strongly
80.0%
60.0%
40.0%
20.0%
0.0%
p<.001
p=.001
AS: 10.7
AS: 12.2
AS: 37.6
AS: 27.1
AS: 11.3
AS: 6.7
Q9A
Q9B
Q9C
2004
2000

2000 vs. 2004

Q9D: The Oregon Health Plan should pay for services provided to the sickest individuals first. Those with mild forms of treatable conditions may not have treatments paid for.

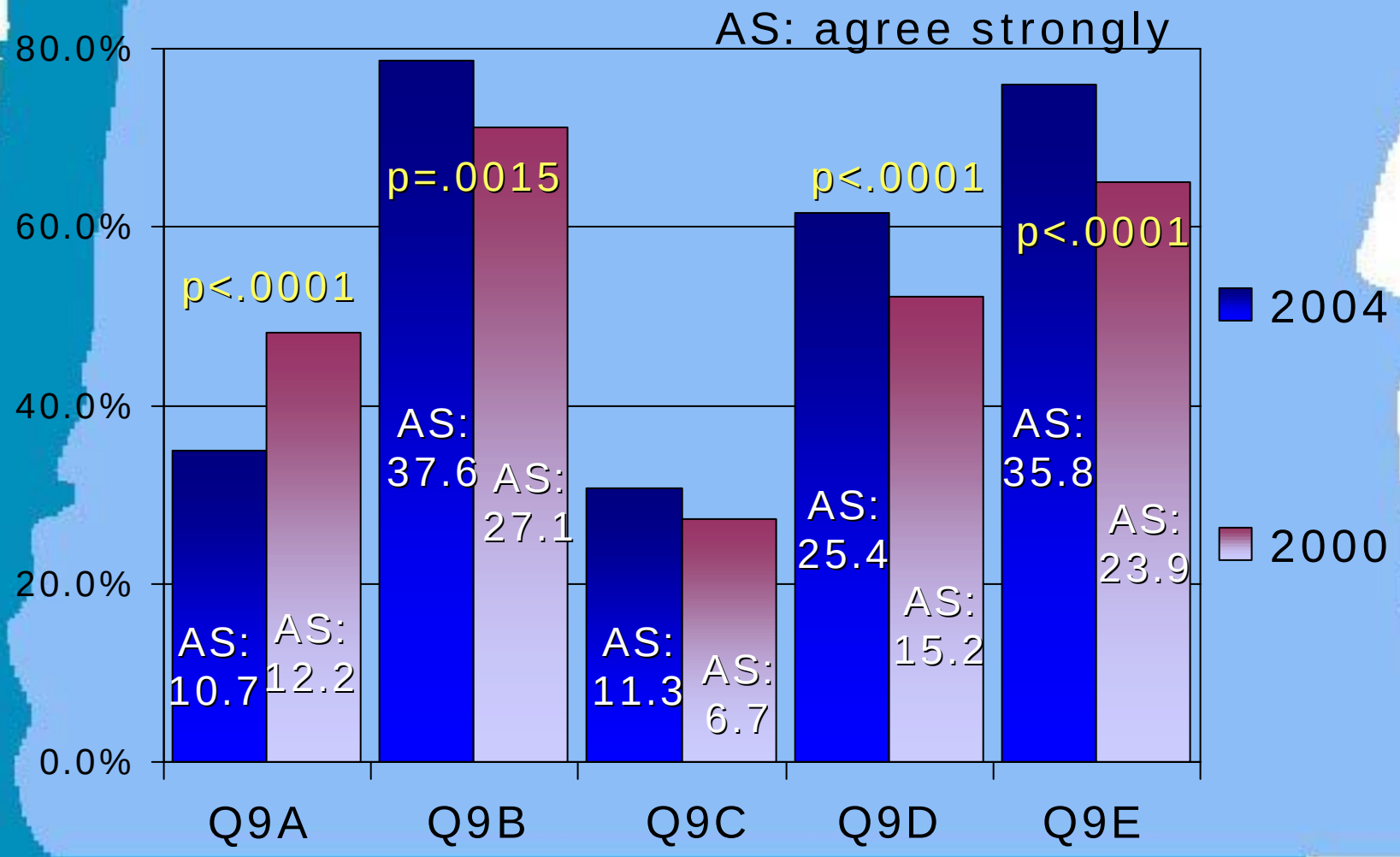
2000 vs. 2004


AS: agree strongly
80.0%
60.0%
40.0%
20.0%
0.0%
p<.0001
p=.0015
p<.0001
AS: 10.7
AS: 12.2
AS: 37.6
AS: 27.1
AS: 11.3
AS: 6.7
AS: 25.4
AS: 15.2
Q9A
Q9B
Q9C
Q9D
2004
2000

2000 vs. 2004

Q9E: The Oregon Health Plan should pay for treatments for health problems that are likely to progress to a serious and potentially life-threatening condition first. Effective treatments for conditions that are not likely to become serious or life-threatening may not be paid for.

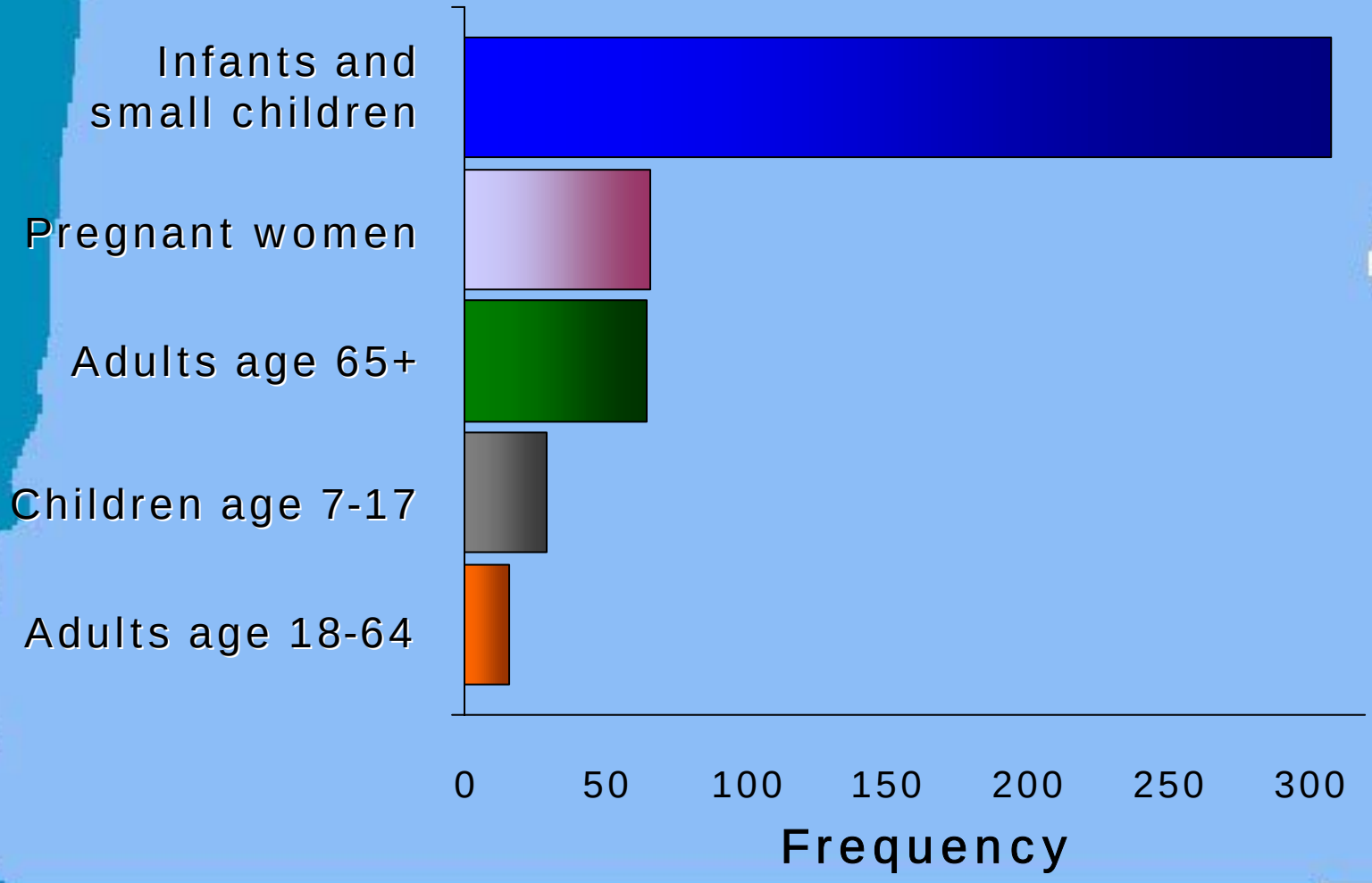
2000 vs. 2004


AS: agree strongly
80.0%
60.0%
40.0%
20.0%
0.0%
p<.0001
p=.0015
p<.0001
p<.0001
AS: 10.7
AS: 12.2
AS: 37.6
AS: 27.1
AS: 11.3
AS: 6.7
AS: 25.4
AS: 15.2
AS: 35.8
AS: 23.9
Q9A
Q9B
Q9C
Q9D
Q9E
2004
2000

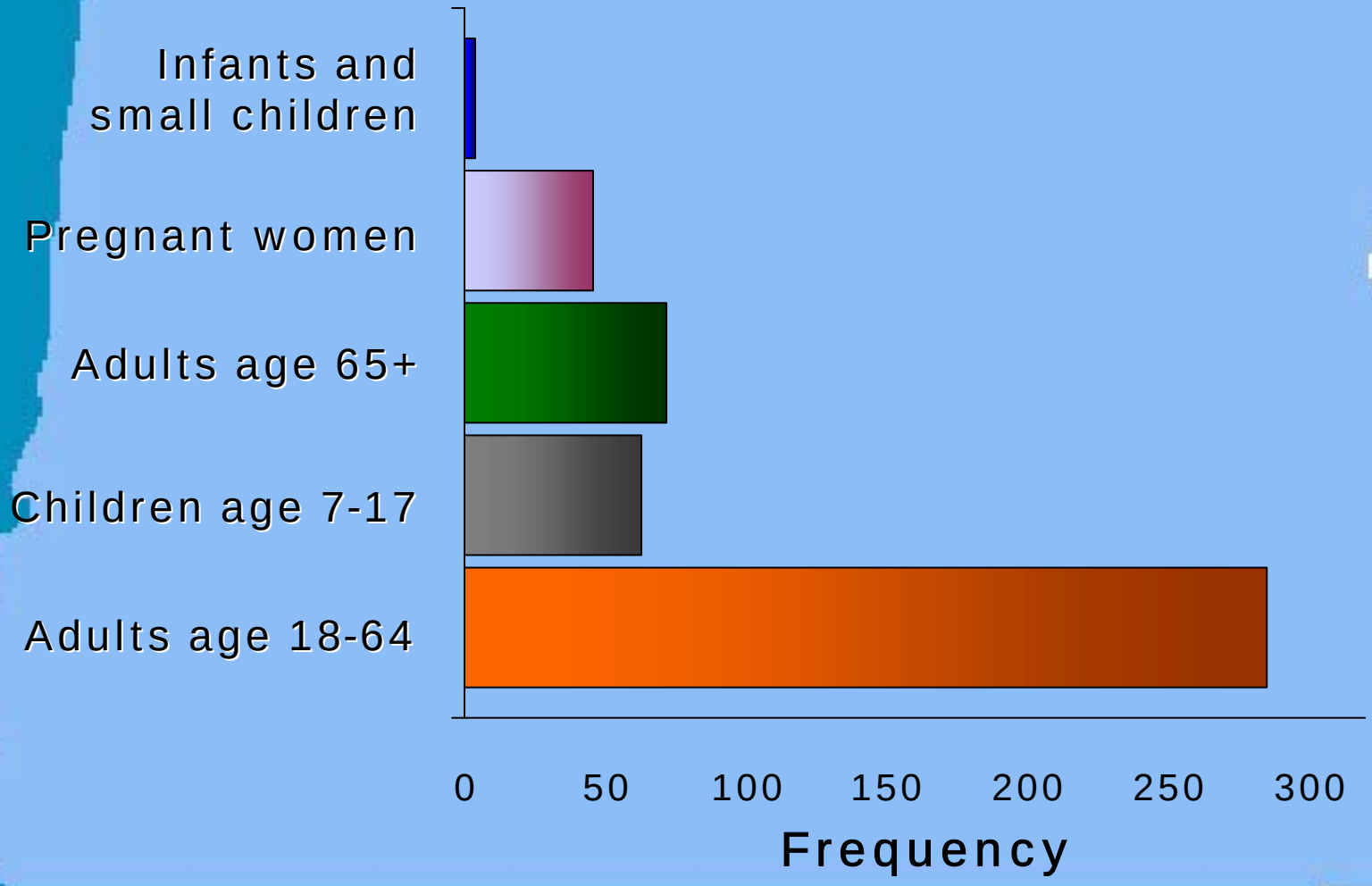
Priority among groups

- New in the 2004 survey
- Five questions
  - Name top priority in Q1, second priority in Q2, etc.
  - Groups:
    - Infants and small children
    - Children age 7-17
    - Adults age 18-64
    - Adults age 65+
    - Pregnant women

Priority 1 (2004)



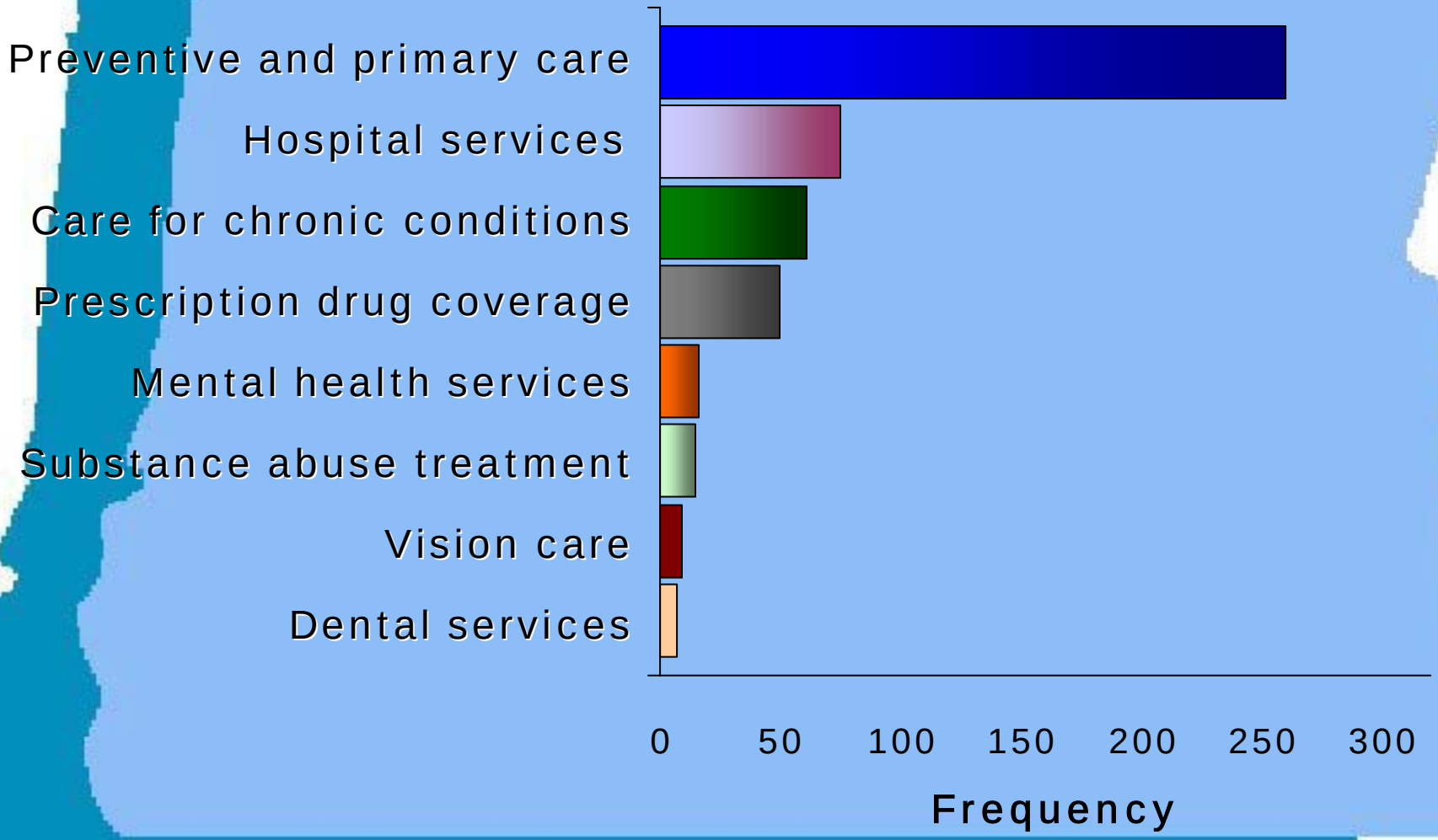
Priority 5 (2004)



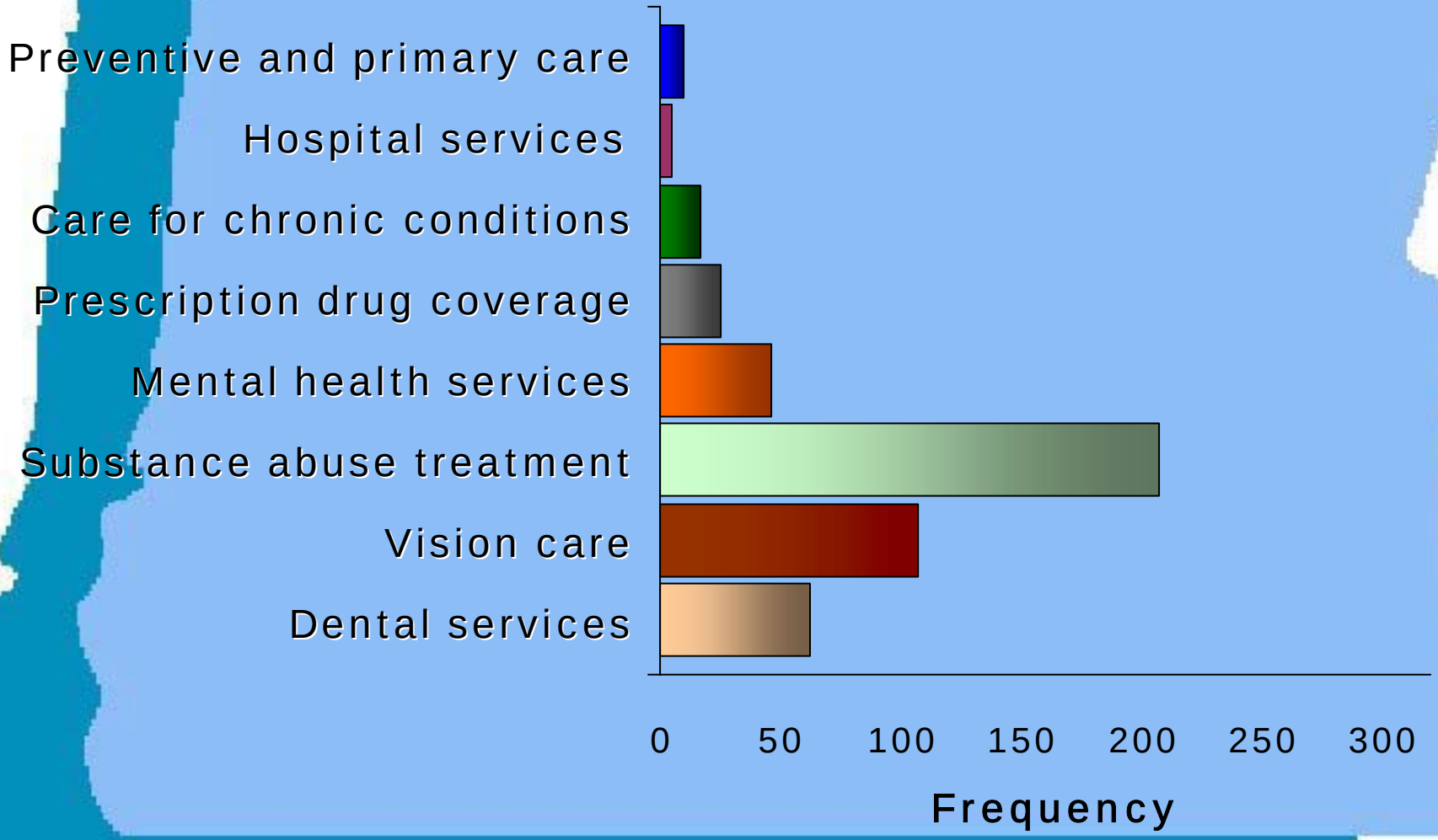
Priority among services

- Eight questions, new in 2004
  - Same format
  - Services
    - Primary and preventive care
    - Hospital services
    - Care for chronic conditions
    - Dental services
    - Prescription drug coverage
    - Vision services
    - Mental health services
    - Substance abuse treatment

Priority 1 (2004)



Priority 8 (2004)



Public health humor

Oregon's Mental Health Service System for Children

Recent trends in provision of mental health services
&
Changes in characteristics of children served

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Oregon Department of Human Services
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Present goal:

Begin to *broadly describe* what is happening within the children's service system.

Future goals:

Explain significant trends and patterns in the data.

Predict impact of treatment on client well-being (accomplished in part via linking of these data to other data sources, e.g., child welfare data, juvenile justice data)

Data Sources for Current Analyses

Client Process Monitoring System (CPMS)

Medicaid Database (MMIS)

Client Process Monitoring System (CPMS) tracks:

- Clients receiving *outpatient* (non-hospital) treatment from a government-funded mental health / addiction services provider, regardless of insurance eligibility

- Both clients receiving outpatient *mental health* services and outpatient *chemical dependency* services (different data elements for these two groups)

- *Episodes* of service: Data on client at beginning and end of treatment episode (does *not* contain data on service encounters within episode)

Medicaid database tracks:

- *Eligibility* and *enrollment* status of clients who are at some point eligible for services *reimbursable through Medicaid*
- All health care *encounters* associated with Medicaid claims (mental health treatment is more often reimbursable through Medicaid than chemical dependency treatment)
- Client and provider demographics and characteristics
- Billing information (service charges)

Analyses of data on all children who received government-funded mental health or chemical dependency services between 1/1999 and 12/2003

(Excludes children seen in hospital settings only)

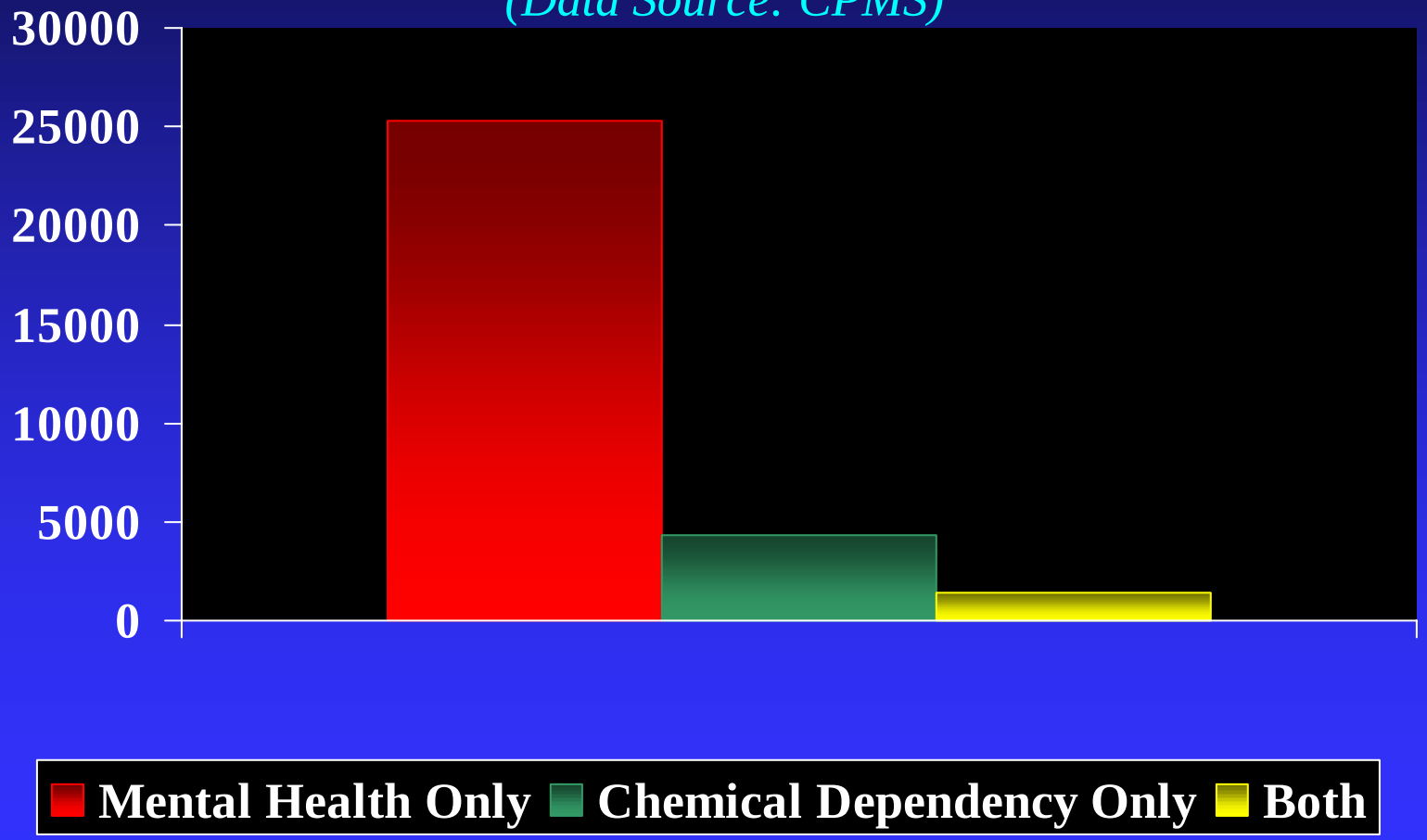
How many children are in treatment for mental health and/or addiction problems?

