Oregon Health Policy Commission

Presentation to the Joint Committee on Human Services

September 13, 2004

2004

Administered by the
Office for Oregon Health Policy and Research

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Oregon
Theodore R. Kulongoski, Governor

Health Policy Commission
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September 13, 2004

The Honorable Bill Fisher, Co-Chair
The Honorable Billy Dalto, Co-Chair
Joint Committee on Human Services
State Capitol Building, Room 354
Salem, Oregon 97301

To the Joint Committee on Human Services:

On behalf of the Health Policy Commission, I want to thank you for the opportunity to appear before you today. Today's report reflects an enormous amount of work by commissioners, public members and staff. We hope this is the beginning of an ongoing dialogue that helps craft Oregon's health policy.

The Health Policy Commission was created by the 2003 Legislature to replace the Oregon Health Council. We began work in January 2004. As a new commission, we approach our charge with energy and good faith. Our initial goal is simply to find the best way to add value to Oregon's health care policy-making process. It is very important to us to remain relevant to the policy-making process and to stay connected to the Legislature and the Governor. We look to you for guidance as to the best way to collaborate with this committee on an ongoing basis.

The Commission is comprised of ten individuals with a breadth of experience. The Commission also has four non-voting legislative members (Sen. Richard Devlin, Sen. Ben Westlund, Rep. Alan Bates and Rep. Bill Garrard) with whom we have been honored to work. While a wide array of viewpoints is represented, I would note that, unavoidably, not all perspectives and interest groups are reflected on the Commission or even on our working groups, which I describe below.

For that reason, beginning last week, the Commission has undertaken a month-long dialogue with Oregonians to capture their thoughts on health care problems and solutions. Throughout the month of September, we have scheduled ten meetings around the state -- and if last week's meeting here in Salem is any indication, I'm confident we'll gather valuable information.

We are here today to describe our activities, introduce our vision, and recommend some initial actions for the upcoming 2005 Legislative Session. We would prefer more time to develop these and other ideas, but we understand the legislative timetable. Please keep in mind that we're not finished; in fact, we're just getting started. In addition to crafting a series of proposals for the upcoming session, our intent is to identify a longer-term vision and agenda for the state's health care policy. We anticipate that many of the Commission's short and long-term recommendations will call for non-legislative approaches, as well.

Over the past eight months, the Commission has worked diligently to develop a process to address our initial legislative directive -- to "develop a plan for and monitor the implementation of the state's health policy." After considerable discussion, the Commission settled on the following mission and goals:

> *Mission*
> To develop and promote policy recommendations to the Governor and Legislature that improve the health of all Oregonians by ensuring access to essential health care and support services, increasing quality and improving outcomes for individuals and society, controlling costs, and encouraging healthy lifestyles.
>
> *Goal Statement*
> Oregon's health care system should:
> 1) Assure all Oregonians access to essential health care services;
> 2) Produce quality outcomes and information that promote informed decision-making by providers and consumers;
> 3) Be adequately financed and efficiently operated to ensure affordability and sustainability;
> 4) Encourage healthy lifestyles through education and incentives;
> 5) Foster collaboration among public and private entities.

As we set out to help improve the health care of all Oregonians, we first must acknowledge the current state of affairs. Our health care system is in crisis. Over 500,000 Oregonians lack health coverage. Low wage families – those earning too much for Medicaid, but not enough to be able to afford health care – are in an impossible bind. At the current rate of health care cost inflation, by 2010 the annual cost for health insurance alone for an Oregonian could equal a minimum wage income. Increasingly, health care costs are constraining our economy and making us vulnerable to overseas workers and business competitors. Close to one third of our health care expenditures are for care that is duplicative, fails to improve health, or may even make the patient worse. In addition, one third of Oregon deaths can be attributed to just three unhealthy behaviors: tobacco use, lack of physical activity and poor eating habits. Over the past ten years, the rate of diabetes has increased by 50% -- driven largely by an epidemic of obesity.

Significant disparities exist in both access and health status for racial and ethnic minorities. For example, 30.7% of Oregon's Hispanic population is uninsured, compared to 12.52% of non-Hispanics. Oregon's African-American population has higher rates of infant mortality, diabetes mortality and stroke mortality than Caucasians.

Not a single member of our Commission – and, I'm sure, not a single person in this room today – is satisfied with the current state of our health care.

With the current crisis, everyone is eager to find "the answer" – the one key reform that will improve Oregonians' health, reduce costs, provide health care to the uninsured, and balance the state budget as well. After considerable study, we reached the unfortunate conclusion:

There is no single, easy answer.

Our health care system is so complex, the root causes of this crisis are so intractable, and the political and financial barriers so significant, that no single reform can "solve" the problem. We'll keep looking for the easy answer, but we're not hopeful; nearly every state has a similar public body studying the issue, along with countless state and federal legislative committees, non-profit think tanks, and business and consumer groups. If someone finds "the answer," it will become apparent to all. More likely, however, the health care system will change incrementally, in large part because of initiatives in various states that point the way. Oregon can and should be a leader in this effort, and working together with the legislature and other stakeholders, your Health Policy Commission proposes to drive this process over the next few years.