In 2003, per CPMS, over 30,000 children had an open chart with a government-funded mental health or addiction services treatment provider.

Far more children were in treatment for mental health problems than for chemical dependency problems. Only a small fraction were in treatment for both mental illness and chemical dependency.

Number of Children in Treatment with a Government-Funded Mental Health or Addiction Services Provider 2003

*(Data Source: CPMS)**



* "In Treatment" = Chart open for at least one day in 2003.

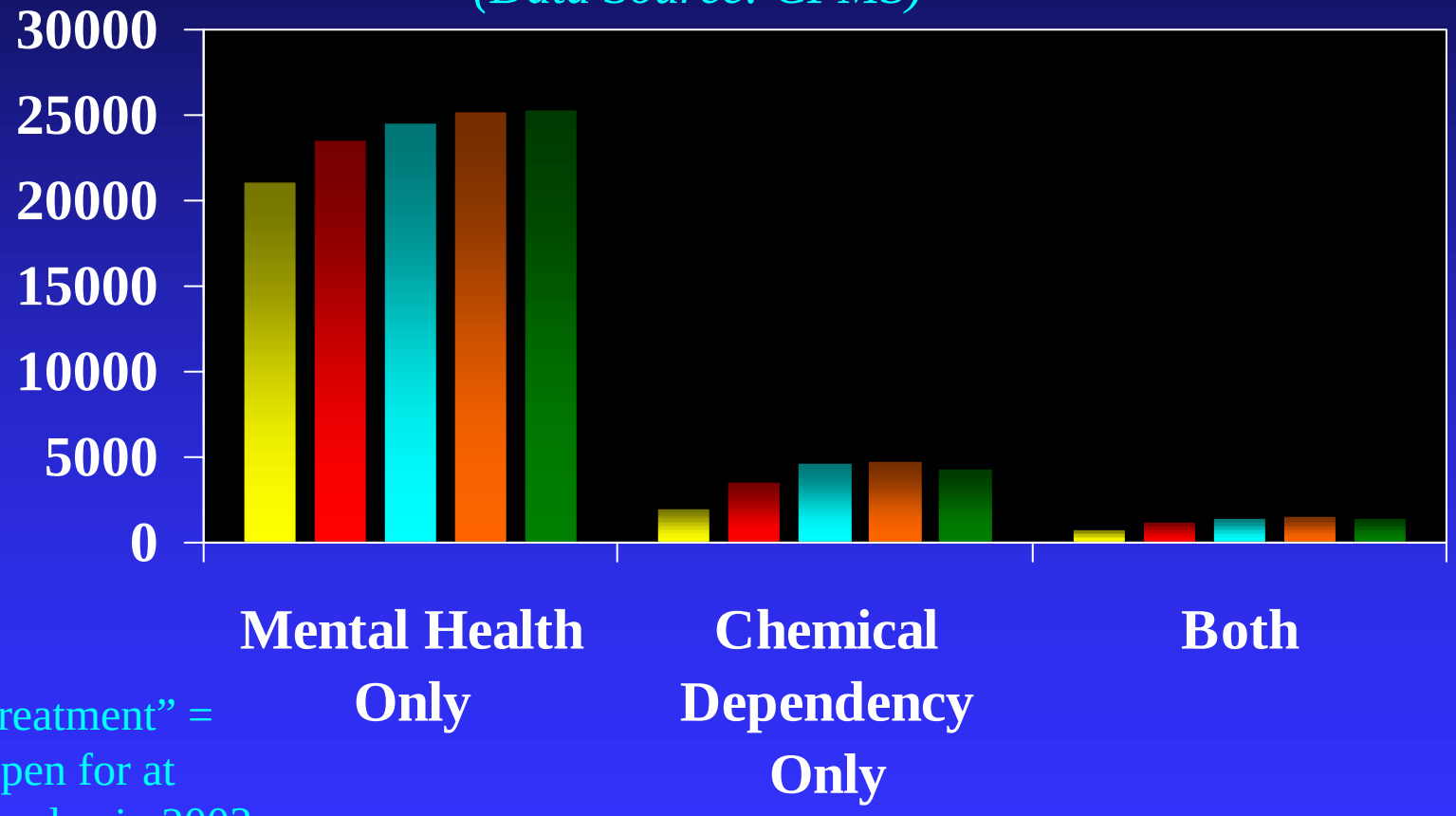
Has there been any change in the number of children receiving treatment?

The number of children in treatment for mental health problems has been increasing (at a decreasing rate) at least since 1999.

The number in treatment for chemical dependency also increased (at a decreasing rate) from 1999 to 2002, but then decreased from 2002 to 2003.

Number of Children in Treatment with a Government-Funded Mental Health or Addiction Services Provider 1999-2003

*(Data Source: CPMS)**

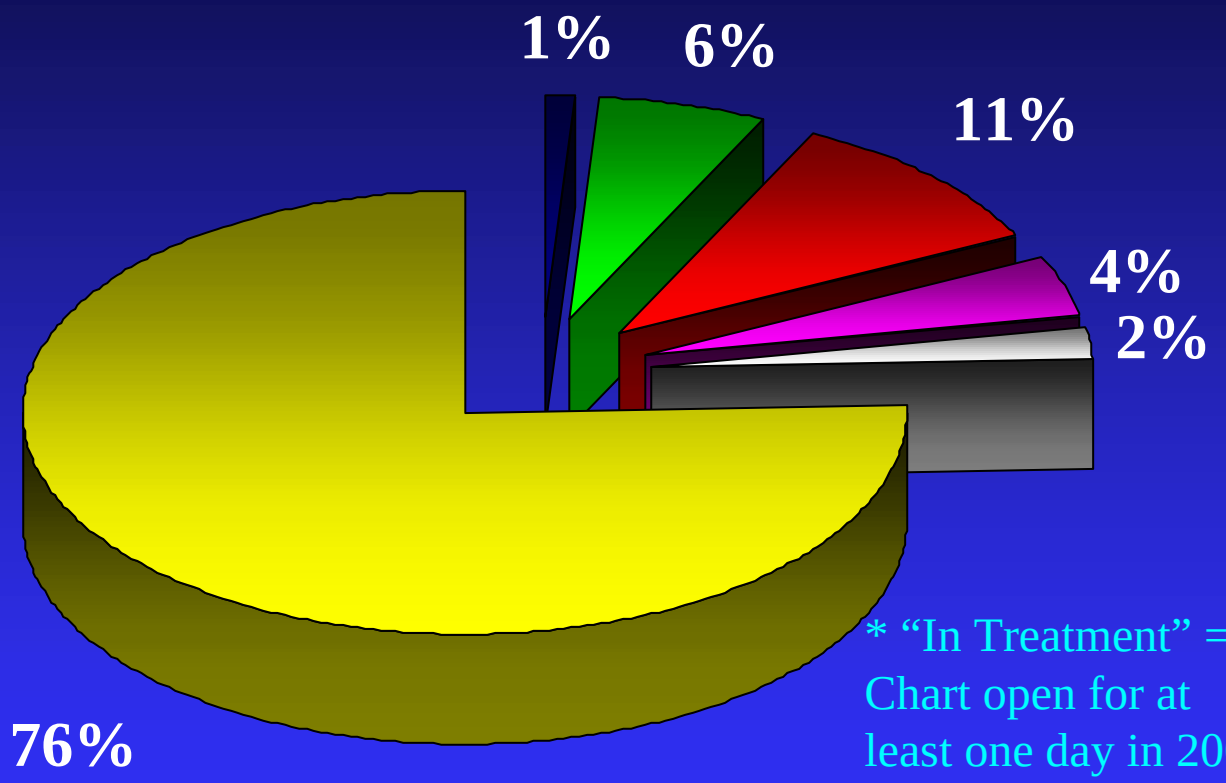


* "In Treatment" = Chart open for at least one day in 2003.

What is the ethnic/racial heritage of the children receiving mental health and/or chemical dependency services?

Race / Ethnicity of Children in Treatment 2003

*(Data Source: CPMS)**



* "In Treatment" = Chart open for at least one day in 2003.

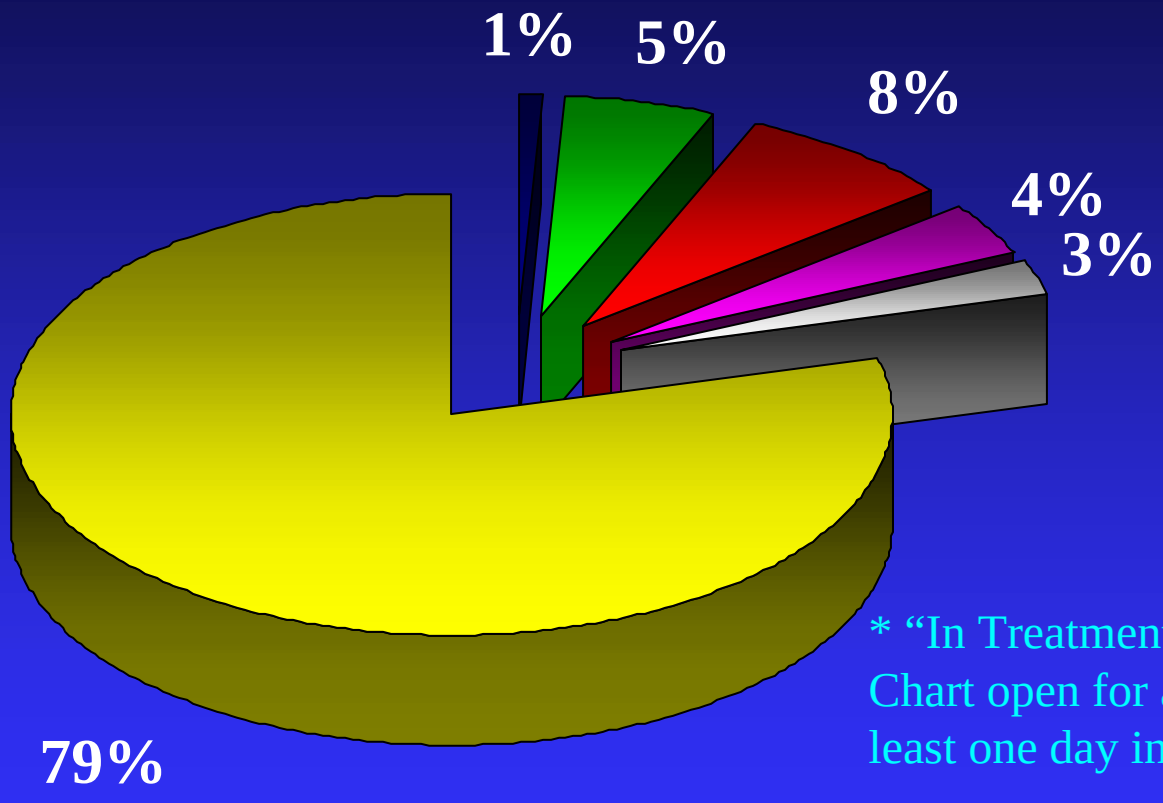
Has there been any change in the ethnic/racial diversity of children receiving mental health and/or chemical dependency services?

There has been an increase in the diversity of the treatment population. Much of the increase in diversity is attributable to an increase in the number of Hispanic children in treatment.

In 2003, 11% of the treated population identified as Hispanic. 5 years earlier, in 1999, only 8% of the treated population identified as Hispanic.

Race / Ethnicity of Children in Treatment 1999

*(Data Source: CPMS)**



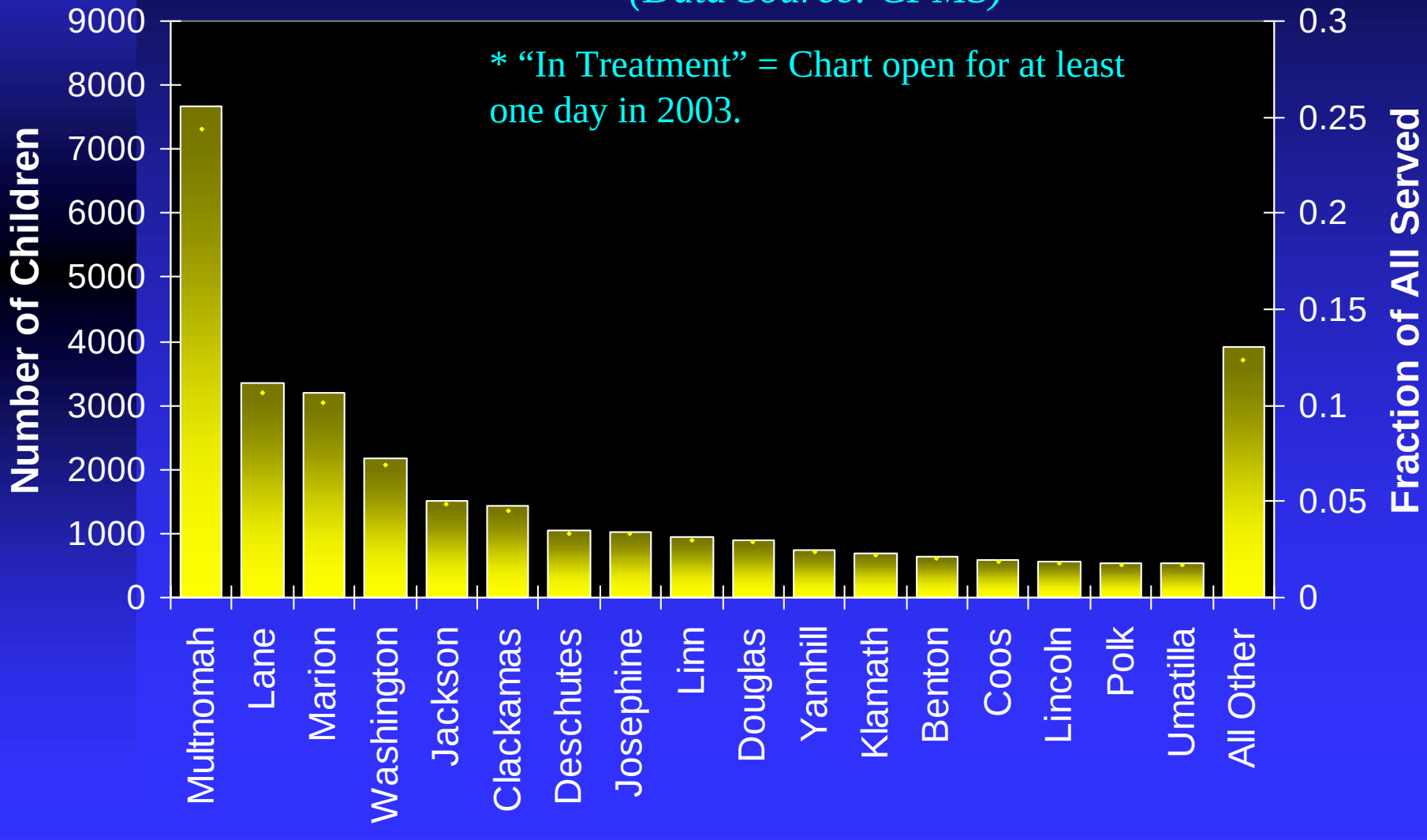
* "In Treatment" = Chart open for at least one day in 2003.

Where do the children receiving mental health and/or addiction services live?

Per CPMS, approximately 25% of the children in treatment live in Multnomah county. An additional 20% live in Lane and Marion counties.

Number of Children in Treatment By County 2003

(Data Source: CPMS)



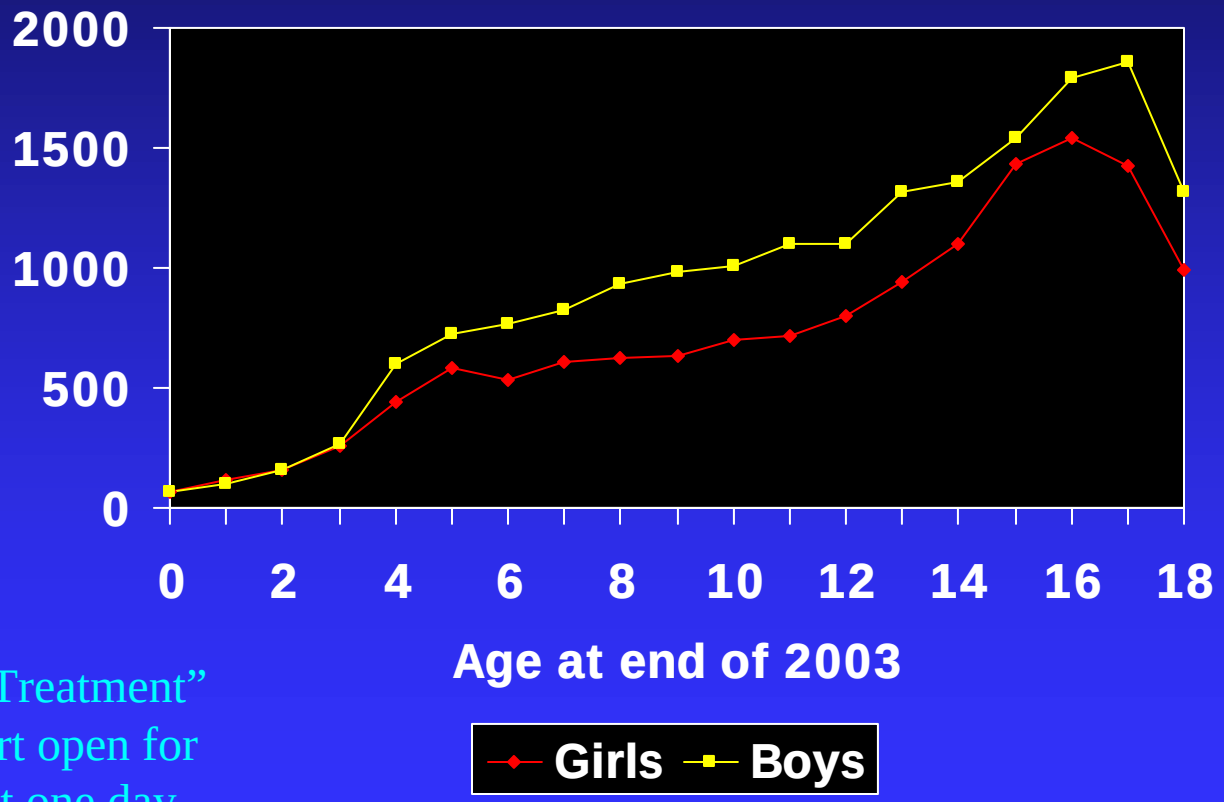
What are the age and sex distributions of children in treatment for mental health and/or addiction problems?

The number of children in either mental health or addiction treatment increases with age, until at least age 16.

After age 3, the number of boys in treatment exceeds the number of girls in treatment.

Number of Children in Treatment with a Government-Funded Mental Health and/or Addiction Services Provider, 2003 By Age and Gender

*(Data Source: CPMS)**

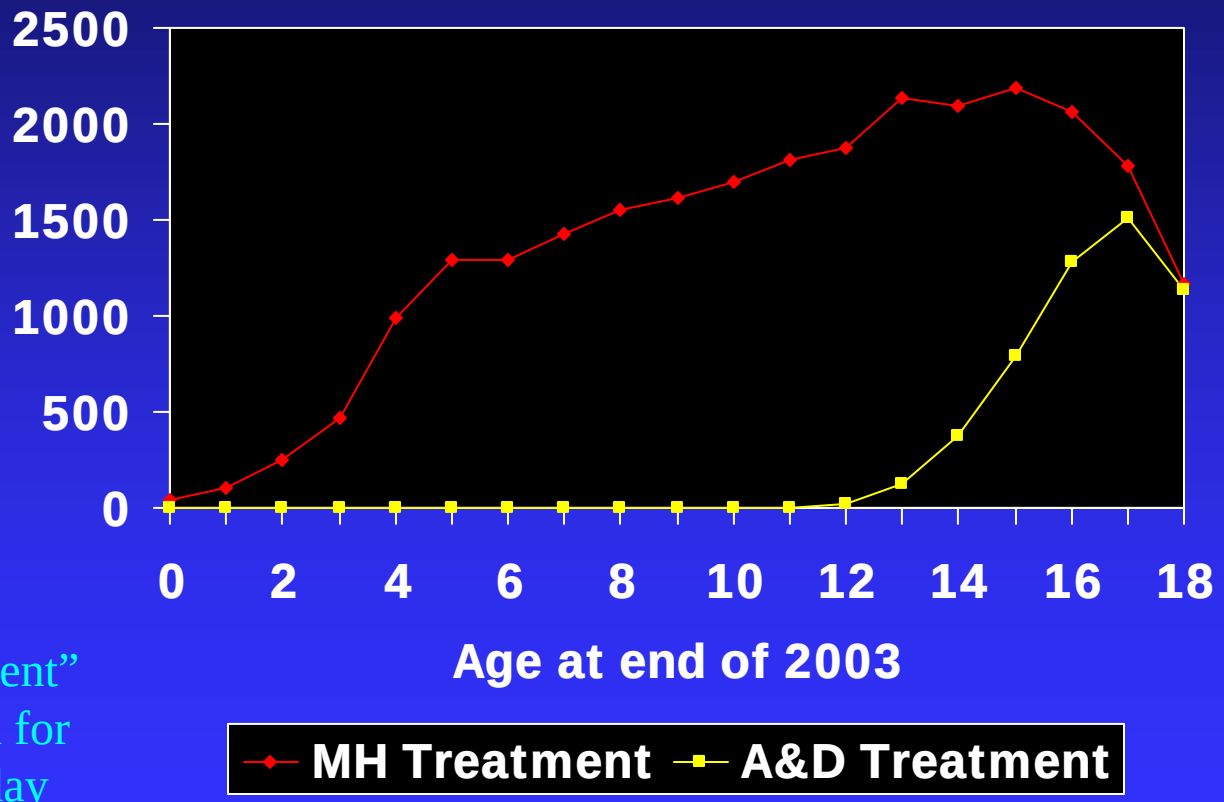


* "In Treatment" = Chart open for at least one day in 2003.

Children in treatment for chemical dependency are significantly older, on average, than children in treatment for mental illness.

Number of Children in Treatment with a Government-Funded Mental Health and/or Addiction Services Provider, 2003 By Age and Service Type

*(Data Source: CPMS)**



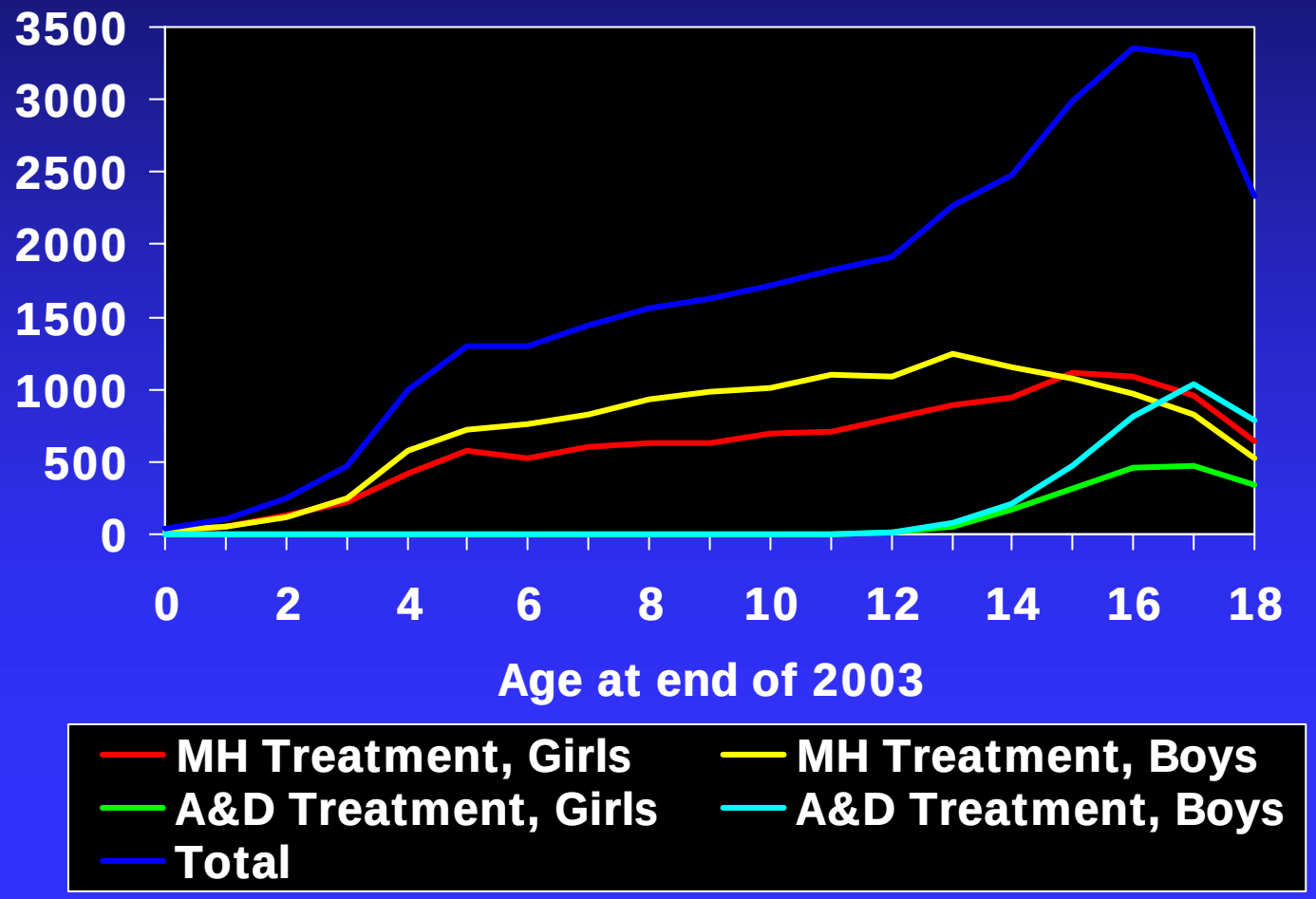
* "In Treatment" = Chart open for at least one day in 2003.