In Oregon, we can look for ways to improve the system by finding appropriate leverage points. Oregon, like other states, can influence the health care system in various ways:

- as a purchaser of health care services for state employees and beneficiaries of various state programs;
- through legislative and regulatory actions that mandate, permit, or restrict certain practices;
- as a convenor of stakeholders; and
- by education of both the general public and health care professionals.

As we consider changes in Oregon's health care system, we must necessarily pay attention to work being done in other states and nationally. Changes in Oregon's health care system must be compatible with national health care policy and economics. Legislative or initiative proposals for wholesale systemic change that would seek to create an entirely different health care system in Oregon than in other states deserve consideration, but must be carefully designed to avoid potential for "selection" by residents of other states, which can drive up Oregon's health costs. Moreover, as a practical matter, the health care system in Oregon and throughout the country is significantly affected by the amount of federal money and regulatory control of health care practices.

Nonetheless, we remain optimistic that Oregon can make dramatic improvements in our health care system – even lead the nation. We must look for key points of leverage. We must find ways in which the state can incent – with carrots or sticks, as appropriate – the behavior, technology, funding streams, and administrative systems that will drive up quality and control costs.

We have identified the following broad principles for improving our system:

1) *Simplify the system.* Unnecessary complexity leads to confusion, cost, and errors.
2) *Invest in prevention.* Scarce dollars will result in the greatest return when we act to prevent injury and disease, rather than merely treat it when it occurs.
3) *Manage chronic and catastrophic care.* Only ten percent of our population is responsible for 69% of our health care costs. This means we'll never control costs until we learn how to better manage treatments for the chronically and catastrophically ill.

4) *Align incentives*. Consumers must have incentives to make health care decisions that drive quality and control cost. Providers, too, must be responsible for the cost and quality effects of the treatment decisions they make; the current predominant fee for service payment system fails to do this.
5) *Increase transparency.* To drive quality through the health care system and for patients, providers, and employers to make informed decisions, appropriate information must be available.
6) *Maintain a broad and strong safety net*. Over the past few years, Oregon's safety net infrastructure has been stretched thin – reflecting a growing number of uninsured and fewer providers serving Oregon Health Plan clients.
7) *Better to ration benefits than to ration people*. The realities of our current budget suggest that we simply can't cover everything if we are to cover everyone. We need to have a rational system for deciding what doesn't get covered. Evidence-based medicine should be central to this system.
8) *Focus on children.* Providing health care to children provides an excellent return on investment.

While these principles describe some general direction, the Commission sought to identify some specific reforms to be considered during the 2005 legislative session which can begin to move us in the desired direction. Due to the breadth and complexity of our health care system, the Commission established four working groups, each with approximately ten members, to analyze potential reforms. The working groups address, respectively, Access, Cost, Health Status and Quality. Each working group was encouraged to establish guiding principles and short and long-term approaches to reform. The initial work product of these groups will be presented to you here today. The working groups propose both legislative and administrative actions. In fact, it is important to recognize that significant systemic change can occur within existing legislative authority. Again, I would like to stress that these legislative concepts are one small step towards the creation of a broader state health care vision. Both the Commission and our working groups have a great deal of work ahead of us.

We hope our work will provide some direction with respect to health care policy. We look forward to working with you and your colleagues in the coming legislative session and beyond.

Sincerely,

Kerry Barnett
Commission Chair

OREGON HEALTH POLICY COMMISSION
ROSTER

Vanetta Abdellatif
Director, Integrated Clinical Services
Multnomah County Health Department
Portland, Oregon

Jonathan Ater, Vice-Chair
AterWynne, LLP
Portland, Oregon

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Senior Vice-President, Strategic
Communications and Public Affairs
The Regence Group
Portland, Oregon

Representative Alan Bates
District 5
Ashland, Oregon

Geoff Brown
Mercer Human Resource Consulting
Portland, Oregon

Alice Dale
SEIU Local 49
Portland, Oregon

Senator Richard Devlin
District 19
Tualatin, Oregon

Representative Bill Garrard
District 56
Klamath Falls, Oregon

Vickie Gates
Executive Director
Oregon Health Care Quality Corporation
Portland, Oregon