The number of boys in treatment exceeds the number of girls in treatment. This is true within both the population treated for mental health problems and the population treated for chemical dependency.

Exception: There are more girls aged 15+ than boys aged 15+ in treatment with a mental health provider.

Number of Children in Treatment with a Government-Funded Mental Health and/or Addiction Services Provider, 2003 By Age, Service Type, and Gender

*(Data Source: CPMS)**



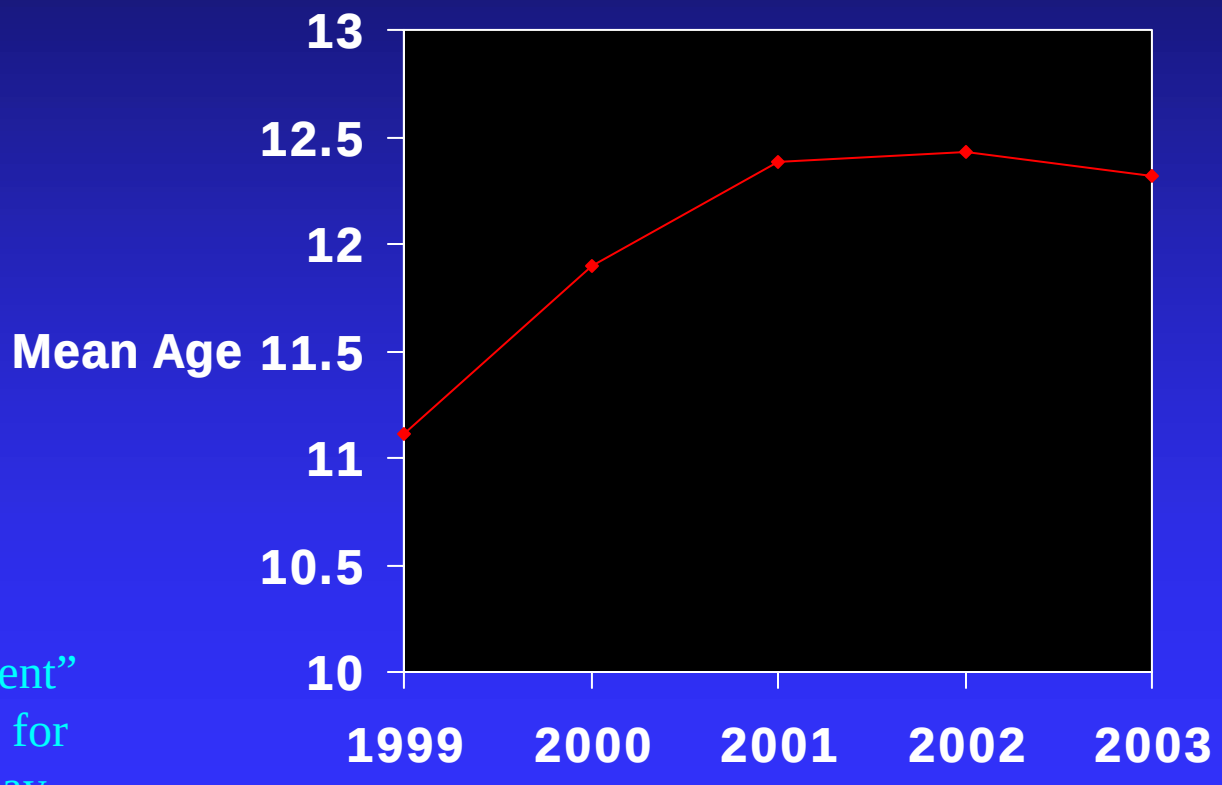
* "In Treatment" = Chart open for at least one day in 2003.

Has there been any change in the age distribution of children in treatment?

Per CPMS, the mean age of children in treatment increased from just over 11 (in 1999) to almost 12 ½ (in 2001). Per this same data source, mean age changed little between 2001 and 2003.

Mean Age of Children in Treatment with a Government-Funded Mental Health and/or Addiction Services Provider 1999-2003

*(Data Source: CPMS)**

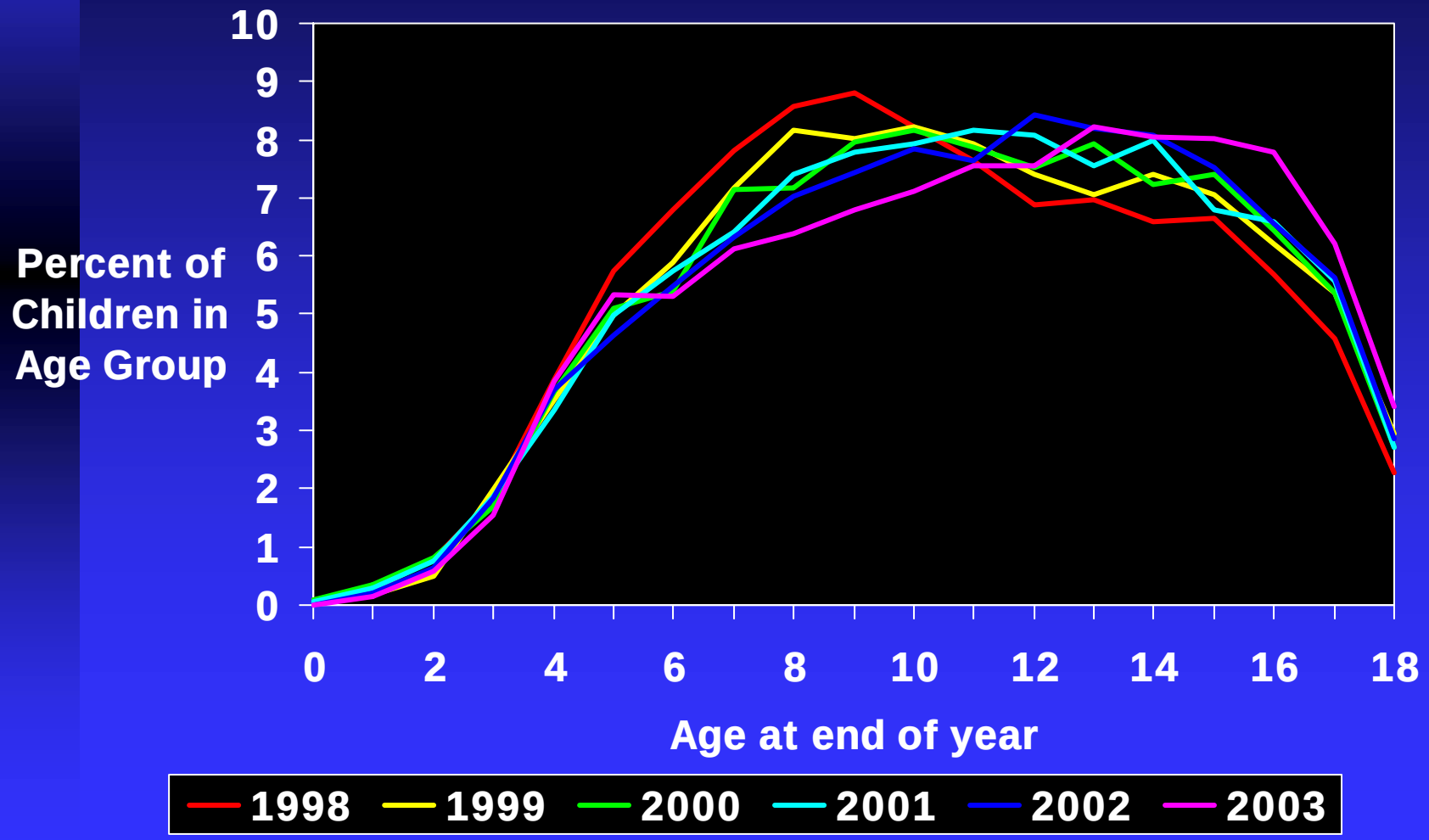


* "In Treatment" = Chart open for at least one day in 2003.

An increase in the average age of children in treatment is also apparent within the subset of children who are Medicaid-eligible and receiving mental health services through managed care. (Change from just under 11 in 1999 to over 12 in 2001-2003.)

Age Distributions for Medicaid-Eligible Children Receiving MHO Services, 1998 – 2003

(Data source: MMIS)

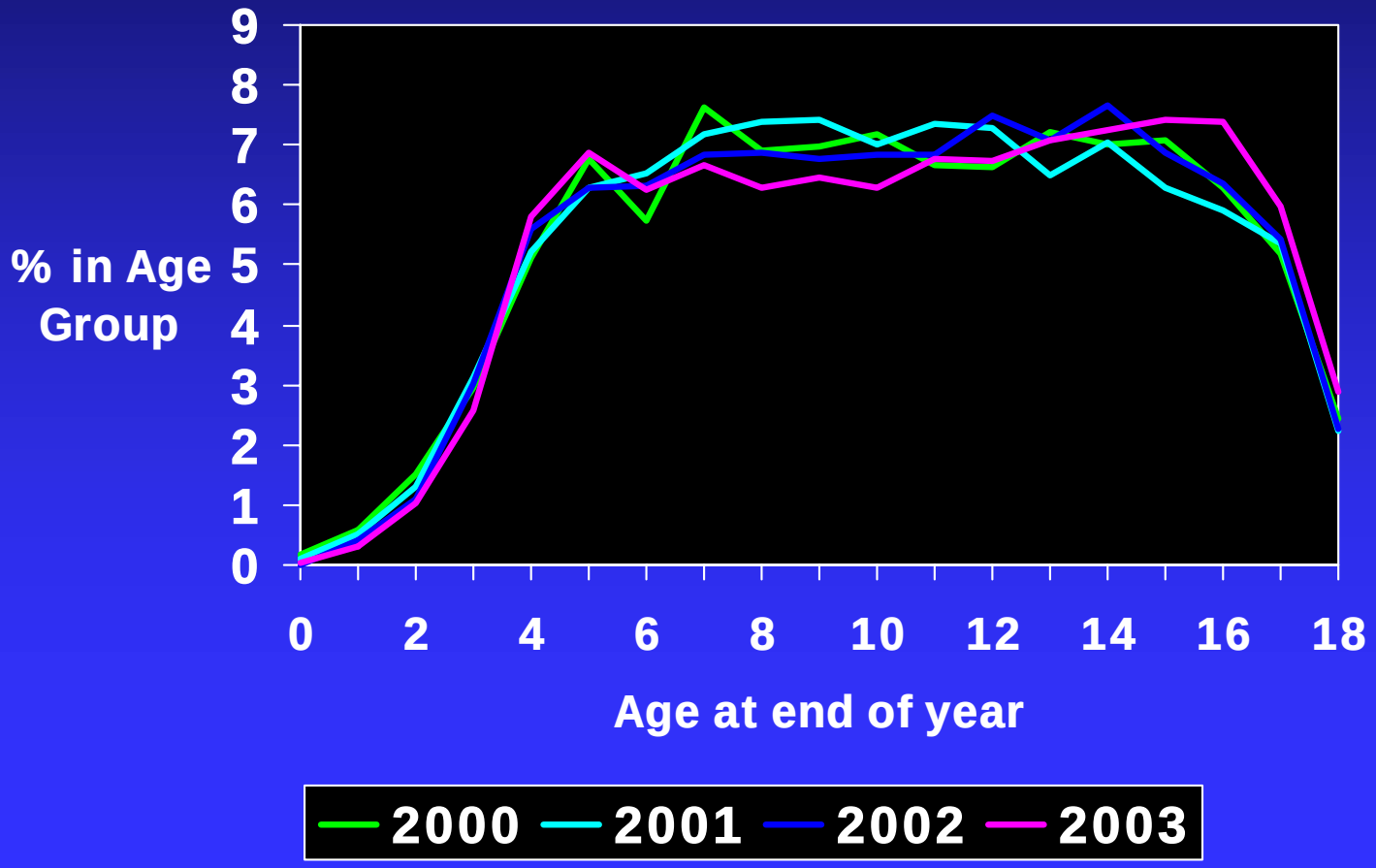


The change in the age distribution of children in treatment is not clearly attributable to a change in the average age at entry into service.

Age Distributions for Medicaid-Eligible Children Entering MHO Service Population, 2000- 2003*

(Data source: MMIS)

**Child considered as "entering" service population if child did not receive service in the two preceding years.*

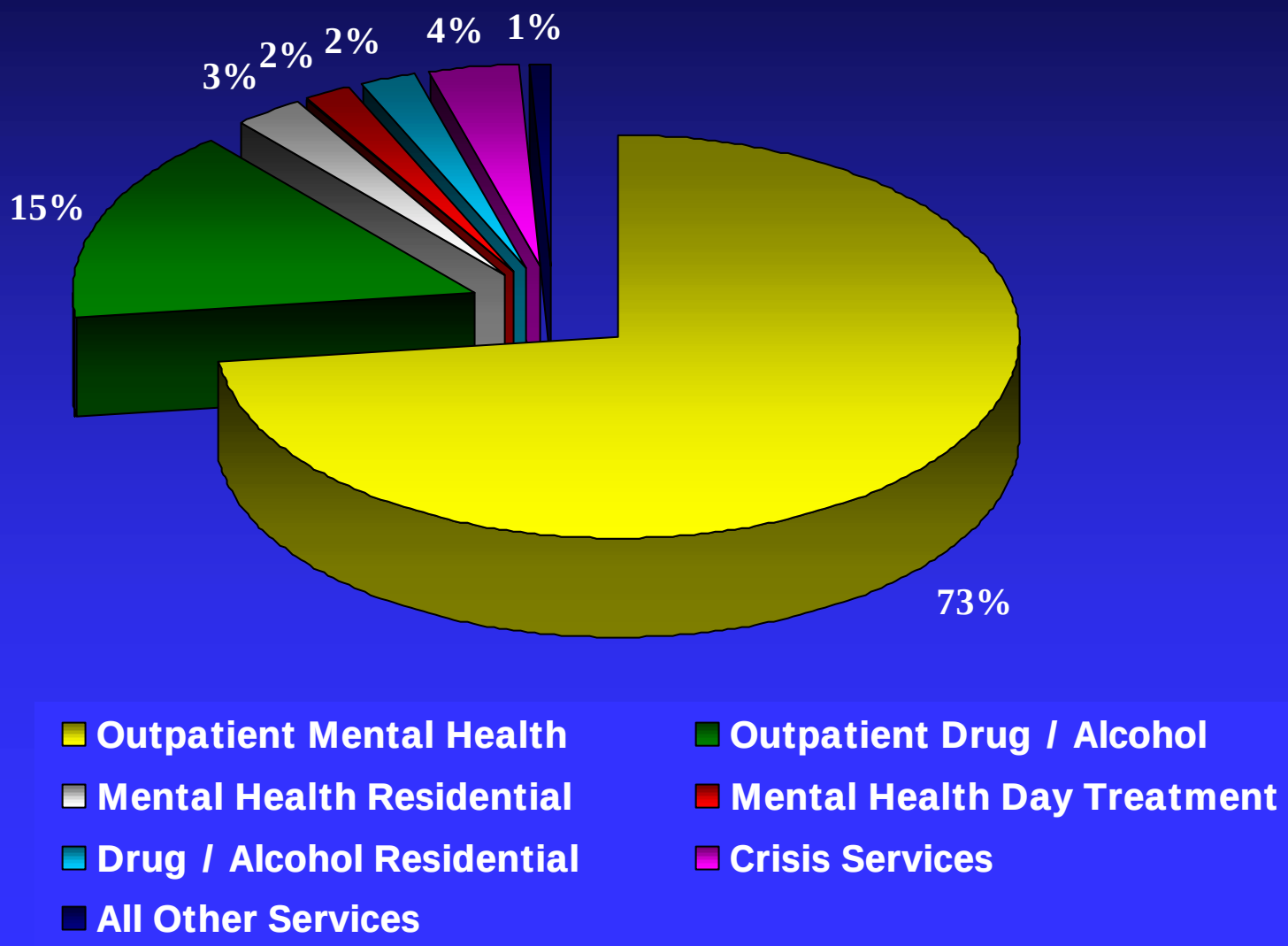


What types of services are being provided to children in treatment for mental health / chemical dependency problems?

The bulk of services provided are basic outpatient services for mental health and addiction problems.

Distribution of Service Episodes, 2003
Children of All Ages
(% of all service episodes falling into each service category)

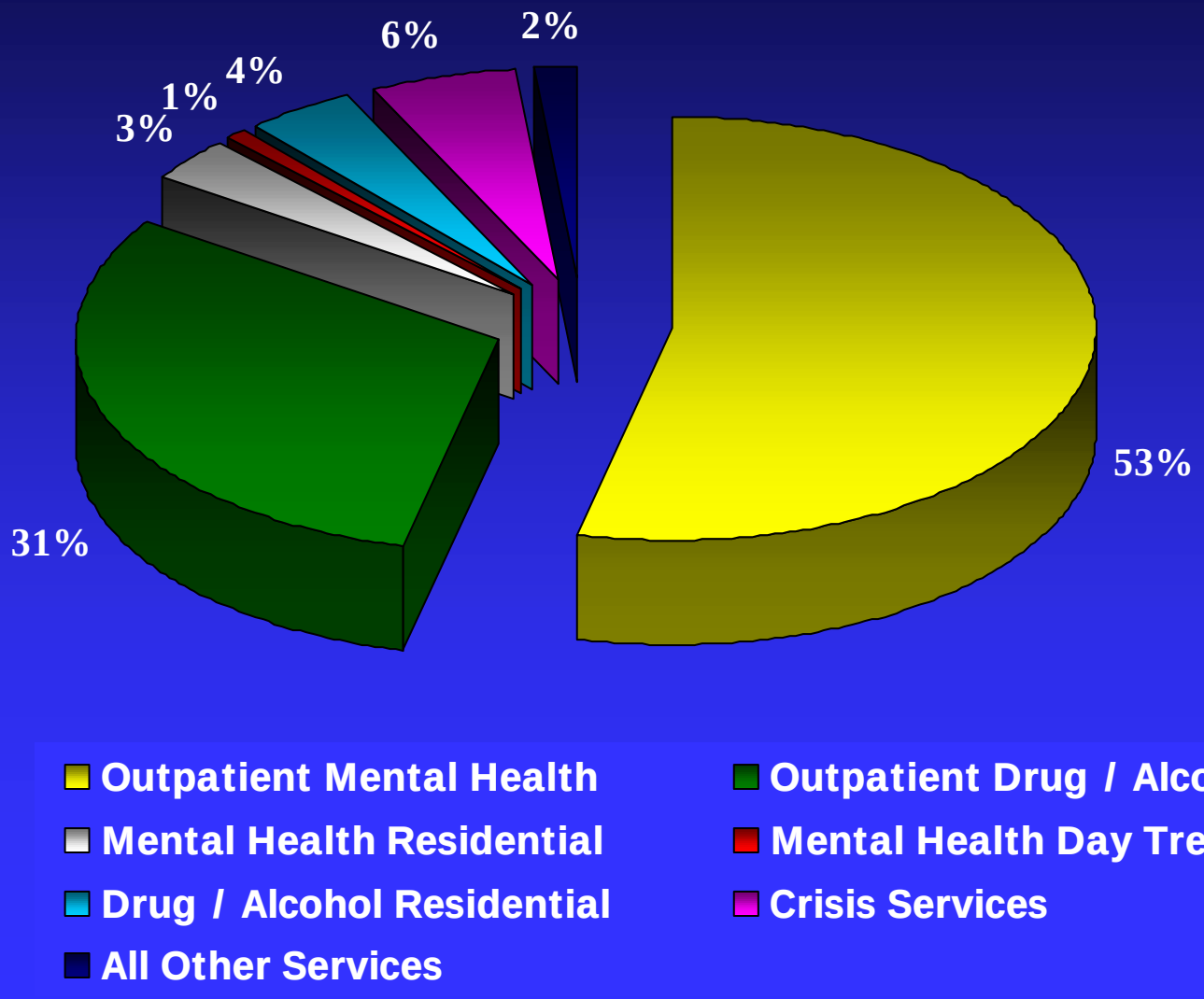
(Data Source: CPMS)



The older children typically receive different services than the younger children.

Distribution of Service Episodes, 2003
Children Aged 13 and up
(% of all service episodes falling into each service category)

(Data Source: CPMS)

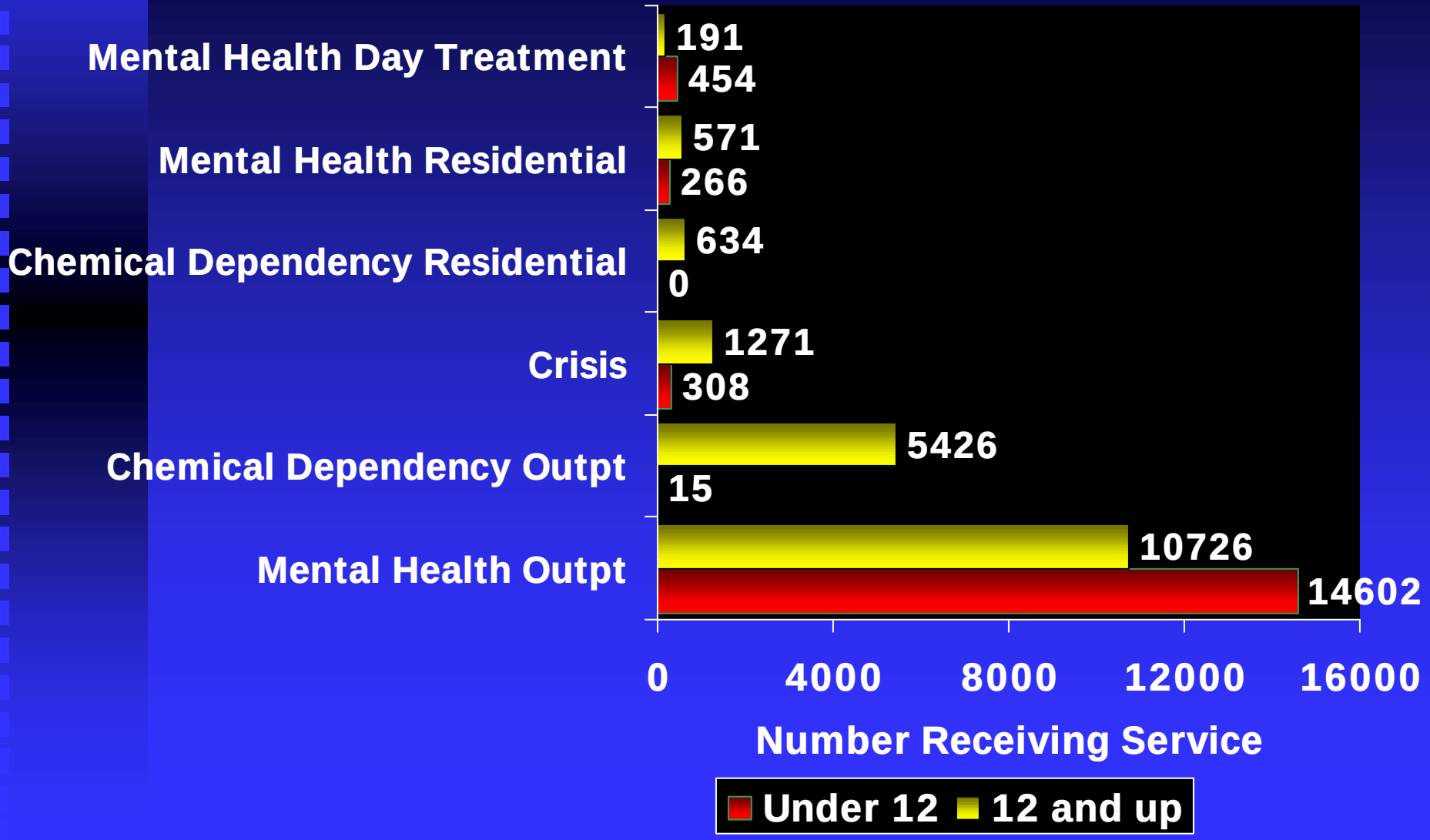


The children receiving mental health outpatient services or psychiatric day treatment services are more likely to be under 12 than over 12.

The children receiving chemical dependency services of any kind, psychiatric residential services, or crisis services are more likely to be over 12 than under 12.