Jim Lussier
President Emeritus
St. Charles Medical Center
Bend, Oregon

Governor Barbara Roberts
Portland, Oregon

Senator Ben Westlund
District 53
Tumalo, Oregon

Rick Wopat MD
Medical Director, Samaritan Health Services
Lebanon, Oregon

Jorge A. Yant
President/CEO, Plexis Healthcare Systems
Ashland, Oregon

OHPC Commission and Work Groups Public Meetings Schedules

Date	Group	Time	Location
Jan. 21, 2004	Commission	9 am. -12 pm.	Capitol Bldg. HR B
Mar. 3, 2004	Commission	1-4:30	Capitol Bldg. HR F
Mar. 31, 2004	Commission	1-4:30	Capitol Bldg. HR F
Apr. 12, 2004	Access	1-4 pm.	Organizational/Salem
April 15, 2004	Commission	1-4:30	Capitol Bldg. HR F
May 4, 2004	Cost	1-4 pm.	Organizational/Portland
May 7, 2004	Access	1-4 pm.	Organizational/Salem
May 17, 2004	Quality	1-4 pm.	Organizational/Portland
May 20, 2004	Commission	1-4:30	Capitol Bldg. HR 350
May 25, 2004	Cost	1-4 pm.	Organizational/Portland
May 27, 2004	Access	1-4 pm.	Organizational/Salem
June 10, 2004	Quality	1-4 pm.	Organizational/Portland
June 14, 2004	Access	10 am. - 1 pm.	800 NE Oregon St., rm 140
June 14, 2004	Cost	1-4 pm.	800 NE Oregon St., rm 140
June 18, 2004	Health Status	10 am. - 1 pm.	Capitol Bldg. HR 350
June 23, 2004	Commission	1-4:30	Capitol Bldg. HR C
July 1, 2004	Health Status	10 am. - 1 pm.	Video Conference
July 6, 2004	Quality	1-4 pm.	800 NE Oregon St., 120-B
July 8, 2004	Access	1-4 pm.	800 NE Oregon St., 120-B
July 12, 2004	Cost	12-3 pm.	800 NE Oregon St., rm 140
July 15, 2004	Commission	1-4:30	Capitol Bldg. HR 350
July 19, 2004	Health Status	1-3 pm.	Video Conference
July 26, 2004	Quality	1-4 pm.	800 NE Oregon St., rm 140
Aug. 2, 2004	Cost	12:30-3:30 pm.	800 NE Oregon St., 120-B
Aug. 9, 2004	Quality	1-4 pm.	800 NE Oregon St., rm 140
Aug. 10, 2004	Health Status	12-2 pm.	Video Conference
Aug. 12, 2004	Cost	9 am. - 12 pm.	800 NE Oregon St., 120-B
Aug. 12, 2004	Access	1-4 pm.	800 NE Oregon St., 120-B
Aug. 19, 2004	Commission	1-4:30	Capitol Bldg. HR F
Aug. 23, 2004	Cost	10 am.-3 pm.	800 NE Oregon St., 120-B
Aug. 26, 2004	Access	1-4 pm.	800 NE Oregon St., 221
Aug. 30, 2004	Quality	1-4 pm.	800 NE Oregon St., 120-C
Aug. 31, 2004	Health Status	12-3 pm.	800 NE Oregon St., rm 445
Sept. 8, 2004	Commission	9 am. - 12 pm.	Oregon State Library rm103
Oct. 21, 2004	Commission	1-4:30	Capitol Bldg. HR 350
Nov. 18, 2004	Commission	1-4:30	Capitol Bldg. HR A
Dec.16, 2004	Commission	1-4:30 pm.	Capitol Bldg. HR F

Oregon Health Policy Commission Community Forums
6 p.m. – 8:30 p.m.

Date:	City:	Location:
September 9, 2004	Salem	Chemeketa Community College; Building 51, Rooms 111 and 112; 4000 Lancaster Drive NE
September 14, 2004	Medford	Skyline Plaza at the Rogue Valley Manor; Rogue Room, 1 Skyline Drive, Medford
September 15, 2004	Eugene	Sacred Heart Hospital Auditorium (there are signs from the main lobby); 1255 Hilyard, Eugene
September 16, 2004	Portland	Portland Adventist Hospital; Lower Level - Education Center A; 10123 SE Market St., Portland
September 21, 2004	Klamath Falls	Community Health Education Center; 2200 Eldorado Blvd., Klamath Falls
September 22, 2004	Bend	Deschutes Services Center; Barnes Room; 1300 NW Wall, Bend
September 23, 2004	Hillsboro	Tuality Health Education Center, Front Auditorium, Hillsboro
September 27, 2004	Newport	Samaritan Pacific Communities Hospital; Education Room; 930 NW Abbey, Newport
September 28, 2004	La Grande	Eastern OR University; Hoke College Center, Room 309; La Grande
September 29, 2004	John Day	Guernsey Building Conference Room; 120 S Washington, Canyon City

Joint Committee on Human Services

Sen. Bill Fisher, Co-Chair

Rep. Billy Dalto, Co-Chair

Presentation by the Oregon Health Policy Commission

September 13, 2004

Commission Overview

- Established in 2003 - House Bill 3653
  - Replaced Oregon Health Council
- Membership

<u>10 Voting Members</u>

- Vanetta Abdellatif
- Jonathan Ater, Vice Chair
- Kerry Barnett, Chair
- Geoff Brown
- Alice Dale
- Vickie Gates
- Jim Lussier
- Governor Barbara Roberts
- Rick Wopat, MD
- Jorge A. Yant