Number of Children Receiving Each Type of Service, 2003 By Age Group

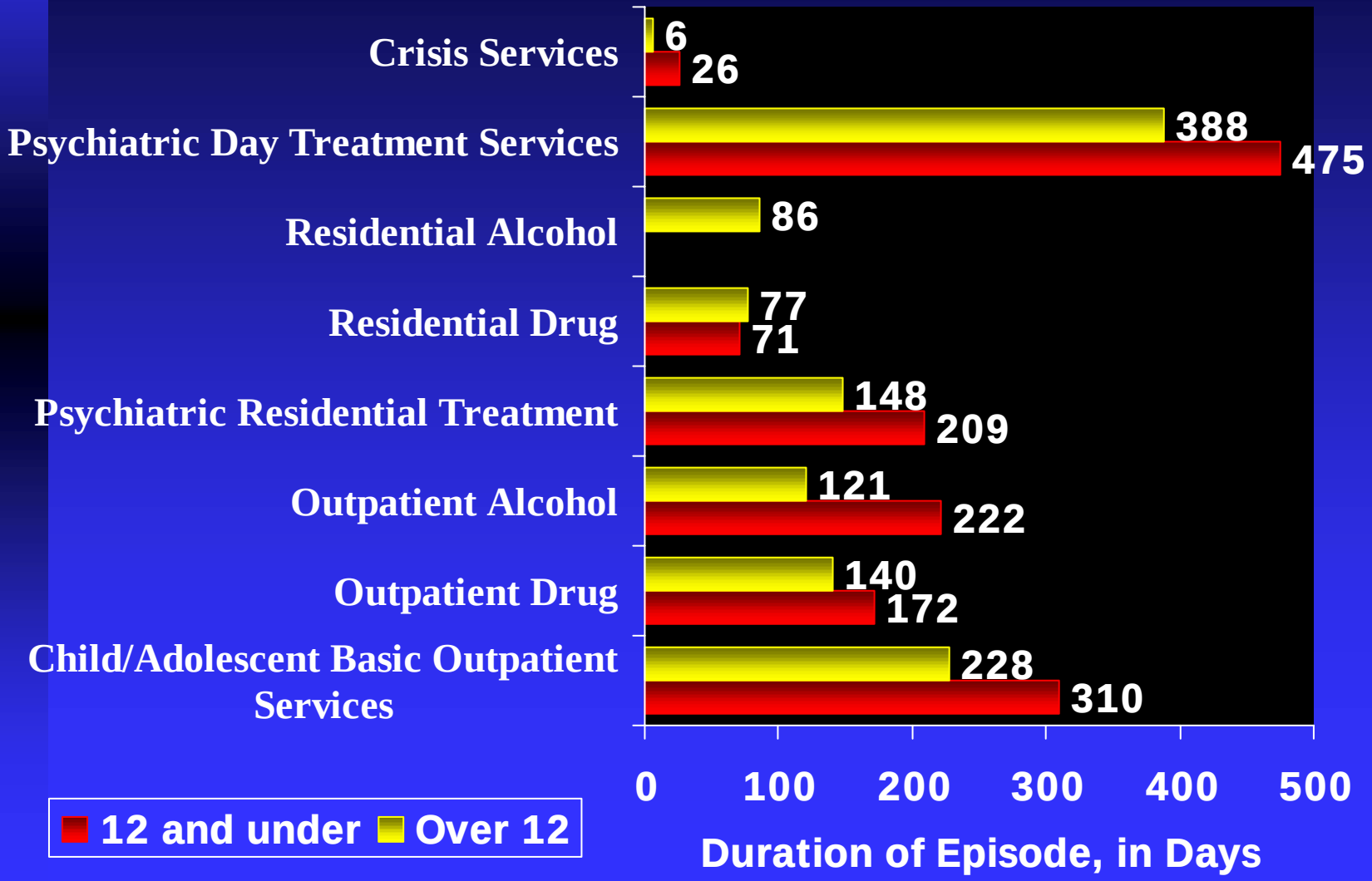
(Data Source: CPMS)



The duration of a service episode typically depends, in part, both on the type of service and on the age of the child.

Mean Duration of Service Episodes Ending in 2003 By Service Type and Age Group

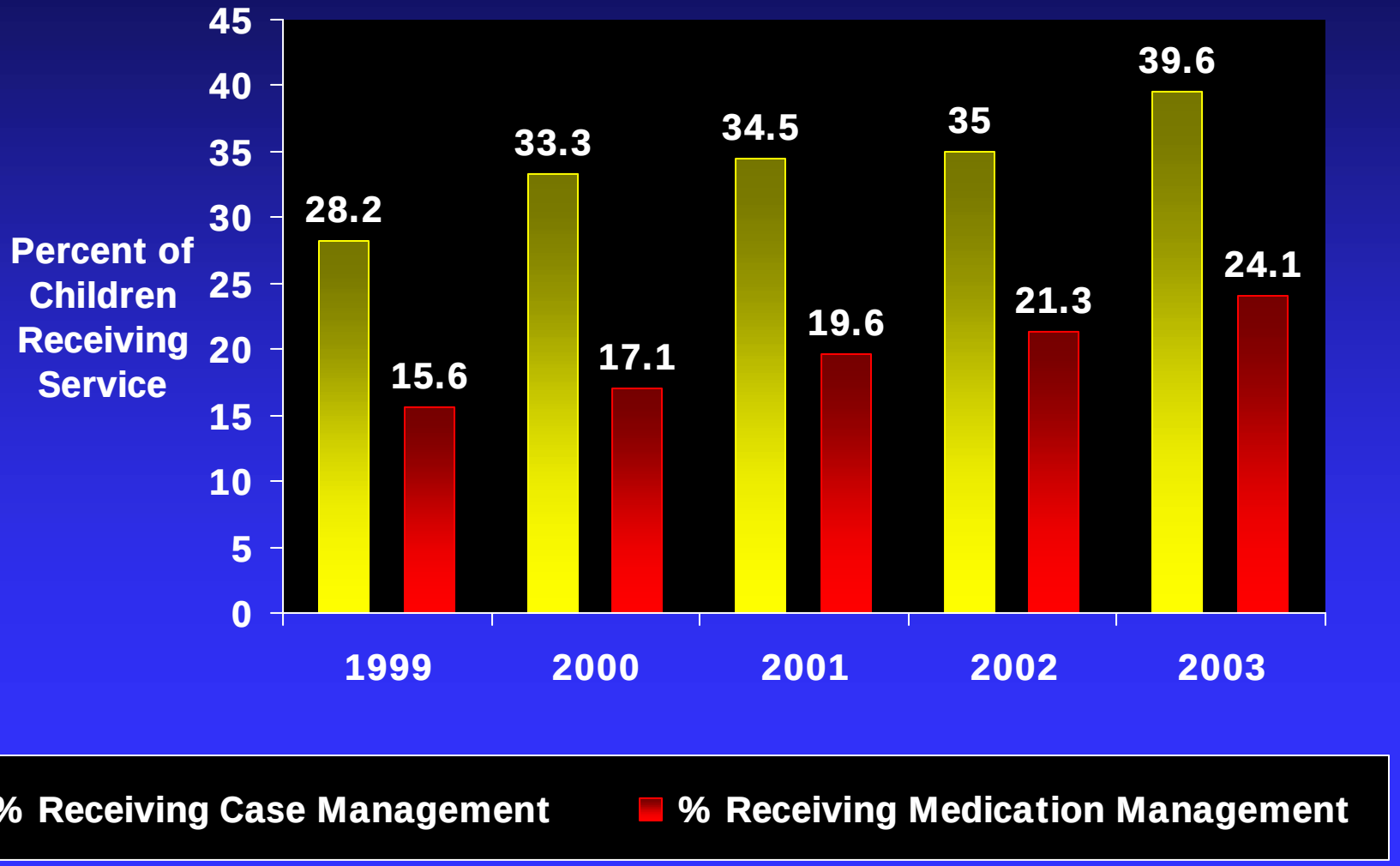
(Open to Close Date. Data source: CPMS)



Has there been any change in the nature or frequency of services provided to children in treatment?

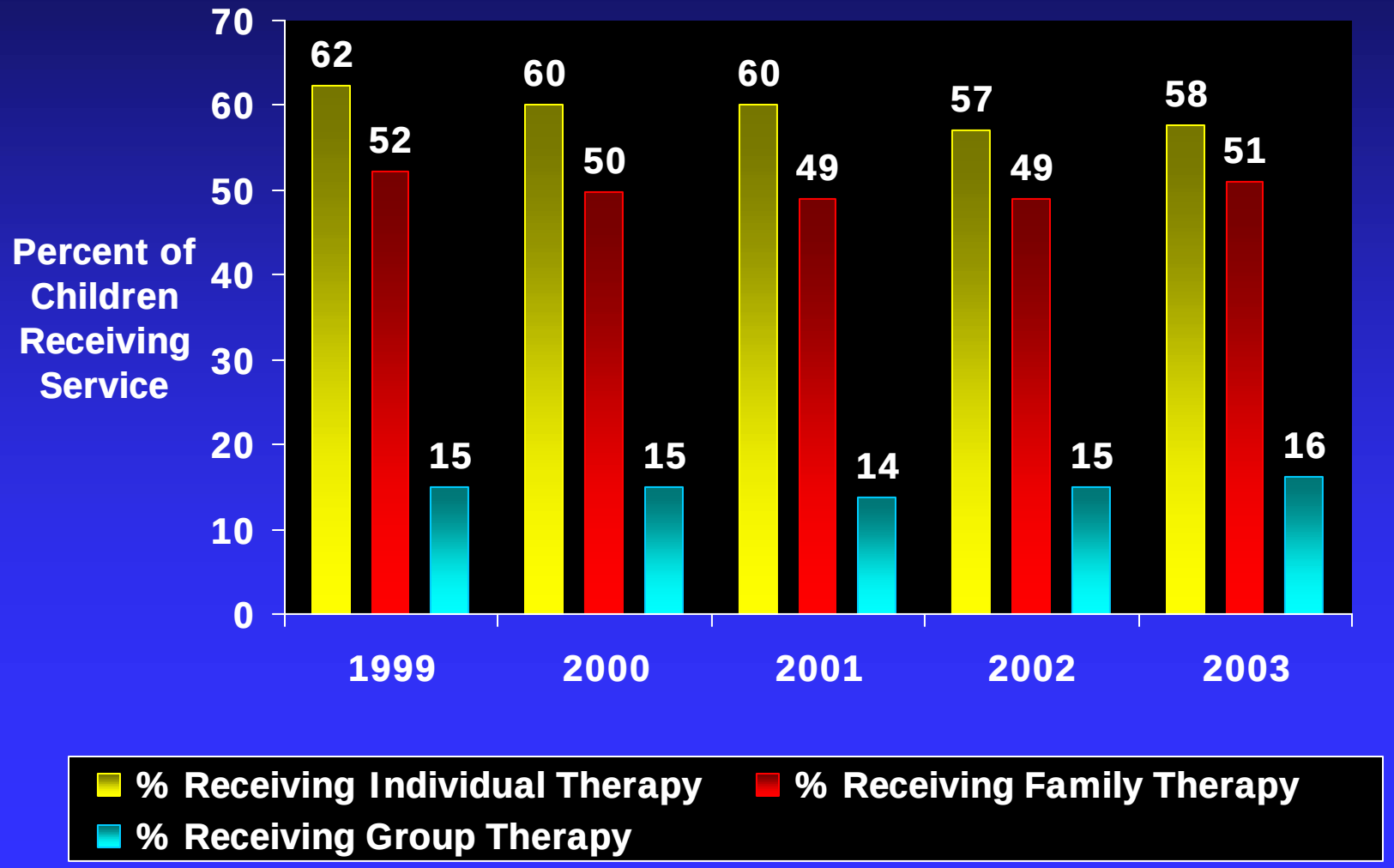
There has been an increase in the frequency with which Medicaid-eligible children receive case management and medication management services through mental health managed care organizations.

Percent of All MHO-Serviced Children Receiving Case Management and Medication Management, 1999-2003 *(Data source: MMIS)*



There has been relatively little change in the frequency with which Medicaid-eligible children receive individual, family, and/or group therapy services through mental health managed care.

Percent of All MHO-Serviced Children Receiving Individual, Family, and/or Group Therapy, 1999-2003 *(Data source: MMIS)*



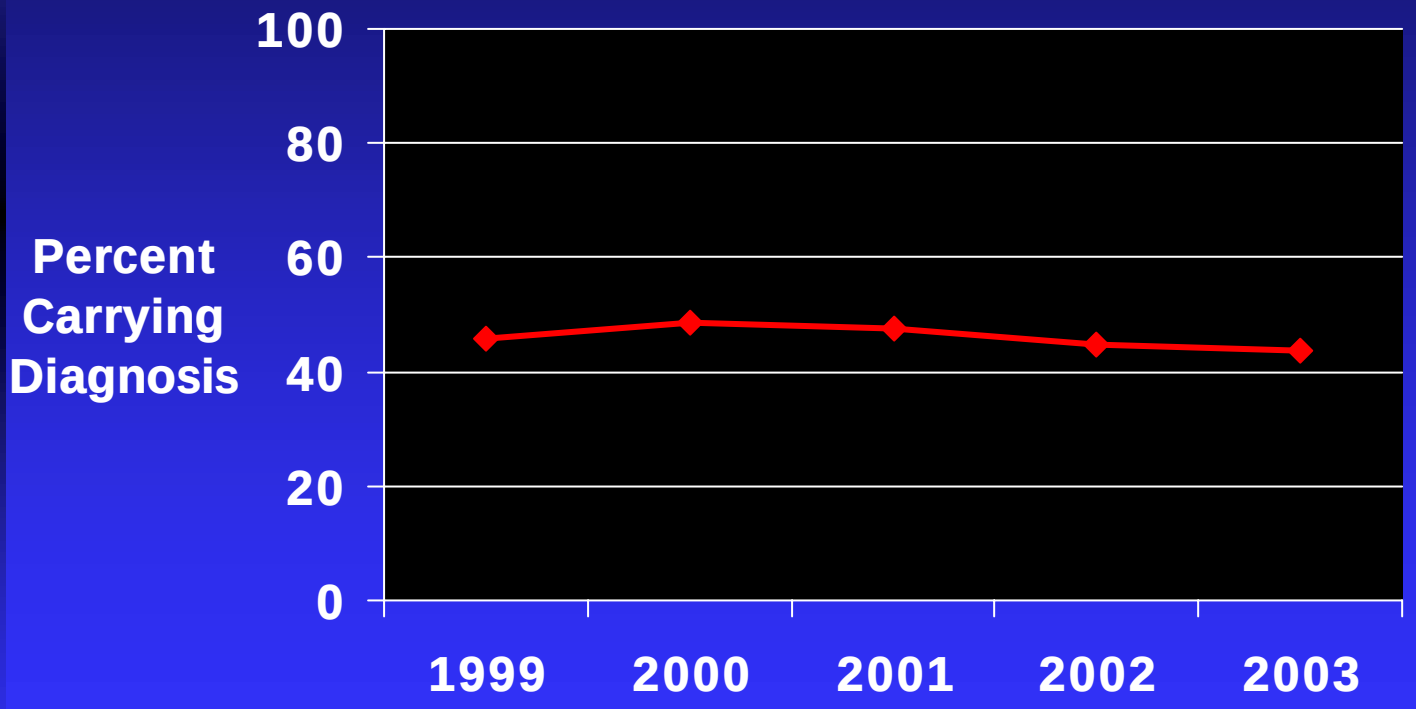
What diagnoses are most common among the children treated in MHO settings?

The most common diagnoses are adjustment disorders, conduct / oppositional defiant disorders, ADHD, depressive disorders, and anxiety disorders (particularly PTSD).

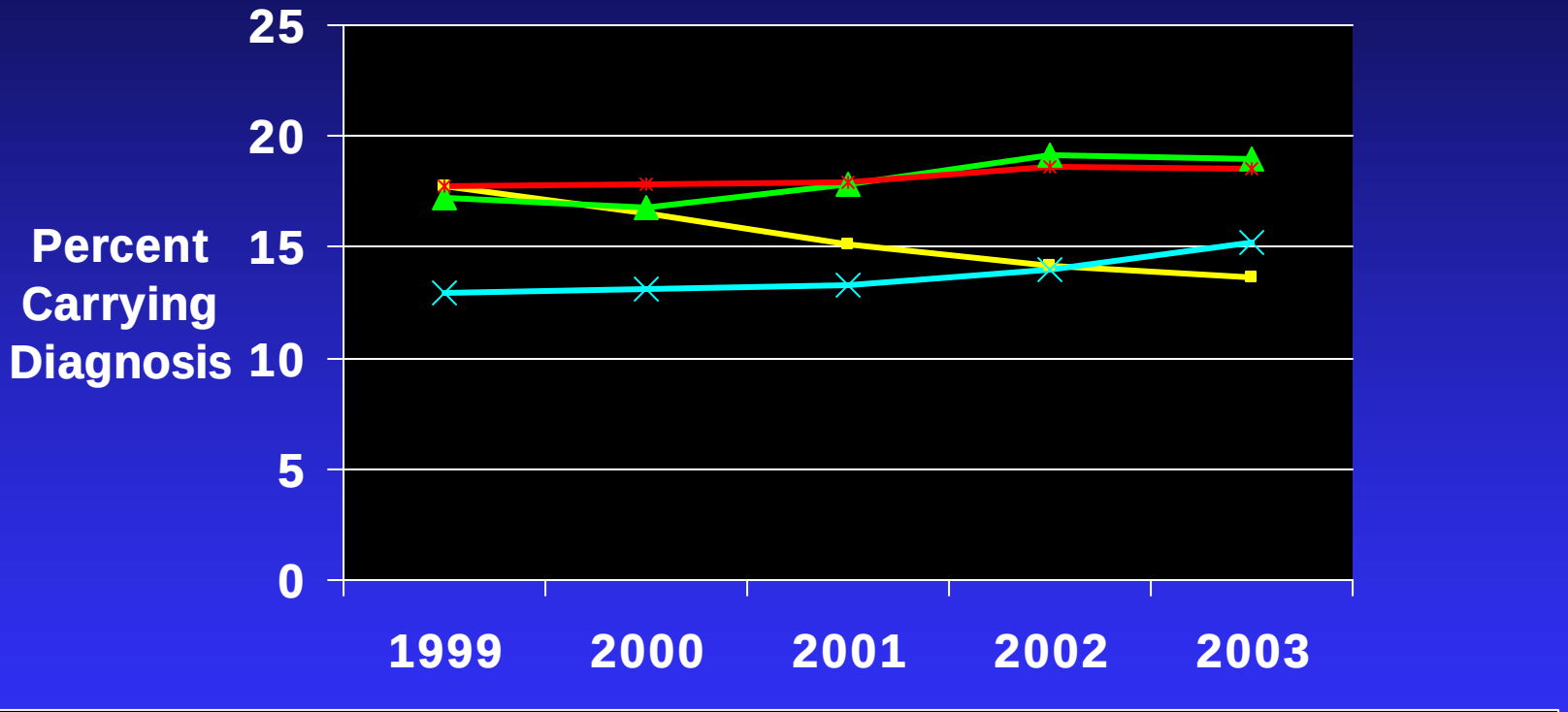
The probability that a child carries one of these diagnoses has changed little over the past 5 years. Exception: The frequency with which children are being diagnosed with conduct disorder / oppositional defiant disorder appears to be decreasing.

Percent of All MHO-Serviced Children Carrying Diagnoses Related to Adjustment Disorder / Relationship Problems 1999-2003

(Data source: MMIS)



Percent of All MHO-Serviced Children Carrying Other Common Diagnoses 1999-2003 *(Data source: MMIS)*

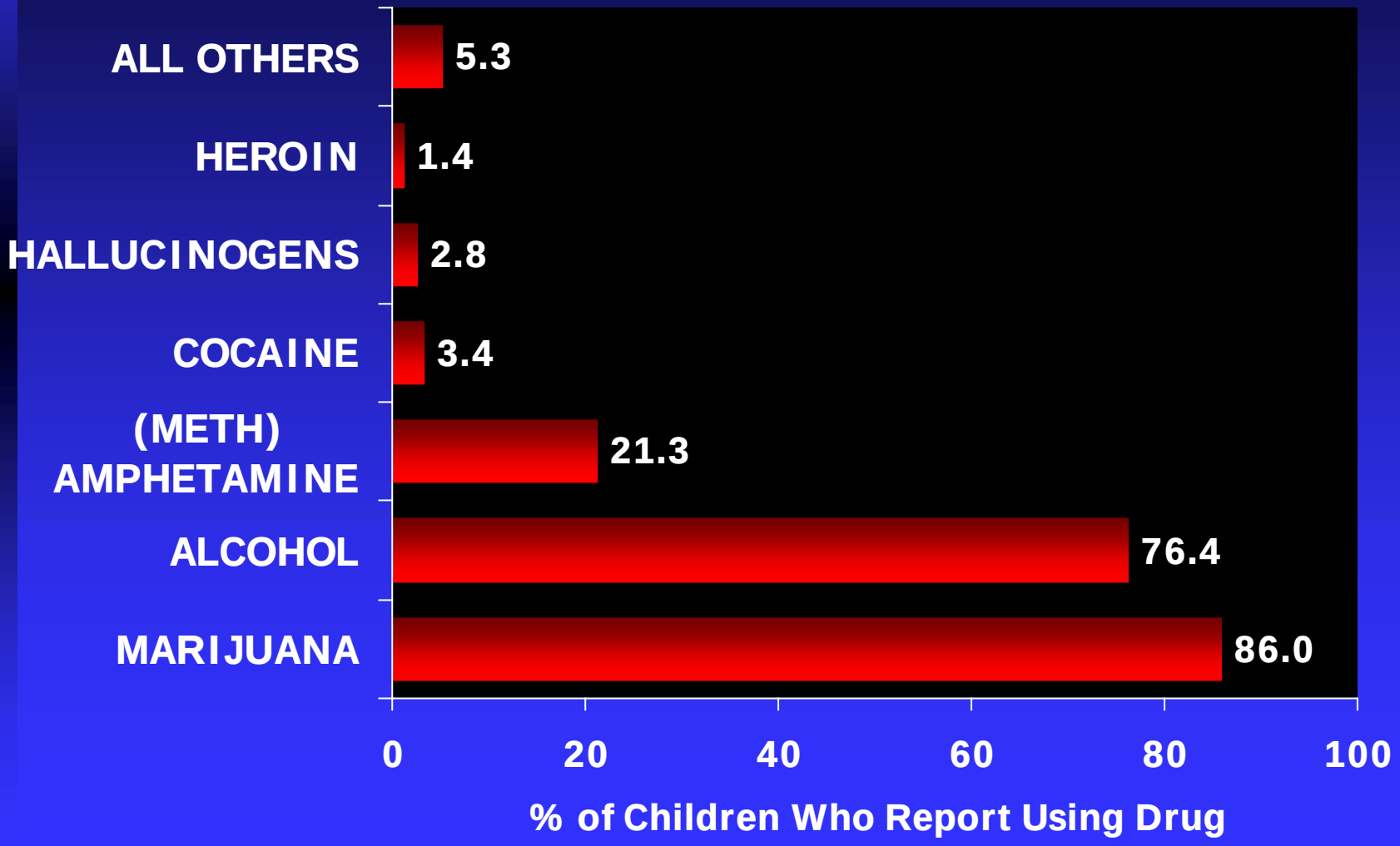


Analyses of data on all children
who received chemical dependency services
between 1/1999 and 12/2003

Marijuana and alcohol are the drugs most commonly used (per report) by children in treatment for chemical dependency. Methamphetamine is also used by a substantial minority of the children in treatment.

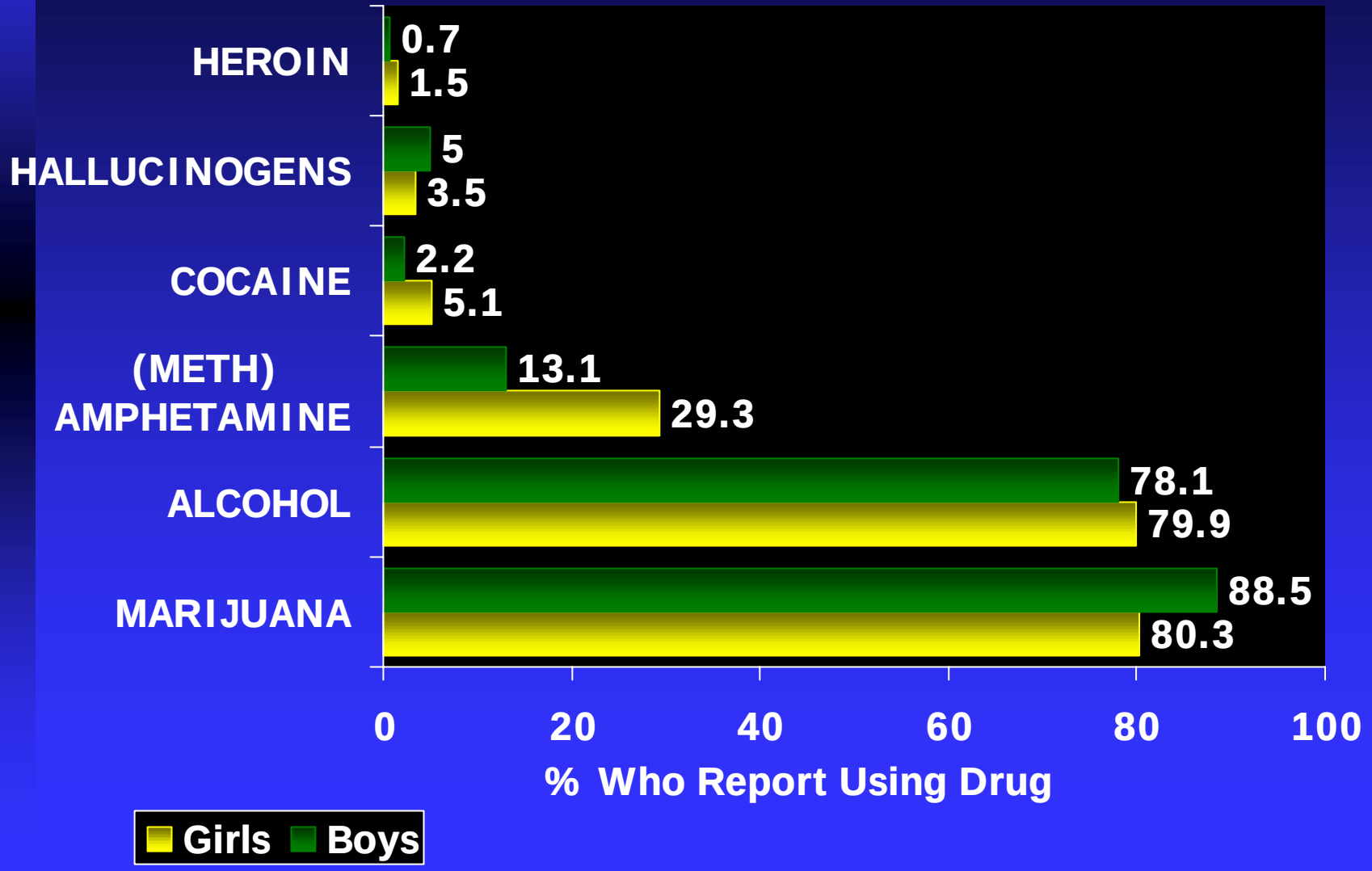
Drugs Reportedly Used by Children in Treatment with a Chemical Dependency Service Provider, 2003

(Data Source: CPMS)



Boys in treatment for chemical dependency are more likely than girls, per report, to have used marijuana and hallucinogens. Girls in treatment for chemical dependency are more likely than boys, per report, to have used alcohol, methamphetamine / amphetamine, cocaine, and heroin.