<u>4 Legislators</u>

- Representative Alan Bates
- Senator Richard Devlin
- Representative Bill Garrard
- Senator Ben Westlund

Commission Overview (continued)

Community Forums

* September 9th - Salem
* September 14th - Medford
* September 15th - Eugene
* September 16th - Portland
* September 21st - Klamath Falls
* September 22nd - Bend
* September 23rd - Hillsboro
* September 27th - Newport
* September 28th - La Grande
* September 29th - John Day

Commission Overview (continued)

Statutory Purpose

- Develop a plan for and monitor the implementation of the state's health policy.
- Identify and analyze significant health policy issues affecting the state.
- Prepare and submit to the Governor and the Legislative Assembly resolutions relating to health policy and health care reform.

Mission

- To develop and promote policy recommendations to the Governor and Legislature that improve the health of all Oregonians by ensuring access to essential health care and support services, increasing quality and improving outcomes for individuals and society, controlling costs, and encouraging health lifestyles.

Goal Statements

Oregon's health care system should:

1) Assure all Oregonians access to essential health care services;
2) Produce quality outcomes and information that promote informed decision-making by providers and consumers;
3) Be adequately financed and efficiently operated to ensure affordability and sustainability;
4) Encourage healthy lifestyles through education and incentives;
5) Foster collaboration among public and private entities.

Oregon Health Policy Commission

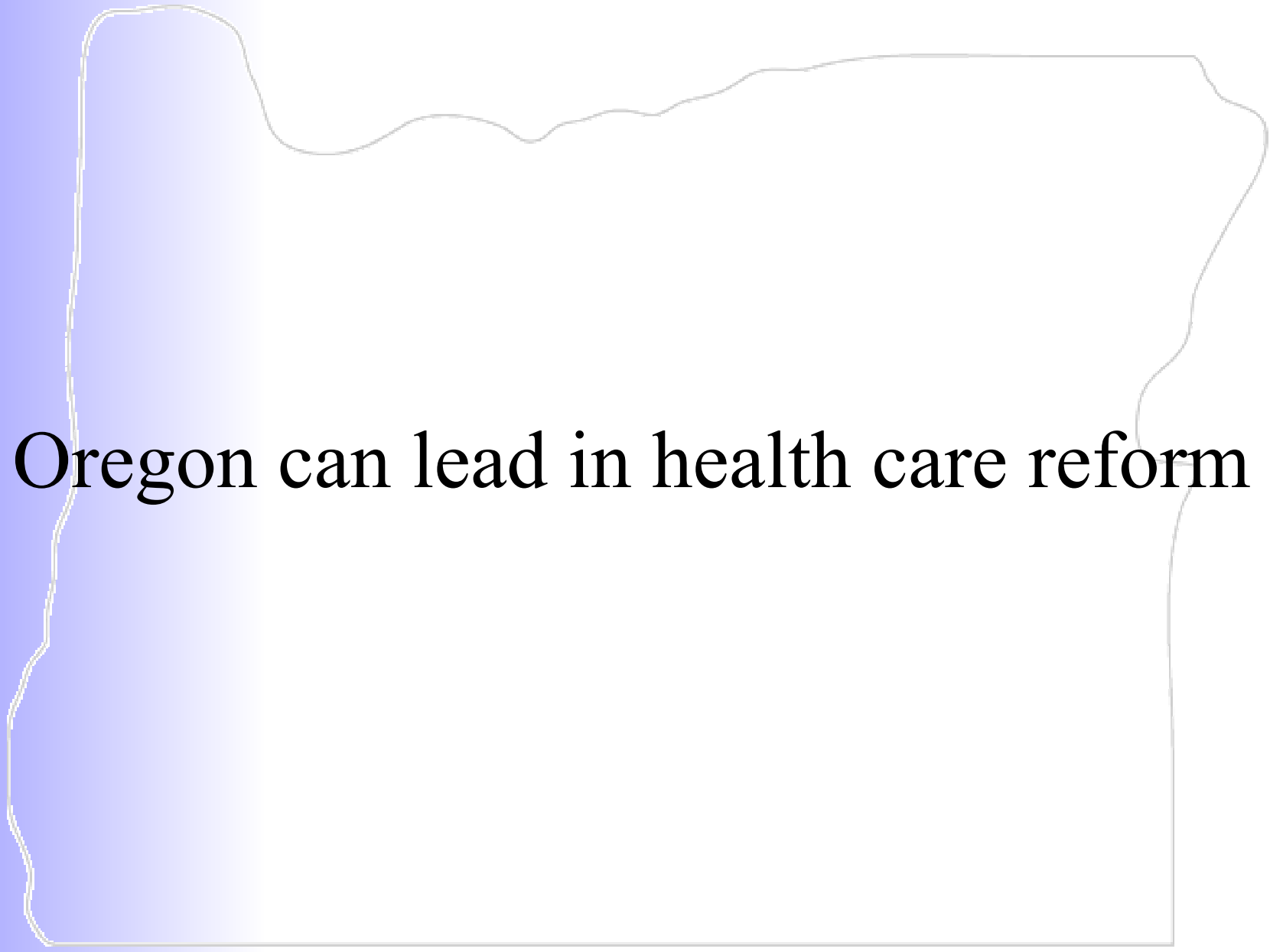
- Short term and long term
- Legislative and non-legislative
- Work in progress

The Health Care System is in Crisis

- Number of uninsured
- Escalating costs
- Lack of quality
- Declining health status
- Racial/Ethnic disparities

There Is No Easy Answer

- We're not the only ones looking
- Incremental change
- Federal Government will play a role



Oregon can lead in health care reform

The State's Role:

- Purchaser
- Regulator
- Convenor
- Educator

Principles for Improving Our System:

1. Simplify
2. Invest in prevention
3. Manage chronic and catastrophic care
4. Align incentives
5. Increase transparency
6. Maintain a broad and strong safety net
7. Better to ration what is covered than to ration people
8. Focus on children

Four Working Groups:

- Health Status
- Access
- Quality
- Cost

These legislative concepts are one small step towards the creation of a broader state health care vision.

HEALTH STATUS WORK GROUP

Health Status Work Group

Governor Barbara Roberts, Co-Chair

Jim Lussier, Co-Chair

Grant Higginson, MD, MPH

Mary Lou Hennrich, RN

Kent Hunsaker

Jim Lace, MD

James Mason, PhD

Heather Young, PhD, RN, GNP, FAAN

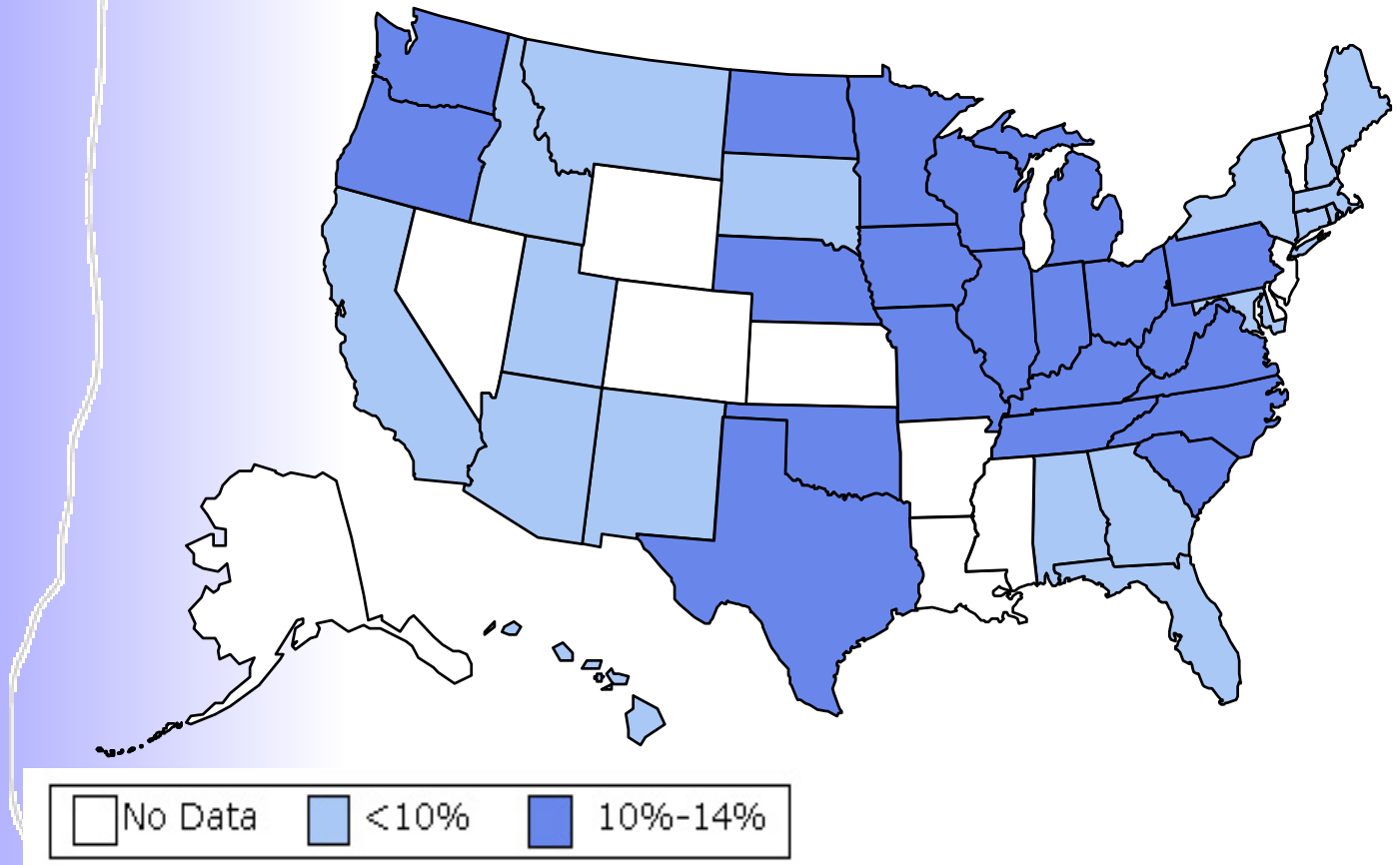
John Valley

Health Status Issues

- One third of Oregon's deaths can be attributed to 3 unhealthy behaviors
  - Tobacco use
  - Lack of physical activity
  - Poor eating habits
- Over the past ten years, the rate of diabetes has increased by 50% -- driven largely by an epidemic of obesity.

Obesity Trends* Among U.S. Adults

Behavioral Risk Factor Surveillance Survey, 1989

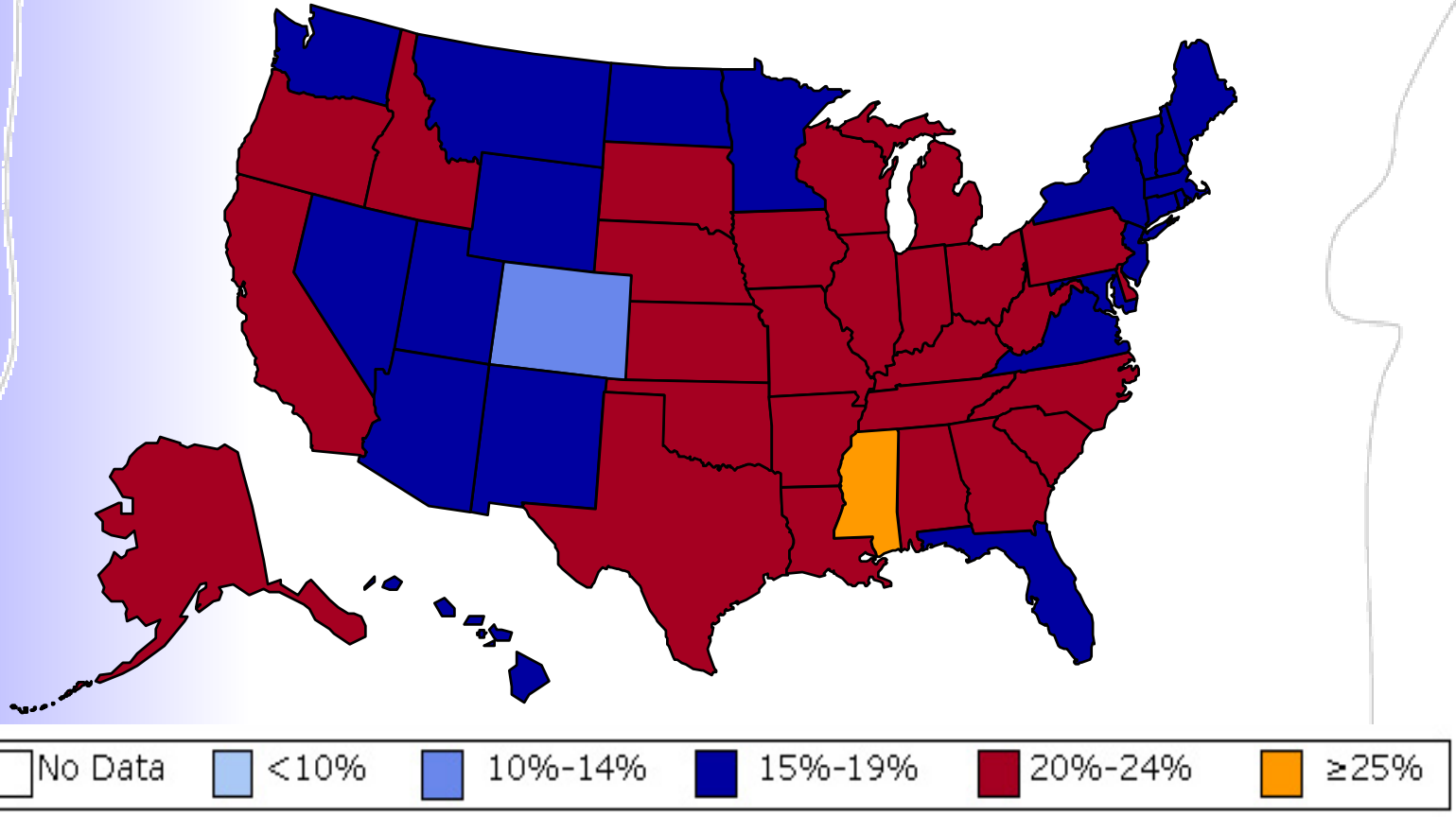


(*BMI ≥30, or ~ 30 lbs overweight for 5'4" woman)

Source: Mokdad A H, et al. *J Am Med Assoc* 1999;282:16, 2001;286:10.