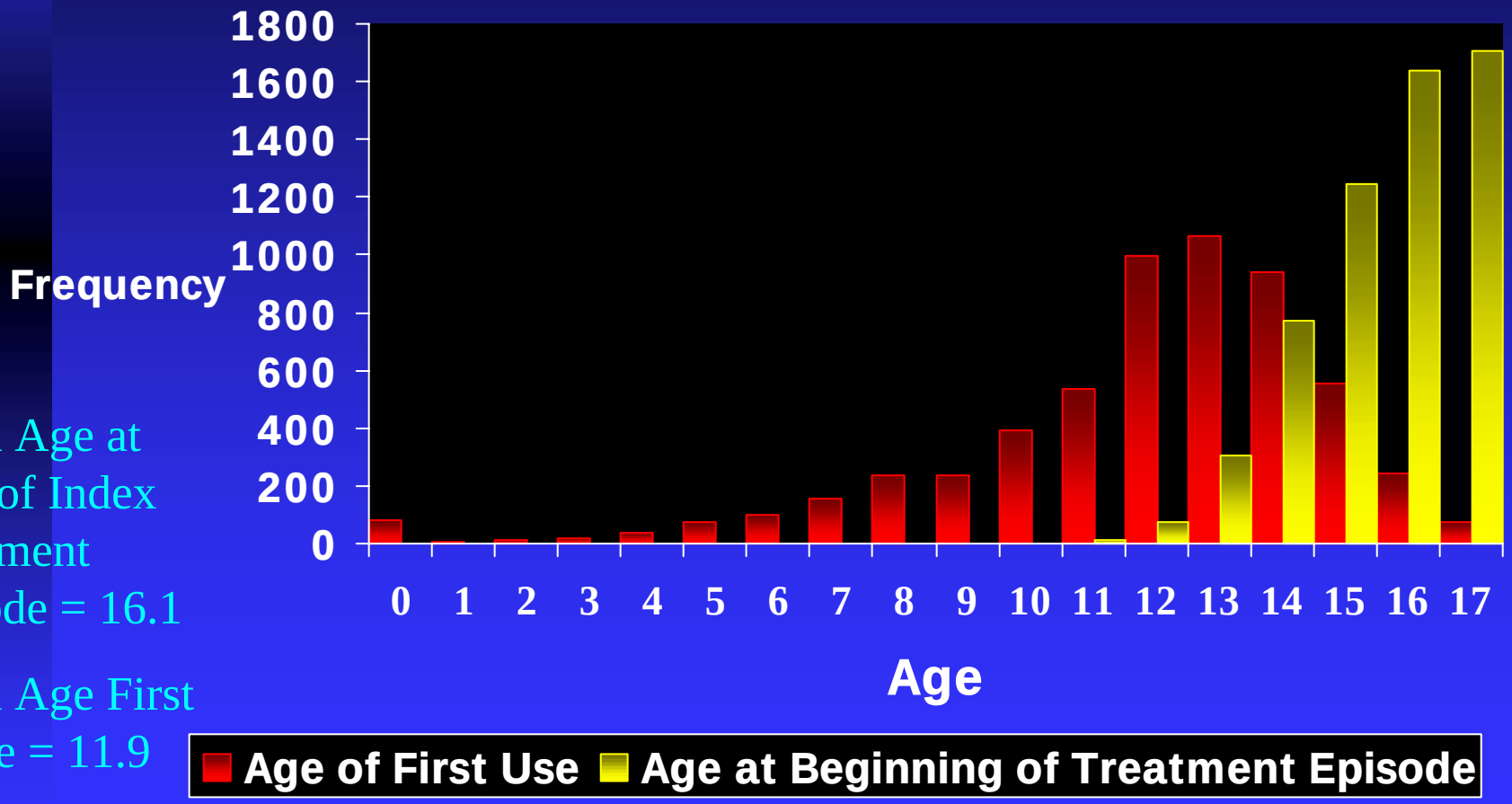
Drugs Reportedly Used by Children in Treatment with a Chemical Dependency Service Provider, 2003 By Gender *(Data Source: CPMS)*



There is typically a several-year lag between age of first use of alcohol/drugs and age of index treatment for chemical dependency.

Age at Beginning of Index Treatment Episode vs. Age at Onset of Drug/Alcohol Use, Per Report Children in Treatment for Chemical Dependency in 2003

(Data Source: CPMS)



Mean Age at Start of Index Treatment Episode = 16.1

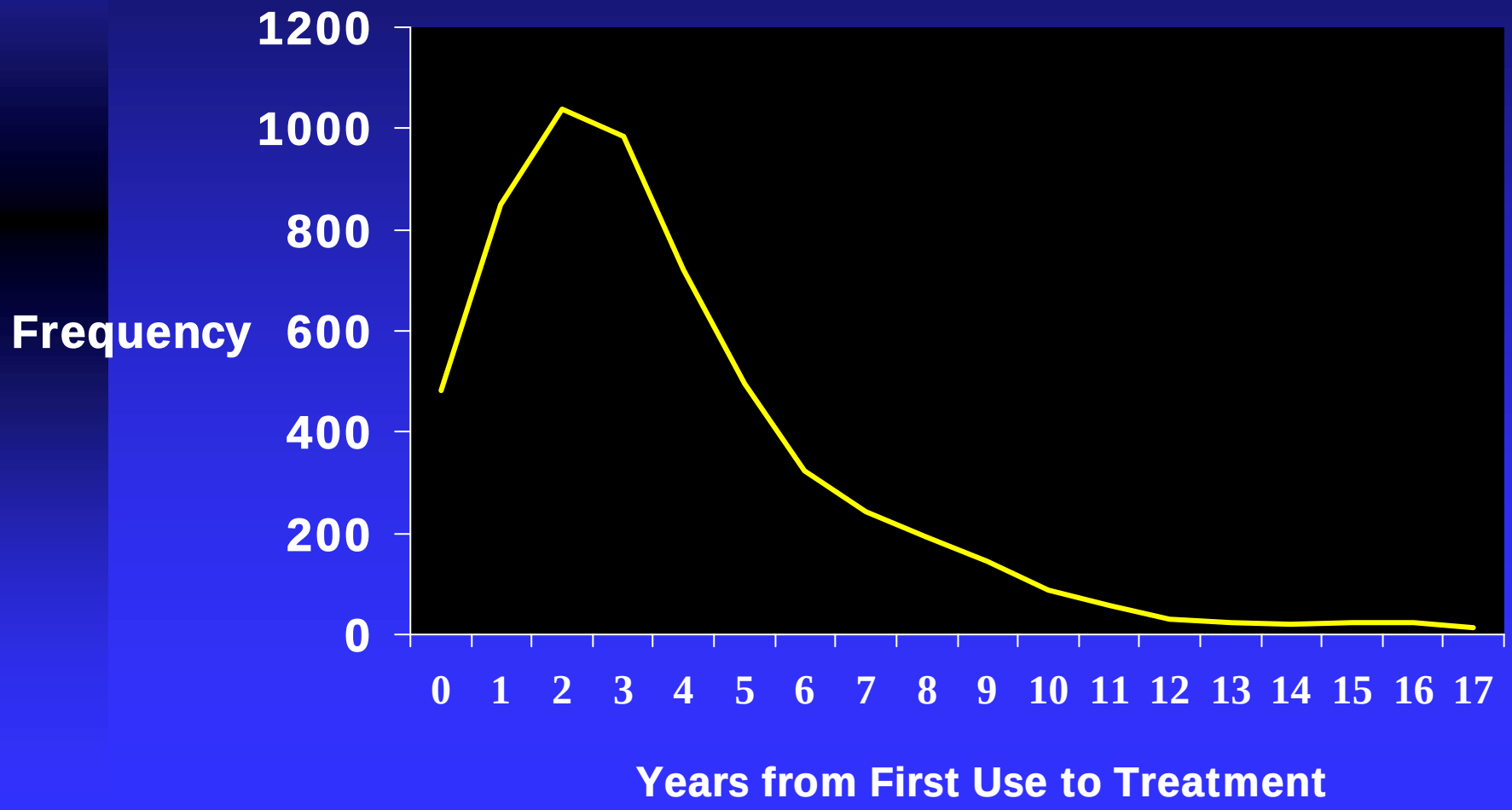
Mean Age First Abuse = 11.9

Years from First Drug/Alcohol Use, Per Report to Onset of the Index Treatment Episode

Children in Treatment for Chemical Dependency in 2003

(Data Source: CPMS)

Mean time from first abuse to treatment = 4.2 years



The age at which children begin using psychoactive substances (per report) depends in part on the substance being used.

Psychoactive Substance	Number of children reportedly using, of those in treatment in 2003 (per CPMS)	Mean Age, First Use
Barbiturates	4	12.3
Tranquilizers	4	12.5
Alcohol	3643	12.5
Marijuana/Hashish	4057	12.6
Inhalants	64	12.9
Heroin	50	13.0
Other Sedatives/Hypnotics	17	13.1
Non-Rx Methadone	2	13.5

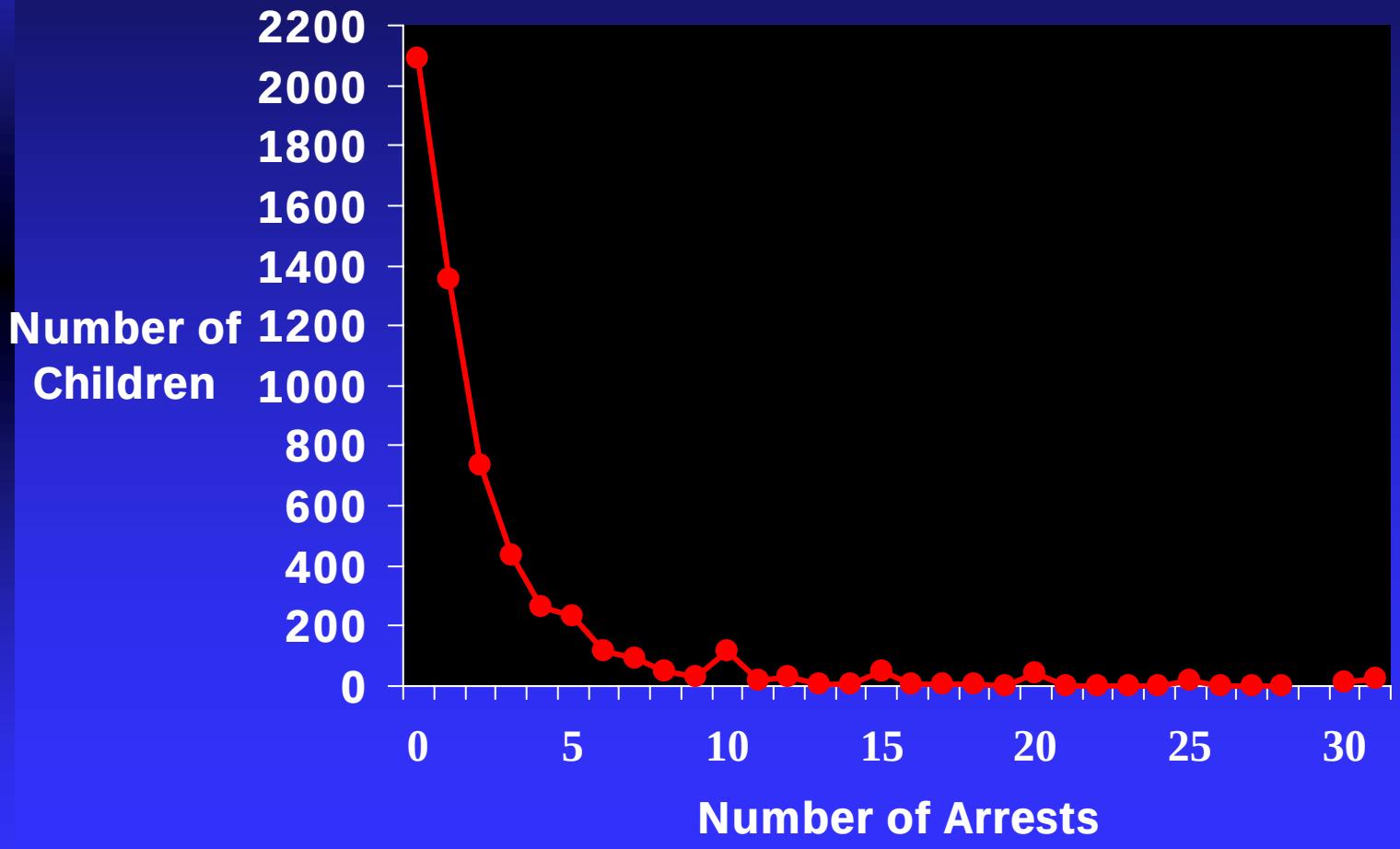
Psychoactive Substance	Number of children reportedly using, of those in treatment in 2003 (per CPMS)	Mean Age, First Use
Hallucinogens	116	13.6
Cocaine	154	13.9
Amphetamines/ Methamphetamines	898	14.0
Other Opiates/Synthetics	71	14.1
OTC	43	14.1
PCP	6	14.5

The typical child in treatment for chemical dependency has been arrested at least once (per report) in the 5 years preceding treatment.

Distribution of Arrests in Past 5 Years for Children in Treatment for Chemical Dependency, 2003

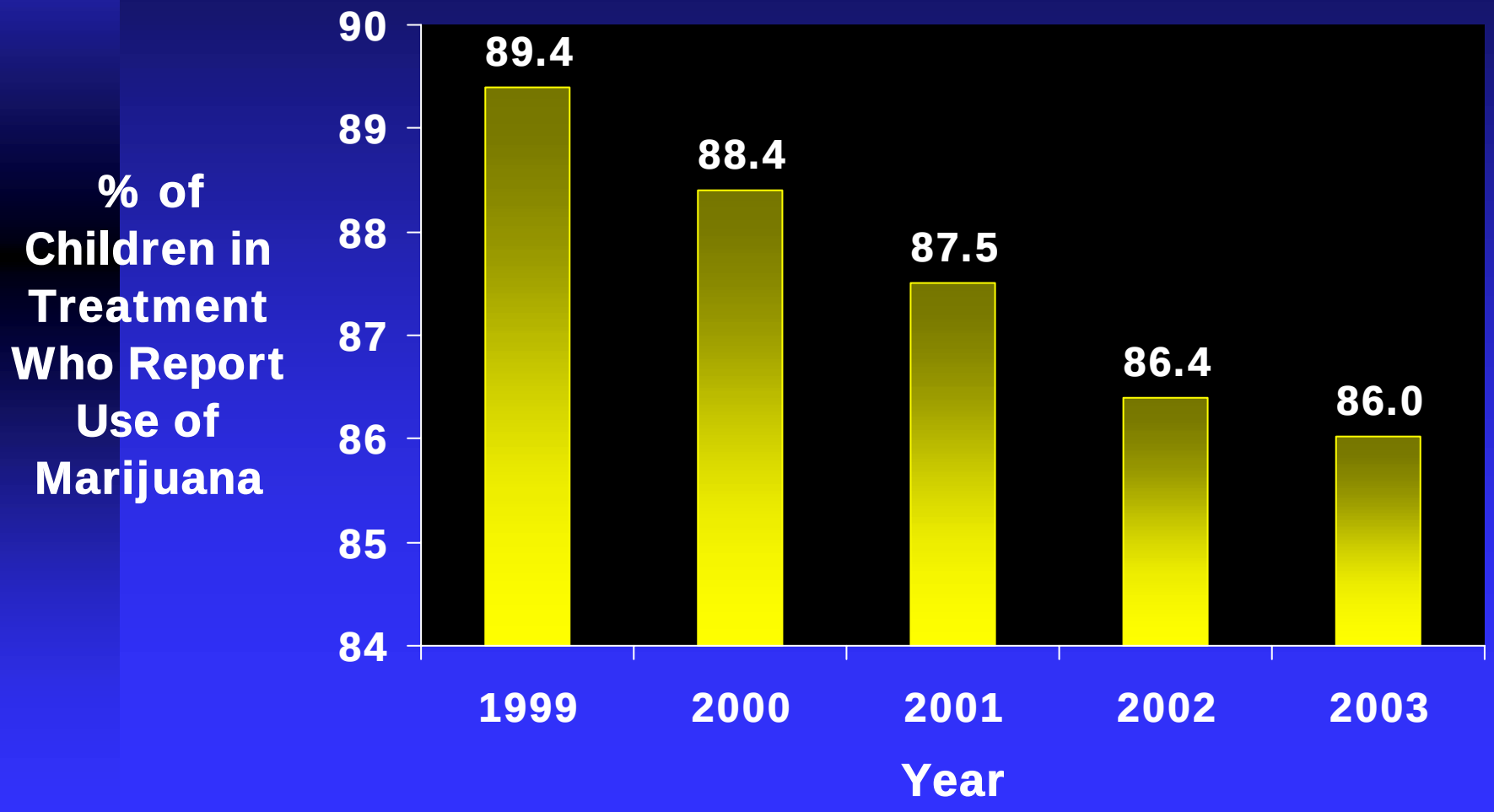
(Mean reported arrests = 2.6 (+/- 6.2); Median = 1)

(Data Source: CPMS)

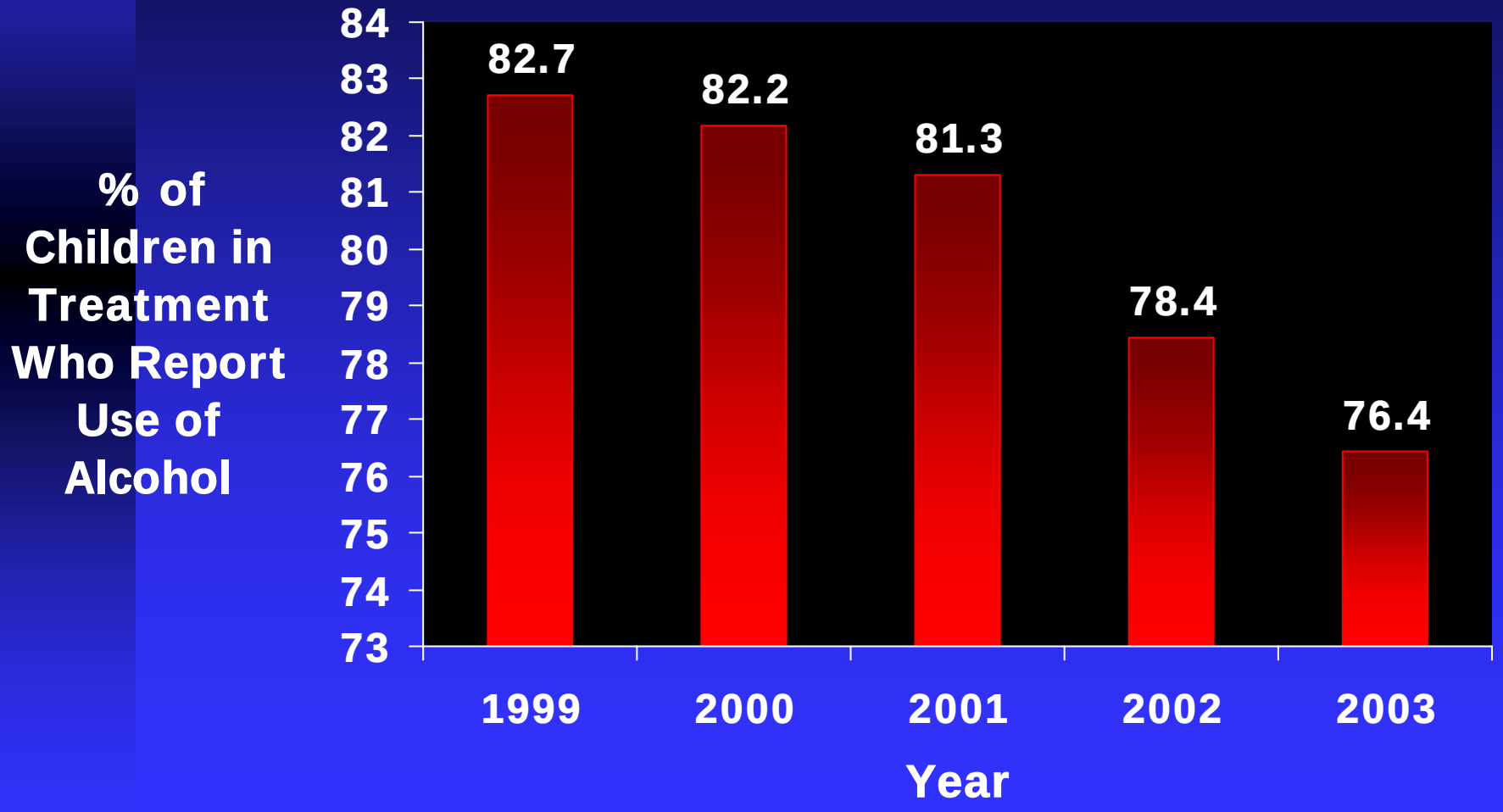


Among children in treatment for chemical dependency, reported use of marijuana, alcohol, hallucinogens, and inhalants has decreased over the past 5 years.

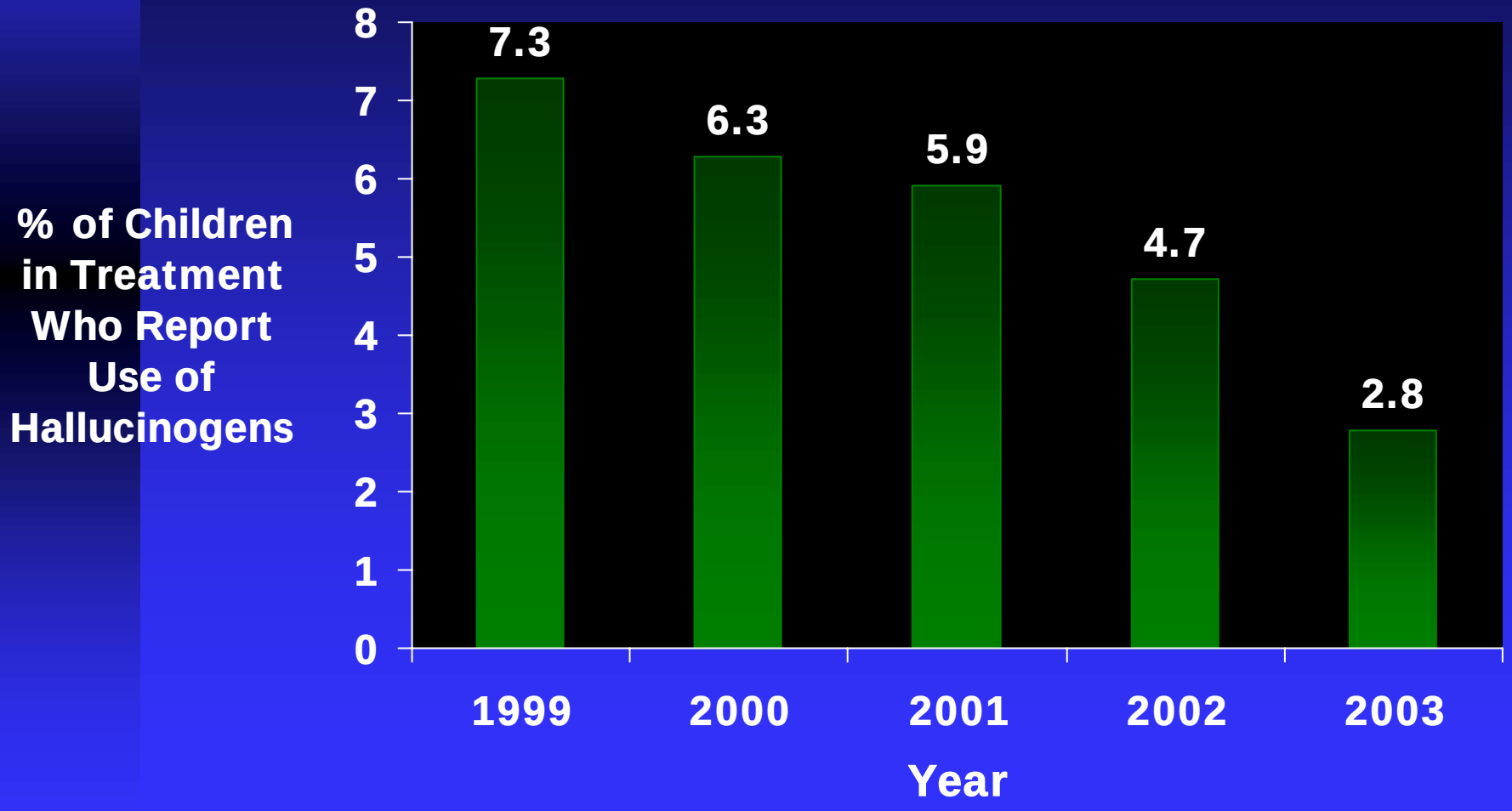
Marijuana Use, Per Report, by Children in Treatment with a Chemical Dependency Service Provider 1999-2003



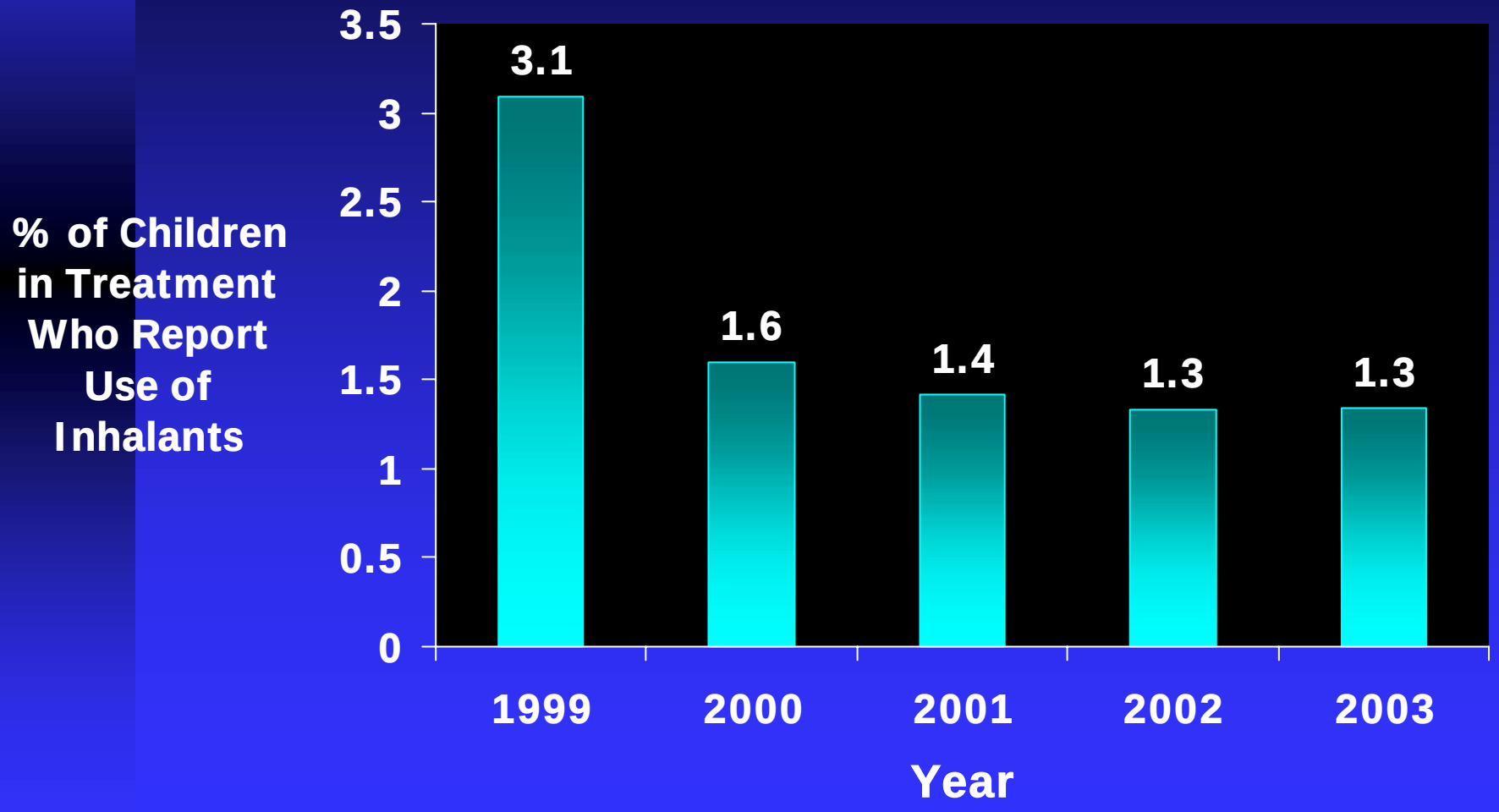
Alcohol Use, Per Report, by Children in Treatment with a Chemical Dependency Service Provider 1999-2003



Hallucinogen Use, Per Report, by Children in Treatment with a Chemical Dependency Service Provider 1999-2003

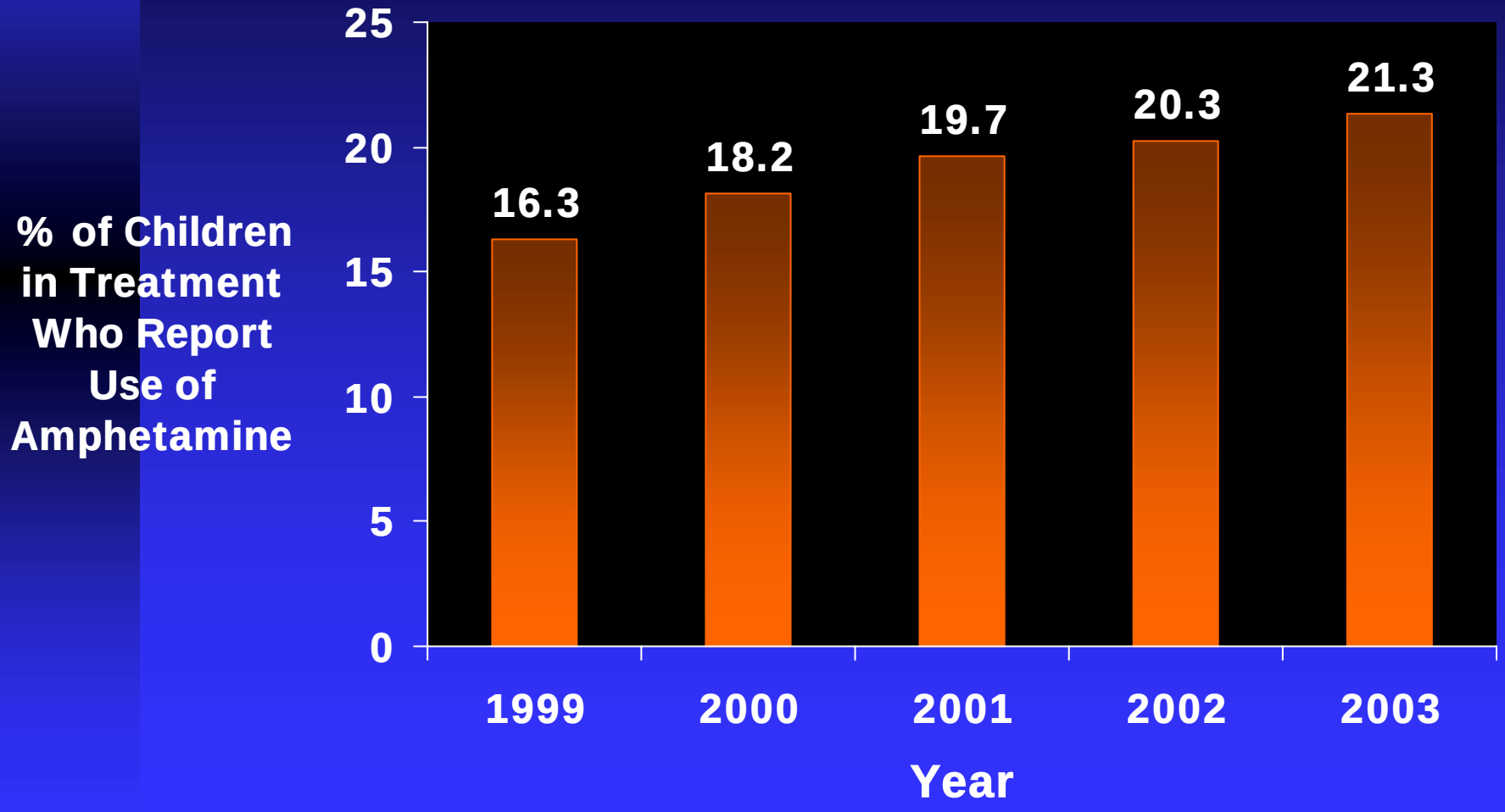


Inhalant Use, Per Report, by Children in Treatment with a Chemical Dependency Service Provider 1999-2003



Among children in treatment for chemical dependency, reported use of amphetamines / methamphetamines has increased over the past 5 years.

Amphetamine/Methamphetamine Use, Per Report, by Children in Treatment with a Chemical Dependency Service Provider 1999-2003



Summary

Each year, per CPMS, as many as 30,000 Oregonian children receive mental health and / or chemical dependency services through the state government.

In a typical year, about 80% of the children are in treatment for mental health problems, 15% for chemical dependency problems, and 5% for both mental health and chemical dependency problems.

The number of children in treatment increases with age, and except among very young children, the number of boys in treatment exceeds the number of girls in treatment.

The children in treatment are older and ethnically more diverse than they were five years ago.

Most services are provided on an outpatient basis. In 2003, almost 90% of service episodes were outpatient mental health services (73%) or outpatient chemical dependency services (15%).

The duration of service episodes ranges widely, from a mean of 6 days (crisis services for children over 12, in 2003) to a mean of 475 days (psychiatric day treatment services for children 0-12, in 2003).

The fraction of children receiving some form of case management in the course of a year has been increasing, from about 28% in 1999 to almost 40% in 2003.

The fraction of children receiving some form of medication management in the course of a year has also been increasing, from under 16% in 1999 to over 24% in 2003.

The fraction of children receiving individual, family, and group therapy in the course of a year has changed little. About 60% of the children in treatment receive individual therapy, about 50% receive family therapy, and about 15% receive group therapy.

There has been little change in the diagnoses carried by children in treatment. About 45% of the children carry a diagnosis of adjustment disorder or parent-child problem. Conduct / oppositional defiant disorders, depressive disorders, ADHD, and anxiety disorders are each diagnosed in about 10 to 20% of the children.

Marijuana and alcohol are the drugs most commonly used by children in treatment for chemical dependency. In 2003, 86% of the children reported use of marijuana, and 77% reported use of alcohol.

Methamphetamines / amphetamines are also used by a substantial minority of the children in treatment. 21% reported use of these drugs in 2003.

In 2003, the boys in treatment for chemical dependency were more likely than the girls to report having used marijuana (88.5% vs. 80%) and hallucinogens (5% vs. 3.5%).

The girls were more likely than the boys to report having used alcohol (80% vs. 78%), amphetamines (29% vs. 13%), cocaine (5% vs. 2%), and heroin (1.5% vs.0.7%).

Among the children treated in 2003 for chemical dependency, there was, on average, a 4-year lag between first use of alcohol/drugs and the beginning of the index treatment episode.

The age at which children begin using psychoactive substances (per report) depends in part on the substance being used. On average, children begin using alcohol and marijuana at age 12 ½, inhalants and heroin at age 13, hallucinogens at age 13 ½, and cocaine and amphetamines at age 14.

The typical child in treatment for chemical dependency reports having been arrested at least once in the past 5 years (in 2003, mean number of arrests = 2.6, median = 1).

Among children in treatment for chemical dependency, reported use of marijuana, alcohol, hallucinogens, and inhalants has decreased over the past 5 years. Reported use of amphetamines / methamphetamines, however, has steadily increased.

Questions / Comments

Substance Abuse Services under the Oregon Health Plan: Still Changing After All These Years

Roy M. Gabriel, Ph.D. Dennis D. Deck, Ph.D.

RMC Research Corporation
522 SW Fifth Avenue, Suite 1407
Portland, OR 97204
www.rmccorp.com

RMC Research Corporation: Who Are We?

- A private, for-profit research, evaluation, training and technical assistance organization
- Headquarters in Portsmouth, NH
- Regional offices in Portland, OR; Denver, CO; Arlington, VA; and Long Beach, CA
- Portland office
  - Opened in 1990; 2 staff and $200,000 in contracts
  - Now 35 staff and about $6 M in grants and contracts
  - Evaluation and Policy Studies in: Behavioral health, School/Community-based Prevention, Math/Science Ed, Reading Comprehension

And the Important Question: What Does “RMC” stand for?

- *QUALITY*

Other Members of RMC Research Team

- Kelly Vander Ley – Quantitative Analyst, Co-Occurring SA/MH Disorders; Behavioral Health and Primary Care
- Wyndy Wiitala – Quantitative Analyst, Administrative data
- Kathy Laws & Ryan D'Ambrosio – Qualitative Analysts, SA Prevention and Treatment, Evidence-based Practices
- Jeff Knudsen – Survey methodology, SA Tx Workforce, SA Prevention
- Jane Grover – Culturally Competent evaluation methods, American Indian Behavioral Health programs
- Matthew Carlson – alumnus

RMC History of Research on OHP and Substance Abuse Services

- 1996 – SAMHSA CSAT: Effects of Managed Care on Utilization and Outcomes of SA Tx Services for Medicaid Adults
- 1997 – SAMHSA CSAT: …for Medicaid Adolescents
- 1999 – SAMHSA CSAT: Follow-up and Continued study on both populations
- 2000 – NIAAA (w/OHSU)
- 2000 – OR OADAP – Qualitative interviews w/providers and MCOs in all OR counties
- 2001 – SAMHSA CSAT – Effectiveness of Integrated COD Tx
- 2002 – NIDA – Effects of Different Financing Mechanisms on Methadone Maintenance Tx (Supplement in 2003 to focus on impact of cuts)
- 2004 – RWJ – Effects of Statewide Budget Reductions on Substance Abuse and Mental Health Services for Oregon's Most Vulnerable Citizens

Key Elements of RMC Research on OHP

- Three-pronged methodology:
  - Construction, analysis of statewide analytic databases
  - Longitudinal follow-up studies of clients in Tx, using standardized instruments
  - Qualitative interviews of key stakeholders at state, county and local provider levels
- Comparisons w/state of Washington in most studies
  - Similar in demographics to Oregon, but very different in health/SA policies
- Partners, partners, partners
  - OR, WA state SA/BH agency, Medicaid staff
  - OHSU investigators (Depts of Psychiatry, Public Health & Preventive Medicine)
  - OHREC

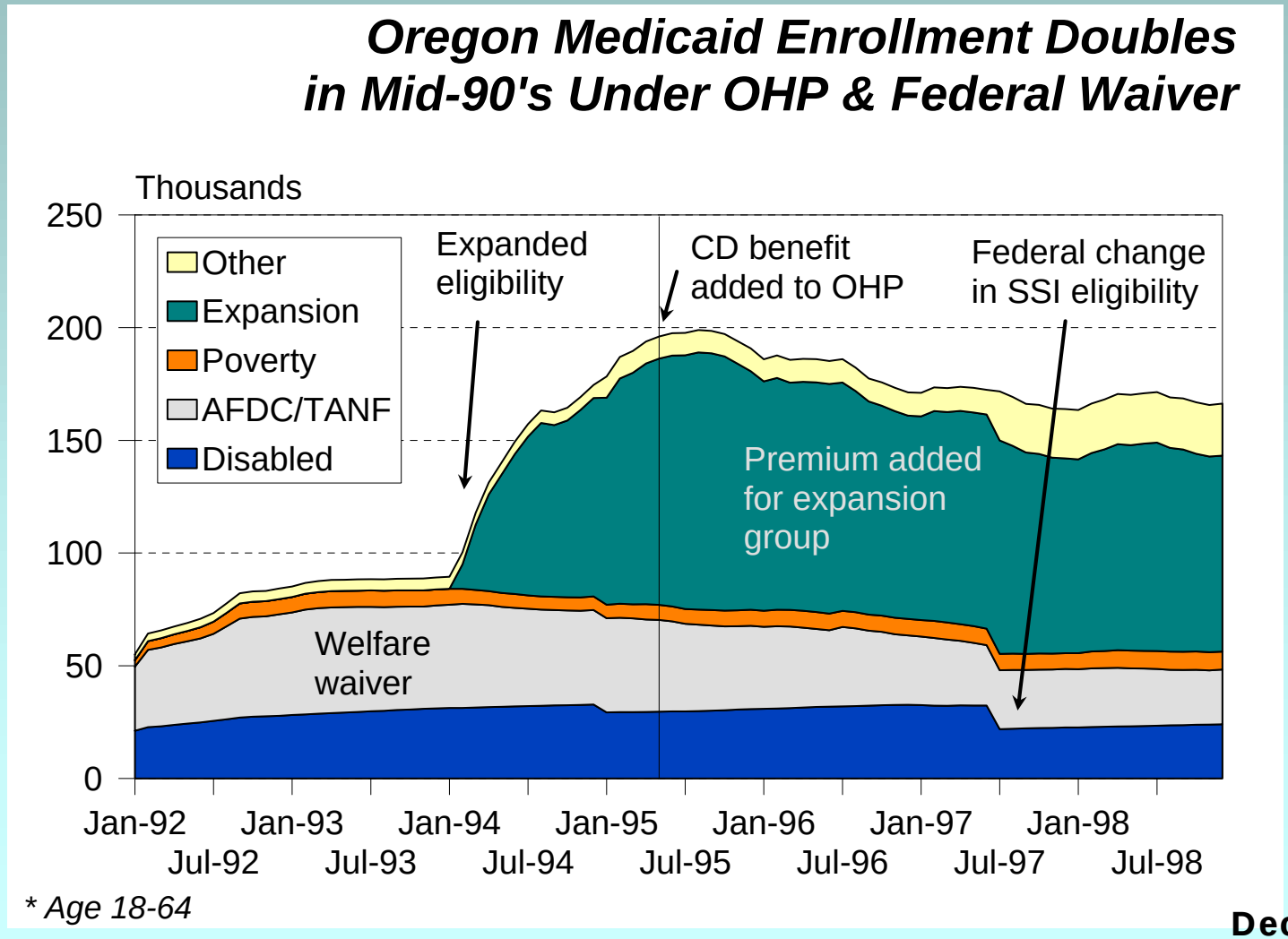
Brief Chronology of OHP Developments w/respect to Substance Abuse Services

Date	Policy Change
Feb., 1994	Expanded eligibility to all under 100% FPL
May, 1995	SA services integrated with medical care under managed care
Jan., 1996	Premium implemented for “Expansion” population in OHP ($6-$20 per mo. w/a number of waivers)
Oct., 2002	New CMS Waiver bifurcates OHP population into two sub-populations: OHP Standard (previous “Expansion”) and OHP Plus (categorical eligibles)
Feb., 2003	Co-pays implemented for OHP Standard ($5) and OHP Plus ($3) Premium payment rigorously enforced (disenrollment & 6-mo. “lockout”)
Mar., 2003	SA/MH benefit eliminated for OHP Standard
June, 2004	Co-pay requirement dropped for OHP Standard
July, 2004	No new OHP Standard enrollees permitted
Aug. 2004	SA/MH benefit reinstated for OHP Standard

Administrative Data Studies

- Trends in Medicaid enrollment and
- Substance Abuse Treatment access and utilization
  - By Medicaid eligibility groups
  - By adult and adolescent populations
- Development of treatment outcome measures, severity indicators

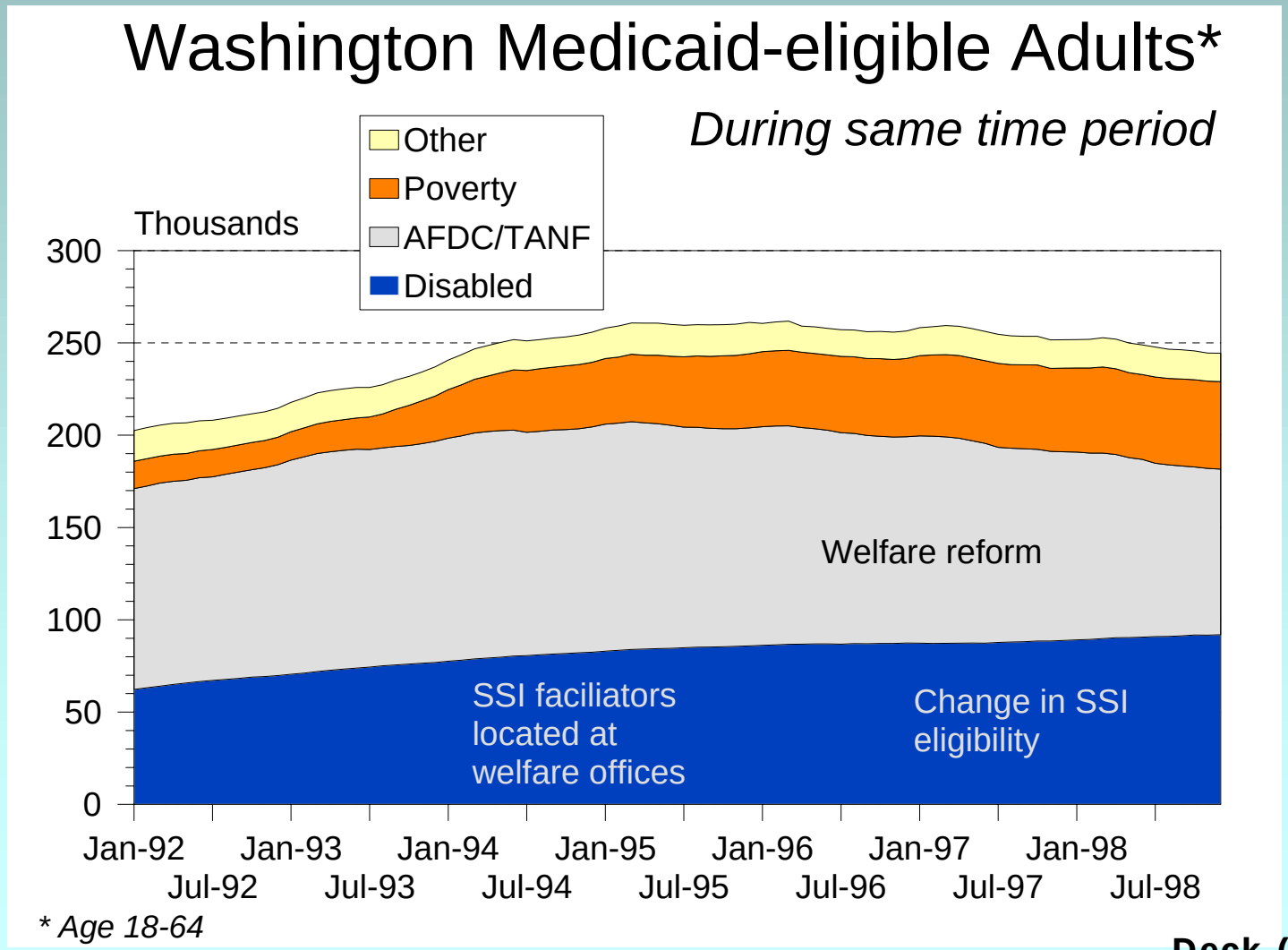
Medicaid expansion in Oregon: Adults* 1992–1998



* Age 18-64

Deck (2000)

Medicaid expansion in Washington: Same time period

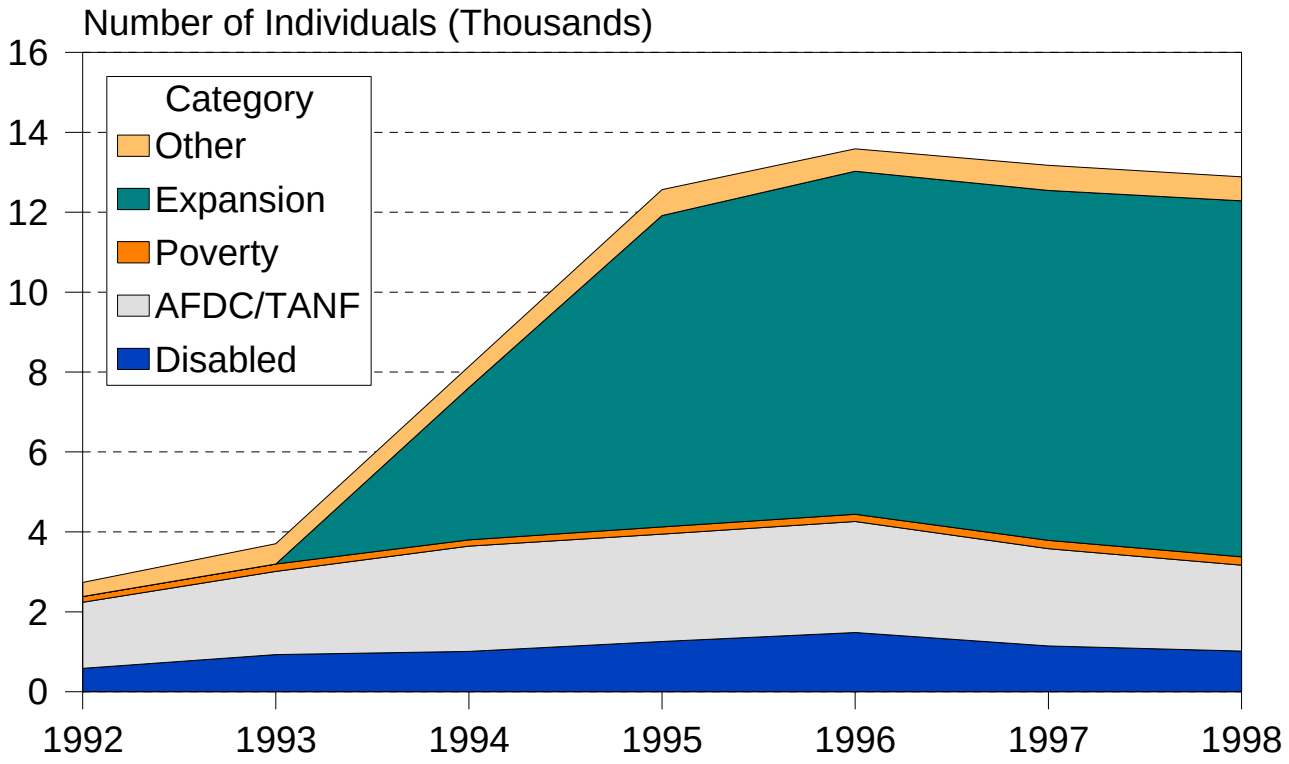


Deck (2000)

OR Admissions to SA Tx: 1992–1998 (Medicaid Adults)

Oregon Admissions to Treatment

Number of Medicaid-eligible adults admitted to at least one treatment service during year



Source: State treatment database (CPMS) and Medicaid eligibility files

Deck (2000)