Obesity Trends* Among U.S. Adults

Behavioral Risk Factor Surveillance Survey, 2001



(*BMI ≥30, or ~ 30 lbs overweight for 5'4" woman)

Source: Mokdad A H, et al. *J Am Med Assoc* 1999;282:16, 2001;286:10.

Emerging Health Status Issues

- Kids without Preventive Healthcare Services
- Growing Population with Chronic Conditions
- Seniors Facing Institutional Confinement
- Mental Health Patients Incarcerated
- No Incentives for Good Health Habits
- The Boomers are Coming

What Oregonians Face

- Healthcare Costs are Multiplying
- Health Status is Going Down
  - Aging Population
  - Chronic Conditions
  - Cost/Access/Quality Issues
  - Healthy Habits are Not Incentivized
- Citizens are Managing their Lives Around Healthcare Issues

GOAL – Health Status

- "Improve the health status of Oregonians by fostering supportive environments that are conducive to healthy lifestyles through effective state policy, education, preventive services, incentives and collaboration."

A Comprehensive Initiative

Healthy Oregon

Program

Next Steps (1) – Health Status

- **Tobacco Use:**
- Reinstate the cigarette tax of 10 cents that was repealed as part of Measure 30 to fund the Oregon Health Plan.
- Allocate 10 percent of unallocated Master Settlement Agreement revenue for the Tobacco Prevention and Education Program (TPEP).
- Return the Tobacco Prevention and Education Program (TPEP) to voter-mandated funding level.
- Support amending the Oregon Clean Indoor Air law to protect all workers from secondhand smoke.

Next Steps (2) – Health Status

- **Obesity/Nutrition/Physical Activity:**
- Establish an Advisory Council on Wellness to within the Department of Education.
- Require school district administrators to convene advisory committees to develop policies on access to nutritious foods and appropriate exercise.
- Set guidelines for non-USDA foods and beverages sold in schools.

Next Steps (3) – Health Status

- **Obesity/Nutrition/Physical Activity:**

- Direct the Department of Education to develop and implement a pilot project for selected schools to send "student health status" report card home which reports body mass index and an explanation of the health effects of body mass index, nutrition and physical activity.

- Support establishing a minimum for required minutes of physical education

Next Steps (4) – Health Status

- **Obesity/Nutrition/Physical Activity:**

- Continue to appropriate moneys to Department of Human Services for provision of fruits and vegetables from farmers' markets to individuals eligible for Women, Infant and Children Program, and for older adults eligible for food stamps.

Next Steps (5) – Health Status

- **Oral Health:**

- Require the fluoridation of all public water systems in Oregon.

- Support expanding the scope of practice for dental hygienists to increase access to services necessary to meet the oral health care needs of medically underserved Oregonians.

- Support removing barriers for licensed out-of-state dentists who want to practice in Oregon.

A Comprehensive Initiative

Healthy Oregon

Program

ACCESS WORK GROUP

Access Work Group

Rick Wopat, MD, Co-Chair

Vanetta Abdellatif, Co-Chair

Tina Castañares, MD

Ross Dwinell

Jackie Gaines

Denise Honzel

Craig Hostetler

Anne Potter

Carlton Purvis, III

Dick Stenson

Karen Whitaker

Access to Health Care

- Access to affordable basic healthcare services is essential to preventing disease and disability and improving the health and productivity of the population.

Barriers to Access

- **Financial**
  - Lack of insurance - 500,000 Oregonians are currently without health insurance.
  - Rising costs making healthcare unaffordable
- **Geographic** – distance and distribution
- **Cultural**
- **Lack of enabling services -** transportation, interpretation

Barriers to Access

- **Current finance systems in healthcare**
  - Do not reward providers for prevention and primary care services
  - Disparities in payment levels reduce willingness of providers to care for Medicare and Medicaid patients
  - Rural vs. urban
- **Lack of affordable liability insurance for providers leads to loss of some services**

GOAL - Access

- "Assure all Oregonians access to essential health care services."

Access to What?

- Preventive services
  - Immunizations and other preventive treatments
  - Screening for malignancies and chronic diseases
- Reproductive health care
- Limited outpatient services
- Limited inpatient services

Next Steps (1) - Access

Assessment of Current Resources

Direct the Office of Health Policy and Research to:

1) Create and implement a process for statewide assessment of available health services and resources.
2) Define goals for Oregon regarding number and distribution of providers and health service sites.
3) Do a "gap analysis" between numbers 1 and 2.
4) Use findings to develop a healthcare workforce and services development plan for Oregon for both the short and long-term.

Next Steps (2) - Access

Access to Preventive Services

- Expand health services offered under the Oregon Health Plan to children with incomes less than 300 percent of federal poverty guidelines.
- Expand health services offered under the Oregon Health Plan for reproductive services to individuals with incomes less than 250 percent of federal poverty guidelines.
  - Access to birth control and preconception counseling
  - Pregnancy care

Next Steps (3) - Access

- **Access to Preventive Services**

- Expand the Immunization Program operated by the Department of Human Services to offer immunizations that have been proven effective to individuals not currently served by the program.