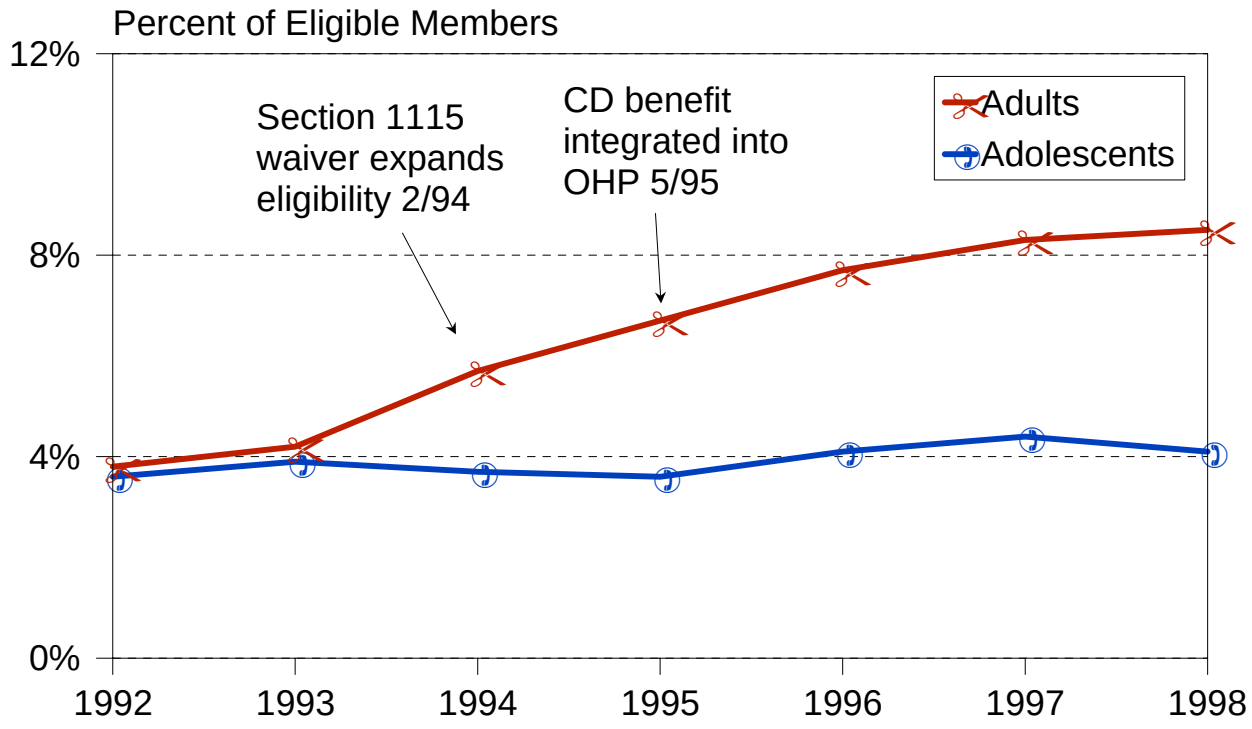
Sidebar: Publicly-funded SA Tx Services

- About 30,000 adults received publicly-funded SA Tx in Oregon in 2000 – about 10,000 of them supported by Medicaid
- Major Tx modalities for OHP adults
  - Outpatient (60% – 70%)
  - Residential (10% – 15%)
  - Methadone Maintenance (5%)
  - Detoxification (15% – 20%)
- Distribution of modalities differs slightly for various Medicaid eligibility groups and for those supported by other public funded
- At the best of times, only 1 in 4 or 1 in 5 adults who need alcohol or drug treatment actually receive it (“Treatment Gap”)

Rates of Access to SA Tx, 1992-1998: Oregon Adults and Adolescents

Oregon Access Rates

Eligible individuals admitted to treatment during year as percentage of average eligible members



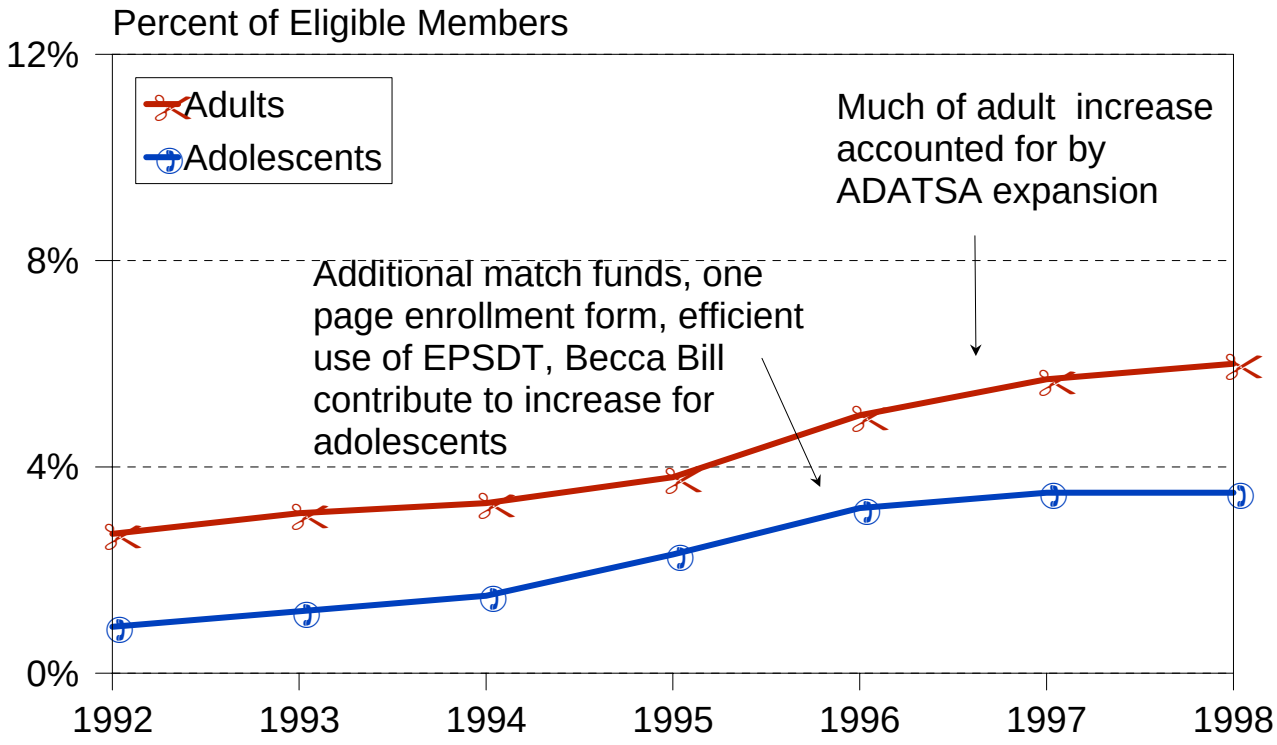
Source: State treatment database (CPMS) and Medicaid eligibility files

Deck (2000), Deck et al (2000)

Rates of Access to SA Tx, 1992-1998: Washington Adults and Adolescents

Washington Access Rates

Eligible individuals admitted to treatment during year as percentage of average eligible members



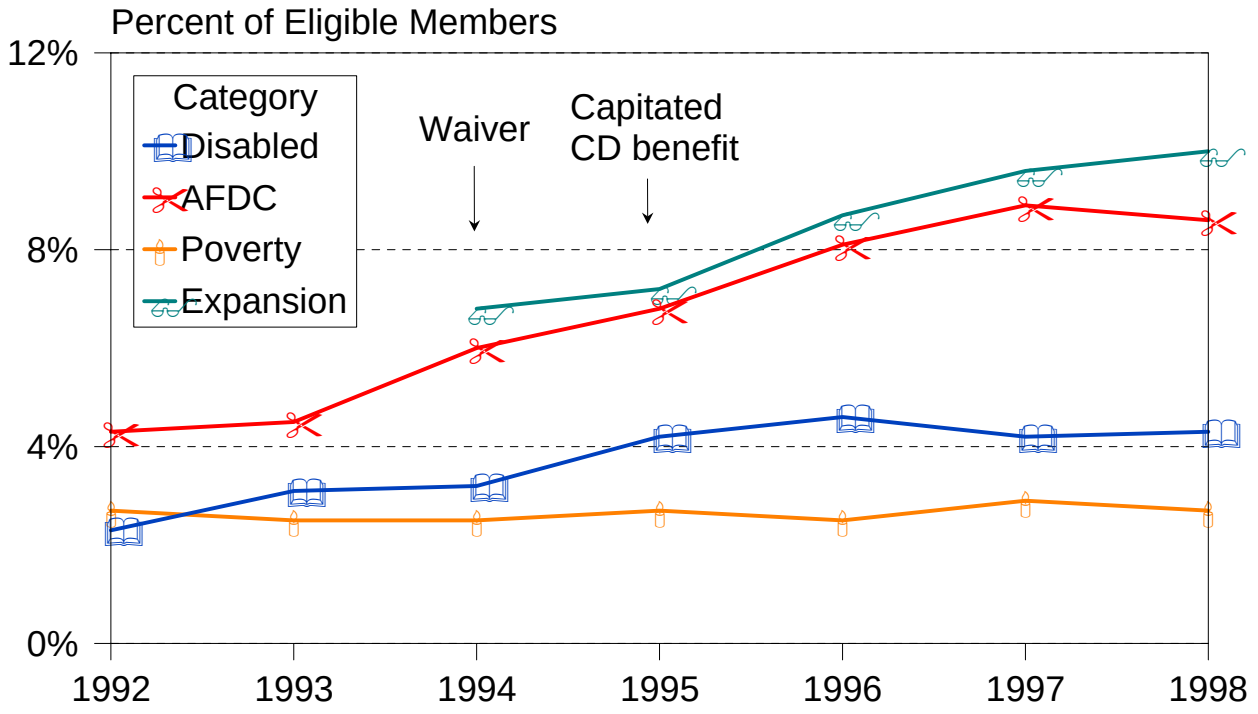
Source: State treatment database (TARGET) and Medicaid eligibility files

Deck (2000)

Access to SA Tx by Medicaid Eligibility Group in Oregon

Oregon Subgroup Access Rates

Adults admitted to treatment during year as percentage of average eligible members



Note. Rate for Other not shown, small group with changing composition
Source: State treatment database (CPMS) and Medicaid eligibility files

Deck (2000)

What We Learned about Access to Tx under the OHP

- Contrary to concerns accompanying the shift to managed care, access to SA Tx did not decline; in fact it increased dramatically for adults under OHP
- No coincident reduction in access to Tx by other publicly-funded adults (i.e., not simply cost shifting)
- No difference in severity of clients treated under OHP vs. other public funds (i.e., not “skimming off the top”)
- Large variation in access to Tx for adults enrolled in different managed care organizations
- Little increase in access to Tx for adolescents

What about Outcomes of SA Treatment?

- Limited information available statewide from administrative databases. RMC formulation:
  - Retention in Tx (advantages over length of stay)
  - Tx Completion (clinical judgment at provider level)
  - Abstinence from AOD at discharge from Tx (self-report)
  - Readmission to Tx within year (a good thing? A bad thing?)
- More detailed, but less generalizable, information available from prospective sample studies
  - Addiction Severity Index (ASI): Degree of problems in alcohol use, drug use, mental health, medical condition, employment, criminal justice involvement
  - Global Appraisal of Individual Needs(GAIN): 8 outcome domains
  - Client Satisfaction with Tx Services
  - Interviews of client samples at Tx entry, 6 mos. and 12 mos. later

Outcomes: Findings from Longitudinal Adult Study Samples

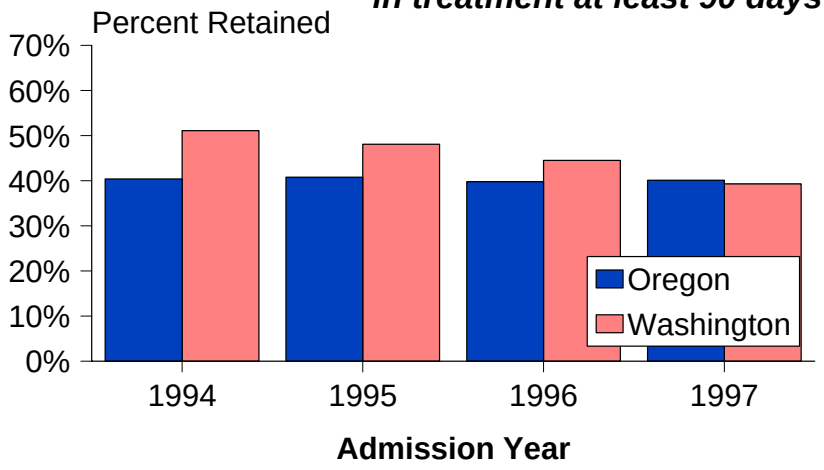
- Significant declines in all problem domains from baseline to 6 mo. follow-up. Improvement persisted, but did not continue, through 12 mo. follow-up
- Strongest difference with comparison state was in more significant improvement in mental and physical health among Oregon clients
- Greater, more lasting improvement among clients who were less severe, had fewer prior Tx episodes, and reported satisfaction with services received
- No differences in Tx outcome by gender, race/ethnicity, self-reported motivation/readiness for Tx, degree of integration in COD Tx

What SA Tx Providers Told Us

- Transition through Medicaid expansion and managed care included several phases and all were difficult. Providers had to become better “business people.”
- Objected to added layers of administration between funding and care; and alleged underwriting of financial losses on physical health care (fruits of integration)
- Different financing approaches across MCOs very influential in quality/consistency of care
- Mandating ASAM diagnosis and placement criteria significantly “professionalized” the field

Retention in Outpatient Treatment

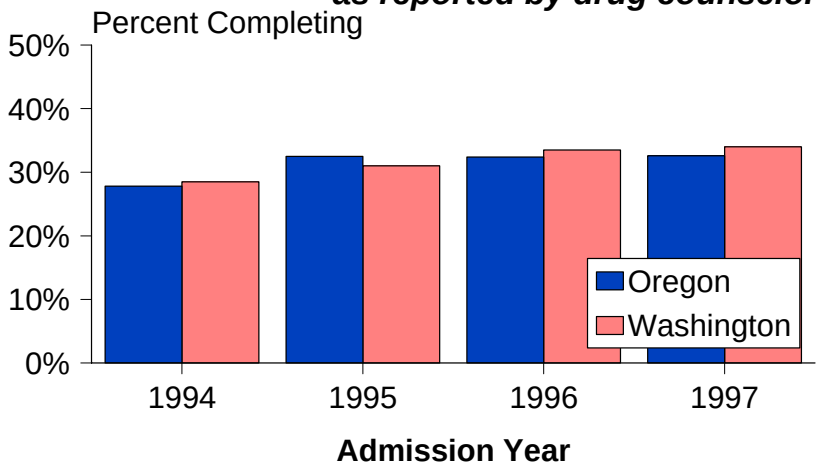
Percent of eligible adults retained in treatment at least 90 days



Excluded deaths, incarceration, moves. Excluded outlier discharge dates.

Outpatient Treatment Completion

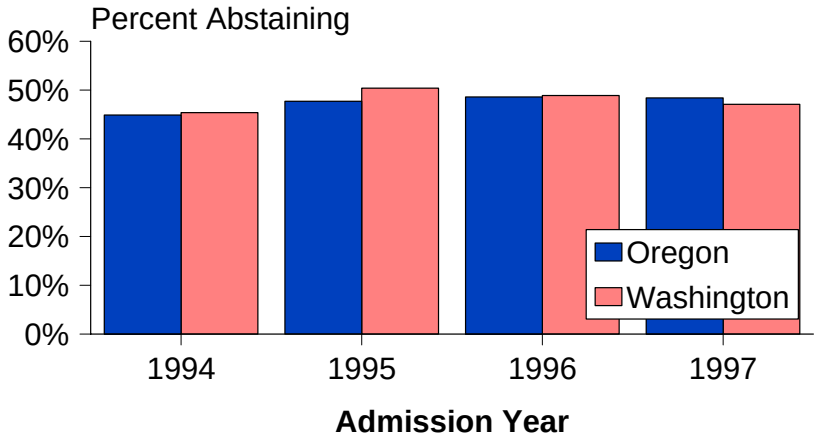
Adults completing treatment as reported by drug counselor



Excluded deaths, incarceration, moves. Greater attention given to quality of outcome reporting in later years in both states.

Abstain at Discharge

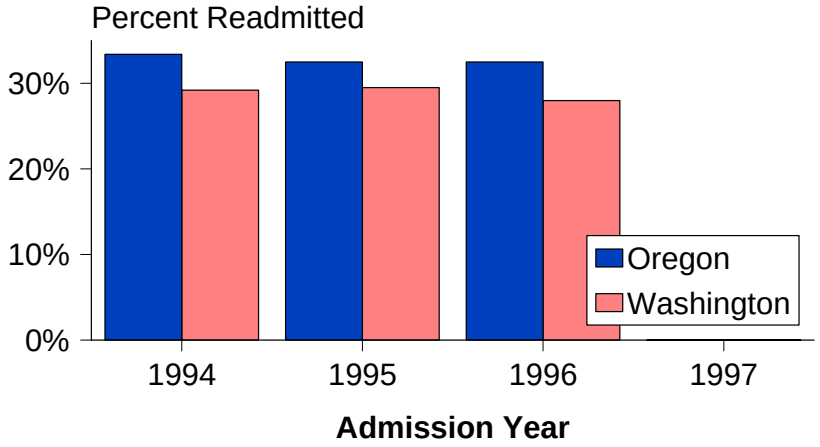
Adults abstaining from use of primary drug during 30 days prior to discharge



Excluded deaths, incarceration, moves. Greater attention given to quality of outcome reporting in later years in both states.

Outpatient Treatment Readmission

Adults readmitted to treatment within one year



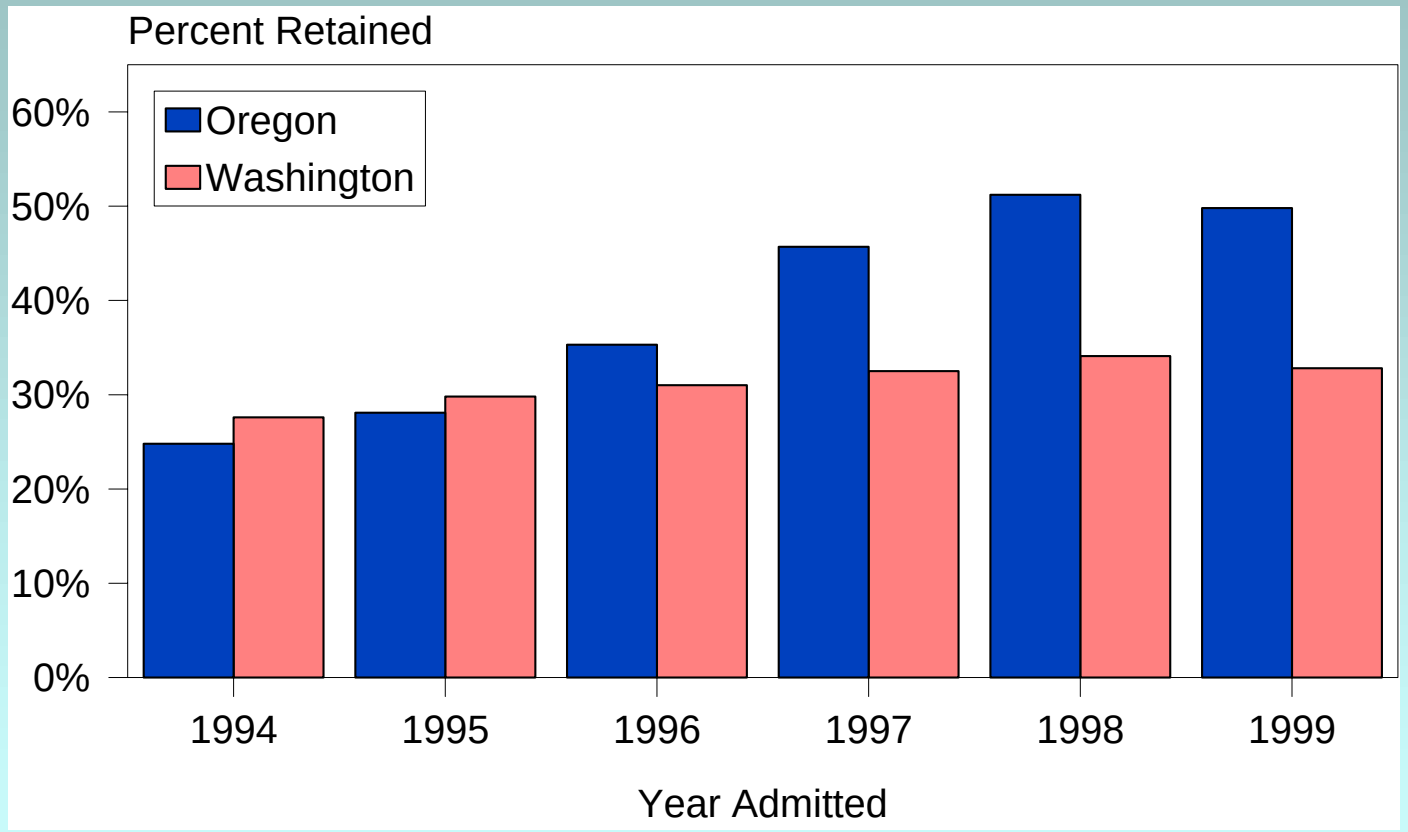
Excluded transfers within 3 weeks of discharge, deaths, incarceration, moves. Part of difference may be due to multiple IDs for some clients in Washington.

Outcomes: Statewide Findings 1992-1998

- Little change in administrative data outcomes from pre- to post-OHP expansion; and similar trends to those found in comparison state, Washington
- For Outpatient Tx:
  - Retention inTx for at least 90 days: 40% to 50%
  - Tx Completion: 25% to 33%
  - Abstinence at discharge: 45% to 55%
  - Readmission to another Tx episode: 30% to 35%
- More positive outcomes for those who had longer continuity of Medicaid coverage and those with lower SA problem severity

Deck (2002), McFarland et al (under review)

Methadone Outcomes: Retention (1 year)



Retention rates by admission cohort for adults (ages 18-64) entering methadone maintenance programs in Oregon (N = 6,863) and Washington (N = 5,308).

Deck & Carlson 2005

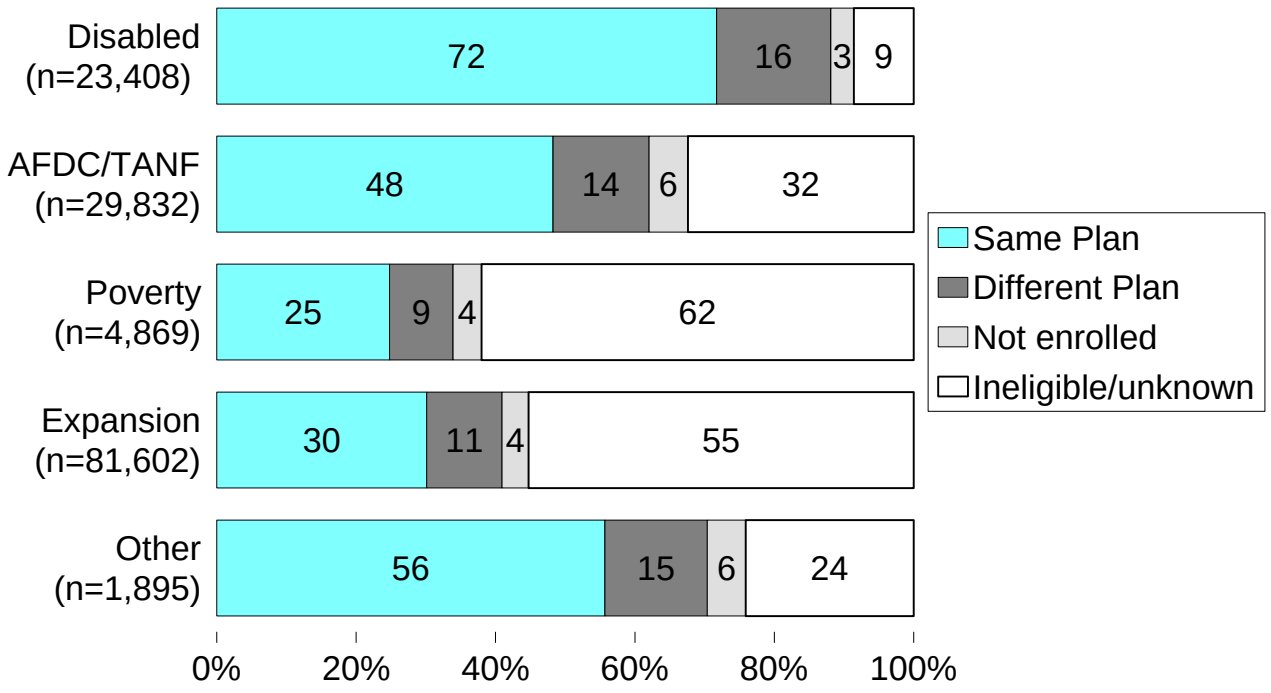
Outcomes for Methadone: Retention (1 year)

- Increased retention in Oregon explains the dramatic increase in MMT utilization starting about 1997.
- Driving force appears to be more adequate financing in Oregon compared to Washington which led to state differences in provider behavior and ultimately better client outcomes.
- Forthcoming in Deck & Carlson (2005) JBHSR [Jan issue]
- We expect something of a reversal in the two states over the next year or two as the impact of cuts to OHPS in Oregon and expanded capacity and funding in Washington play out.

Sidebar: Continuity of Insurance Coverage under OHP, the early years

Stability of Enrollment

Enrollment status of Oregon adults one year later by their eligibility category on 1/1/96



But That Was Then…

- Changes in OHP since 2002 have affected SA services dramatically
  - Monthly premiums, co-pays
  - Elimination of SA/MH benefit for OHP Standard 3/03
  - 51% disenrollment in OHP beginning in 2003
    - Both voluntary and disciplinary
    - Disproportionate among lowest income, most medically needy
  - Decline in use of outpatient, methadone maintenance services since beginning of 2003 for both OHP Standard and Plus
  - Resumption of SA/MH benefit for OHP Standard, 8/03
  - Now what?

RMC Continuing Study

- "Natural Experiment":

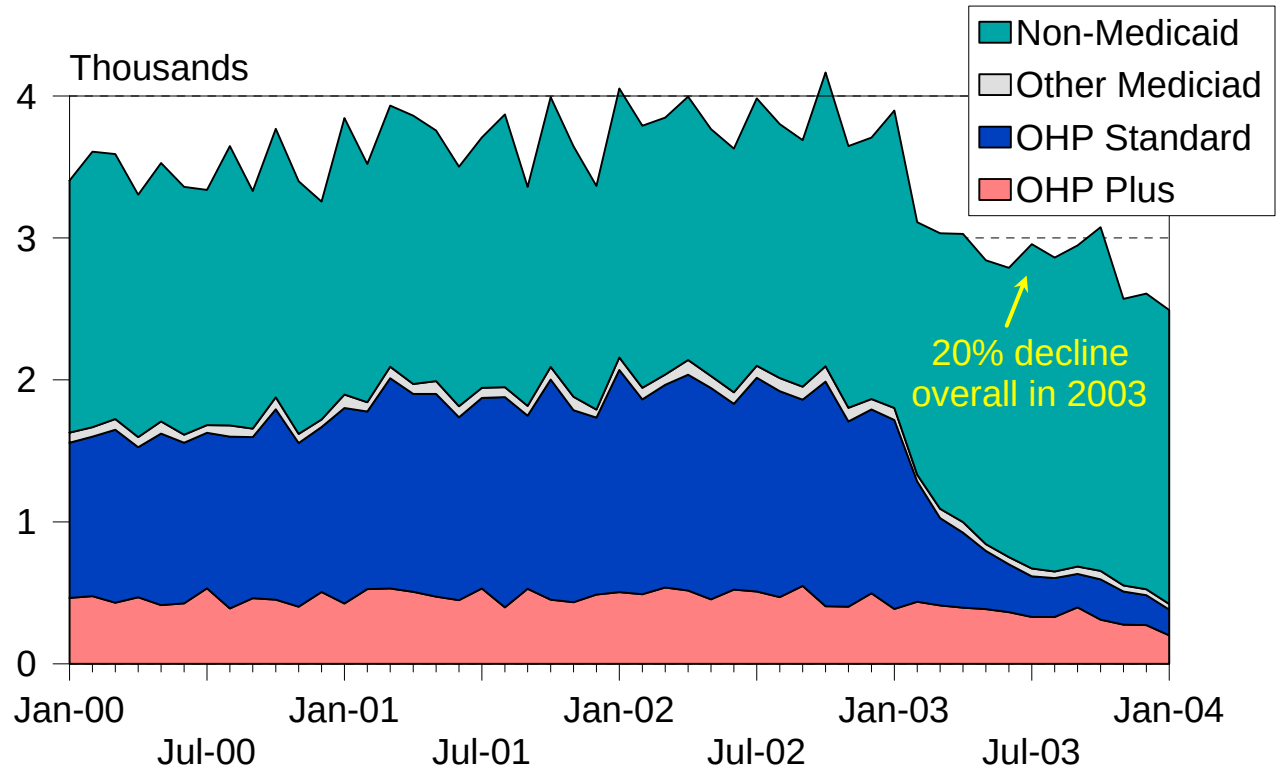
Oregon Health Plan SA / MH Benefit Coverage by OHP Study Population and Time Period

	OHP Policy-Relevant Time Period		
	Prior OHP (OHP: 1/00–12/02)	**Restructured OHP (OHP2: 1/03–8/04)**	**Revised OHP[1] (OHP2: 8/04–)[1]**
Medicaid: OHP Standard	Covered	Not Covered	Covered[1]
Medicaid: OHP Plus	Covered	Covered	Covered[1]
Non-Medicaid: Other Publicly Funded	N/A	N/A	N/A[1]

Recent Trends: Access to Publicly Funded Tx

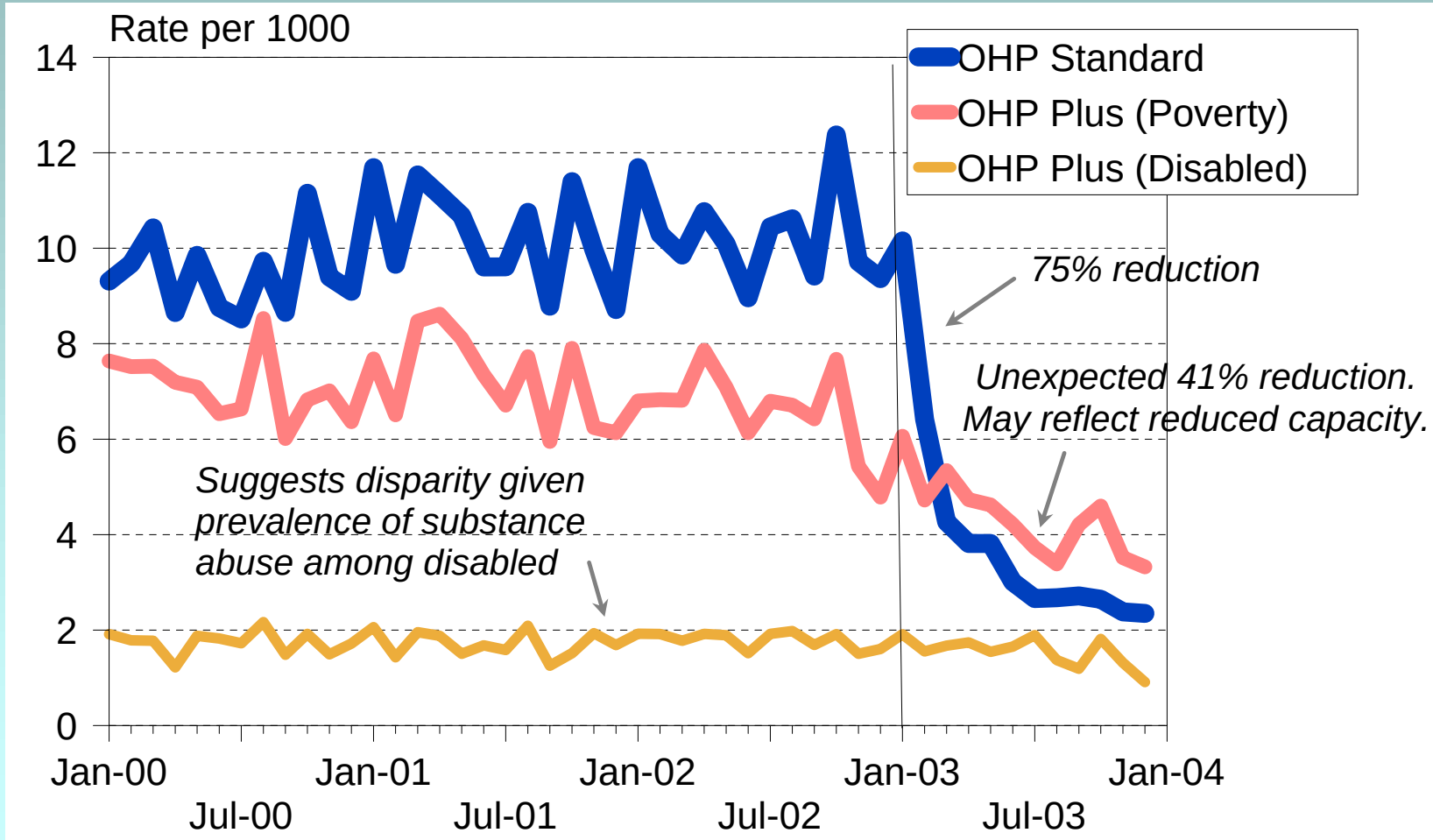
Total Adults Admitted to any Publicly Funded Substance Abuse Treatment

(including Residential Detox)



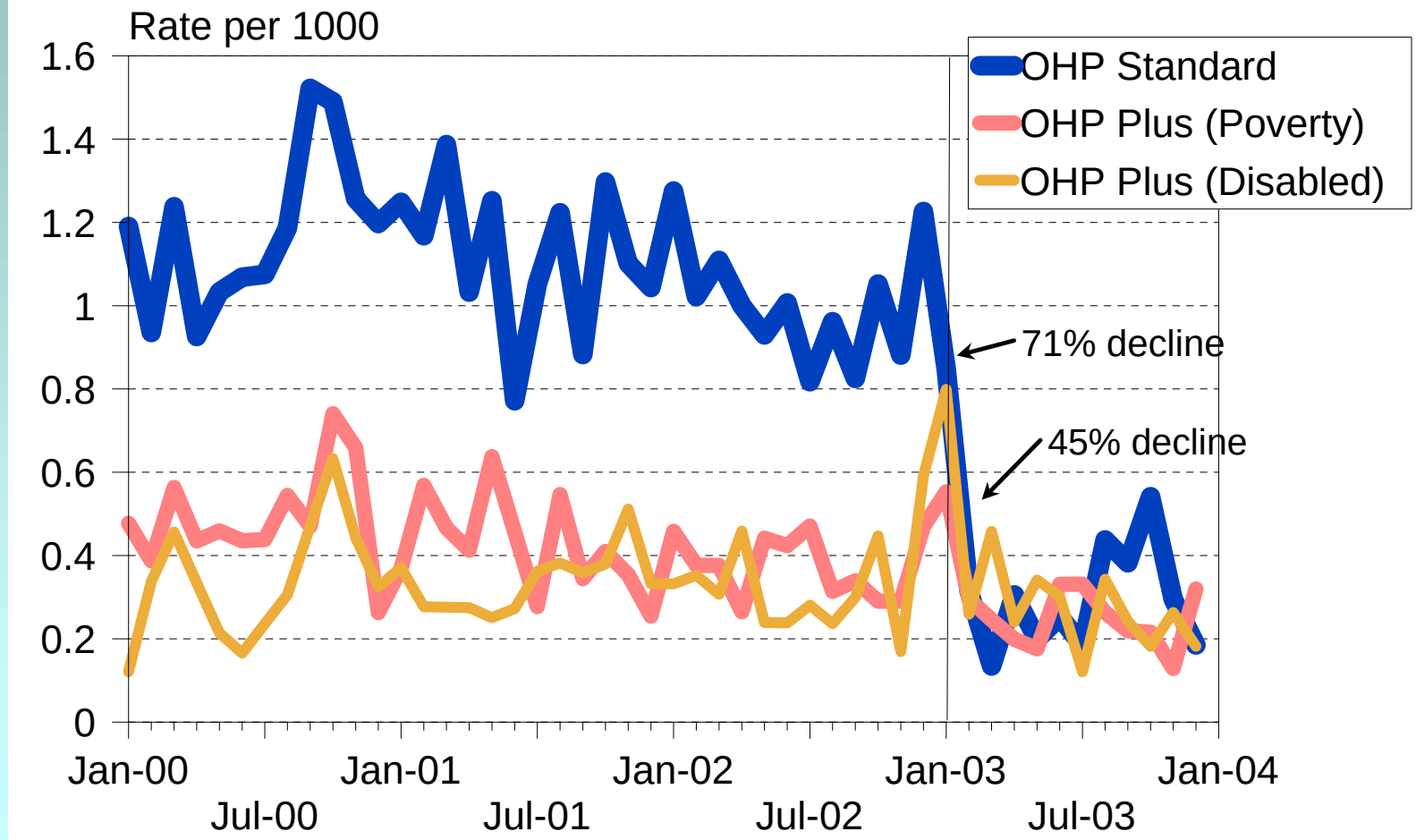
Unduplicated count by month. (% change based on 2002-03 averages)

Recent Trends: Outpatient Admissions



Number admitted by month per 1000 Medicaid eligible that month.

Recent Trends: Methadone Admissions

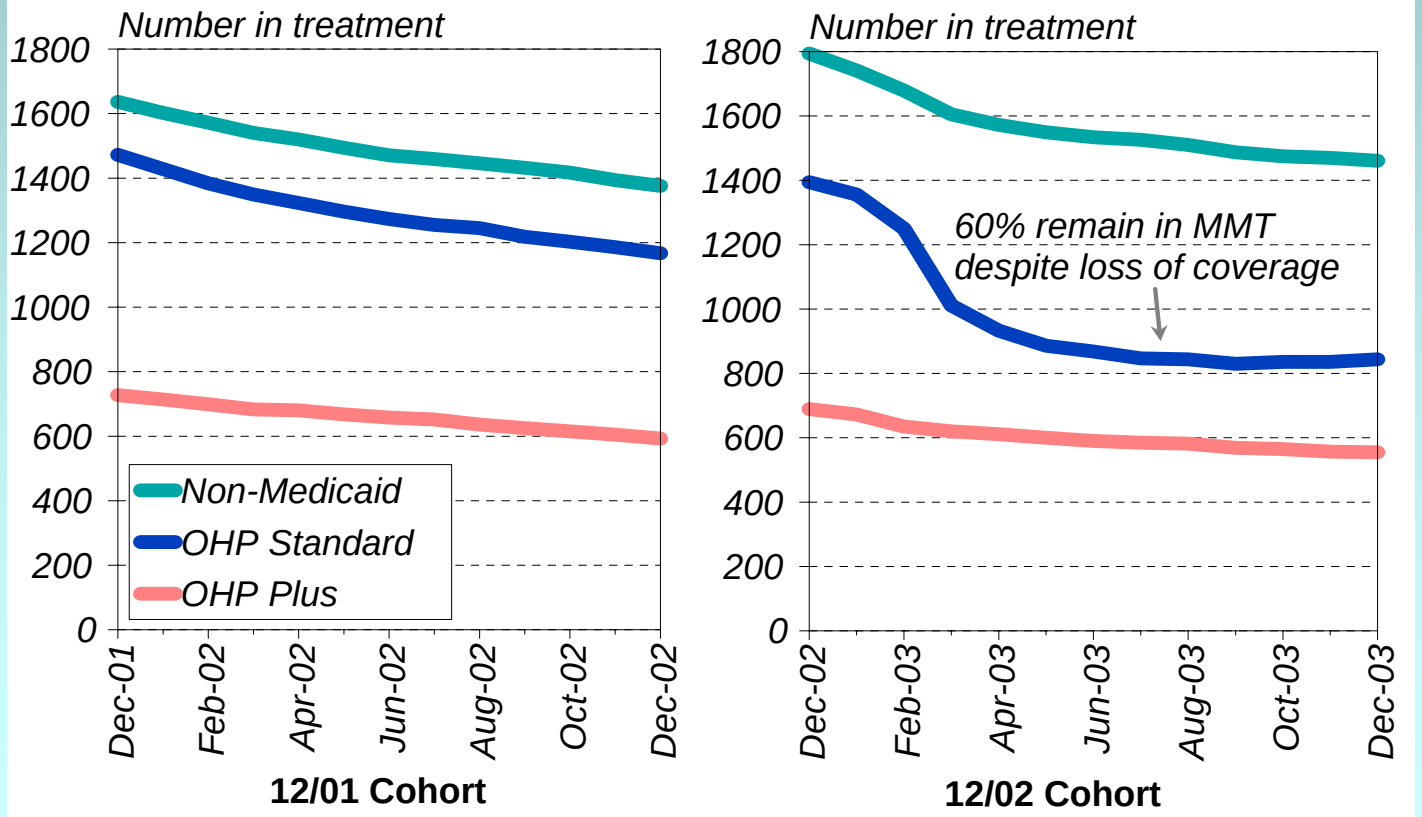


Rate is number admitted by month per 1000 Medicaid eligible that month.

Recent Trends: Impact on those in MMT

Did those enrolled in MMT remain?

Cohort Analysis: Follow continuous MMT enrollment (incl transfers) for two cohorts by Dec eligibility

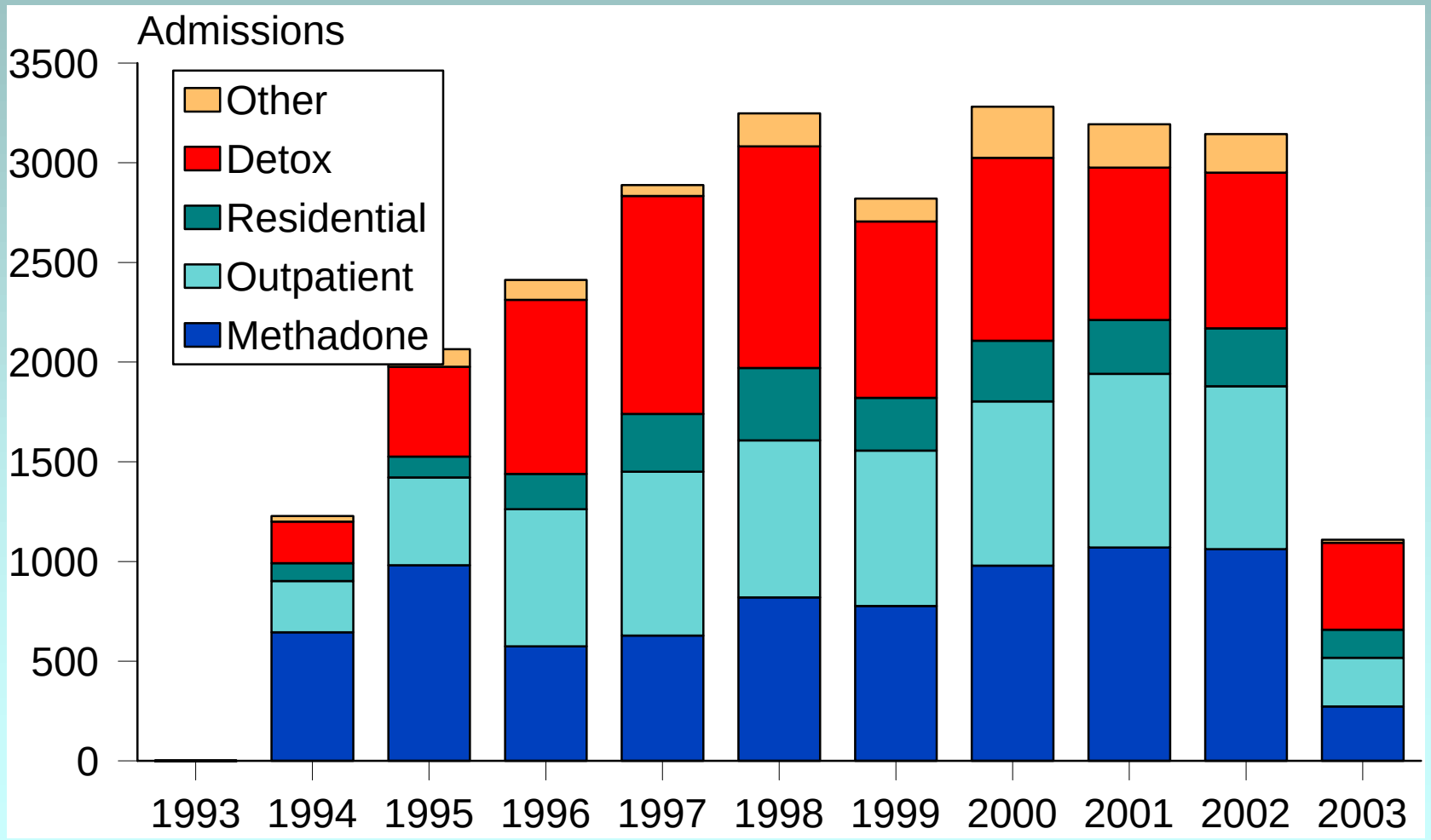


Deck 2004

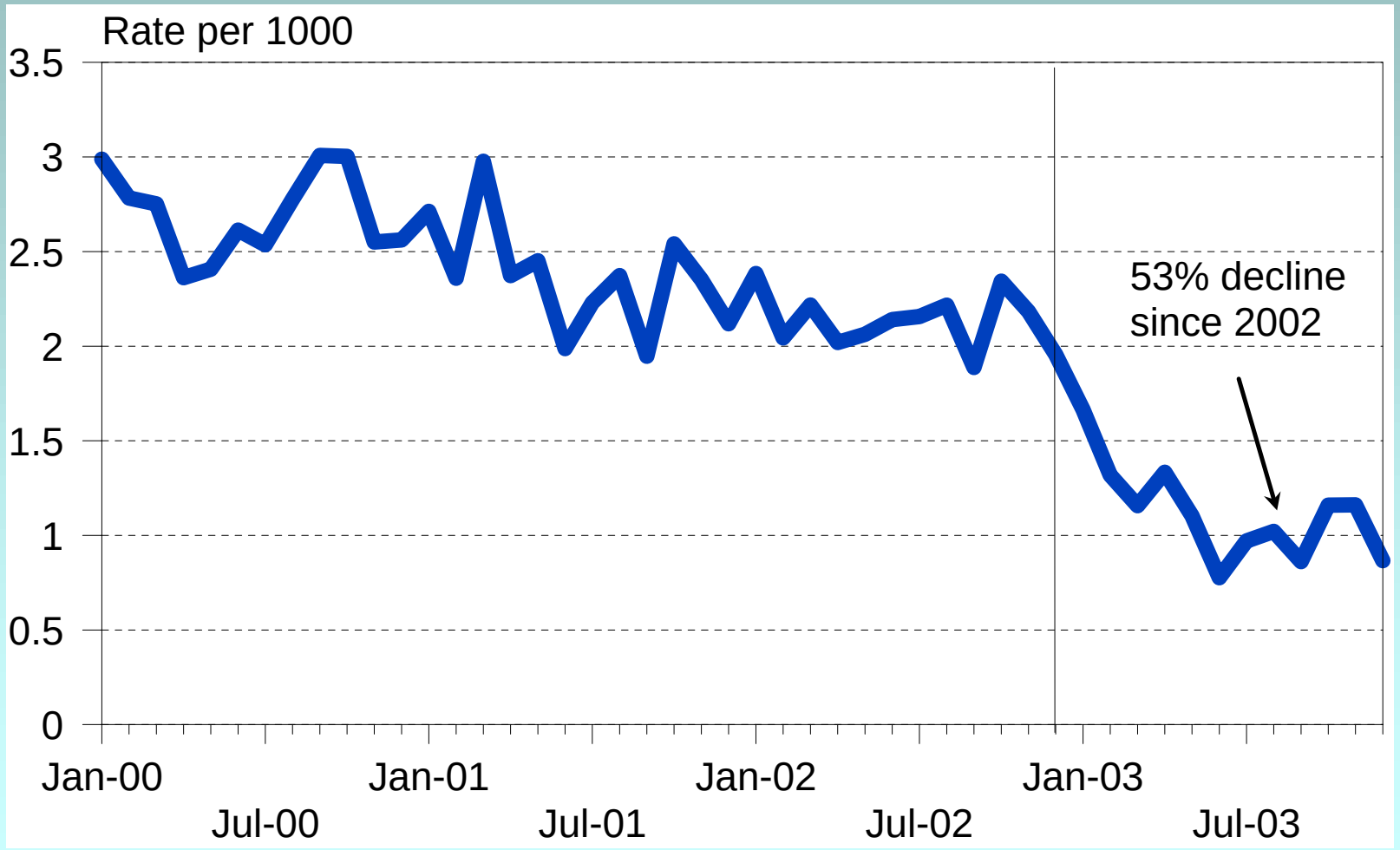
Tentative Conclusion: General Impacts

- The impact on OHPS was immediate and greater than can be explained by disenrollment from Medicaid.
- The impacts are not restricted to OHPS (or even Medicaid).
  - Our data suggests that there has been a broader decline in utilization, consistent with the provider reports of widespread layoffs and clinic closures.
  - Oregon faces potential penalties for failure to meet the Maintenance of Effort criteria for the SAPT Block Grant as a result of these declines.
- There is little evidence that those who lost coverage are getting treatment through alternative public sources or self-pay. There as only a modest increase in non-Medicaid admissions.
- The exception is that 60% of those enrolled in Methadone elected to self-pay (or payers/providers found stop gap funding to reduce impact). Who remains appears not be a function of ability to pay but rather past history in MMT and severity.

OHPS Admissions for Opiates



Recent Trends: New opiate admissions (OHPS)



Deck & Wiitala (in preparation)

Tentative Conclusions: Opiate addicts

- Opiate dependence is highly prevalent among OHPS (20% of those presenting for tx).
- In 2003, the rate of new admissions for OHPS opiate addicts dropped 53% (controlling for disenrollment) .
- Those who do present (controlling for disenrollment) are:
  - Less than half as likely to be placed in the most appropriate modality: a methadone maintenance program.
  - Usually have a past history of MMT.
- Thus we are no longer reaching many of the individuals we most want to get into treatment.

Deck & Wiitala (in preparation)

So What? Why are we concerned about declines in participation in SA Treatment?

- Individuals who need SA care and do not receive it will get help in hospitals, emergency rooms, or wind up in jail – all far more expensive than timely, effective SA Tx
- With all of its imperfections, SA Tx services for those who need them have been definitively shown to:
  - Reduce subsequent health care needs and costs
  - Reduce criminal behavior and incarceration rates
  - Increase employment rates and legal income

Continuing Study Efforts

- Tracking trends in SA and MH Tx access and utilization
- Interviewing samples of clients who expressed need for SA or MH Tx services or who had received these services prior to elimination of benefit 3/03. Retrospective inquiry into
  - Services received (SA/MH Tx, medical)
  - Employment, legal experience
  - Family relationships
- Interviewing administrators and providers at state, county and local levels
- Pushing results to policy forums

Methodological Postscript

- Believe strongly in complementary value of three-pronged methodology
  - Admin data comprehensive but full of developmental challenges and indicators are a bit blunt for program/system improvement purposes
  - Longitudinal studies provide sharper outcomes, but are very expensive and have limited generalizability
  - Key informant interviews and focus group provide unique insights and perspectives but not always accurate (“seldom right, but never in doubt”)

Methodological Postscript (cont.)

- Longitudinal client sample studies suffer from absence of no-treatment control. Newly designed treatment vs “treatment as usual” studies are increasing, but ethical obstacles to having an equivalent “no treatment” group.
- Most convincing cost studies are those using administrative data, comparing over time:
  - Those who needed and received SA TX
  - Those with equivalent need but did not receive SA Tx