Next Steps (4) - Access

Access to Preventive Services

- Direct the Department of Human Services to develop and implement a pilot program that:
  - screens individuals with incomes less than 300 percent of federal poverty guidelines for chronic disease risk factors based on information developed by United States Public Health Services Task Force on Prevention
  - and provides those individuals diagnosed with certain conditions with chronic condition management services.

Next Steps (5) - Access

Access to Preventive Services for Mental Health and Dental Health

- Direct the Department of Human Service to develop and implement a pilot program for dental and mental health preventive services for individuals and families with incomes less than 300 percent of federal poverty guidelines.

QUALITY WORK GROUP

Quality Work Group

Vickie Gates, Co-Chair

Jonathan Ater, Co-Chair

Joel Ario

Karen Burke, RN

Chuck Kilo, MD, MPH

David Lansky, PhD

Michael Leahy

Keith Marton, MD

Gil Munoz

Ron Potts, MD

Glenn Rodriguez, MD

Robert Wheeler, MD

Quality Issues

- New England Journal of Medicine article recently showed that Americans receive recommended care about 55 percent of the time.
- A recent Dartmouth study found that close to one third of our healthcare expenditures goes to care that is duplicative, fails to improve patient health, or may even make it worse.
- A recent study by the Commonwealth Fund found the United States health care system the most inefficient in duplicating tests, repeating medical histories, and not having medical records available at the time of the visit.

Quality Issues

- Ninety percent of health information still moves by fax, phone, or mail.
- The IOM has estimated that between 44,000 and 98,000 Americans die each year from preventable medical errors in hospitals.

GOAL – Quality

- "Improve the results achieved by Oregon's health care system by promoting changes in processes, cultures and payment systems necessary to improve health care outcomes, improve system efficiency, and control costs. To this end, reliable, common, and transparent information is mandatory."

Better outcomes:
A Long Term Process with Many Steps

- Information
  - Measurements of effectiveness and outcomes
  - Widely available to providers, purchasers, consumers and policy makers
- Develop the health information infrastructure: electronic medical records that can be shared across the system
- Support evidence based medicine and shared decision making
- Link payments to quality performance

Next Steps (1) - Quality

- **System Performance: Disclosure and Measurement:**

- Direct the Office of Health Policy and Research to collaborate with state agencies to use existing FTE within the state for the creation of a state web site that:
  - Connects citizens and policymakers to a wide range of information on the cost and quality of health care in the state.
  - Compares providers, health plans, hospitals on quality and cost.
  - Provides information about being a wise health consumer and how best to manage health care dollars.

Developing a Clearinghouse for Health Care Information in Oregon

- Statutory authority already exits within the Health Policy Commission's statutes (ORS 442.045, Section 2)
- Clearinghouse furthers the intent of legislative language in 442.025, …"achievement of reasonable access to quality healthcare at a reasonable cost is a priority for the State of Oregon."

Much of the data is currently available, but is not being used by Oregon consumers and policymakers.

www.minnesotahealthinfo.org

Minnesota's health information "virtual" clearinghouse

- Connects citizens to a wide range of information on the cost and quality of health care in the state.
- Compares providers, health plans, hospitals on quality and cost.
- Provides information about being a wise health consumer and how best to manage one's health

Next Steps (2) - Quality

- **Building the Health Care Information Infrastructure:**

- Governor Kulongoski recently requested that the Quality Work Group identify the necessary infrastructure changes for the statewide implementation of electronic medical records and for the exchange of health information.

Next Steps (2) - Quality

- **Electronic Health Records Subcommittee**
  - Identify barriers to the adoption and implementation of electronic health records;
  - Identify core components of electronic health record and standards for interoperability;
  - Assess status of current implementation in Oregon;
  - Assess costs for primary and acute health care providers to implement;
  - Identify partnership models and collaboration potential;
  - Monitor development of federal standards and ensure compatibility;
  - Identify barriers and develop plan to develop unified record system among public hospitals and clinics.

Next Steps (3) - Quality

- **Supporting Purchasers: Incentivizing Quality**
  - Use the state's health care purchasing leverage to reward quality and investments that lead to higher quality care and providers who participate in provider recognition and voluntary reporting programs such as the Medicare hospital improvement project and the Oregon Patient Safety Commission.
  - Work with other organizations to improve Oregon purchasers' knowledge of strategies to reward quality and encourage collaborative strategies to reward quality and investment to improve quality of care.

COST WORK GROUP

Cost Work Group

Geoff Brown, Co-Chair

Alice Dale, Co-Chair

Mylia Christensen

Allen Douma, MD

Ruby Haughton

Maribeth Healey

Bill Kramer

J. Bart McMullan, Jr., MD

Steve Robinson

Dwight A. Sangrey, PhD, PE

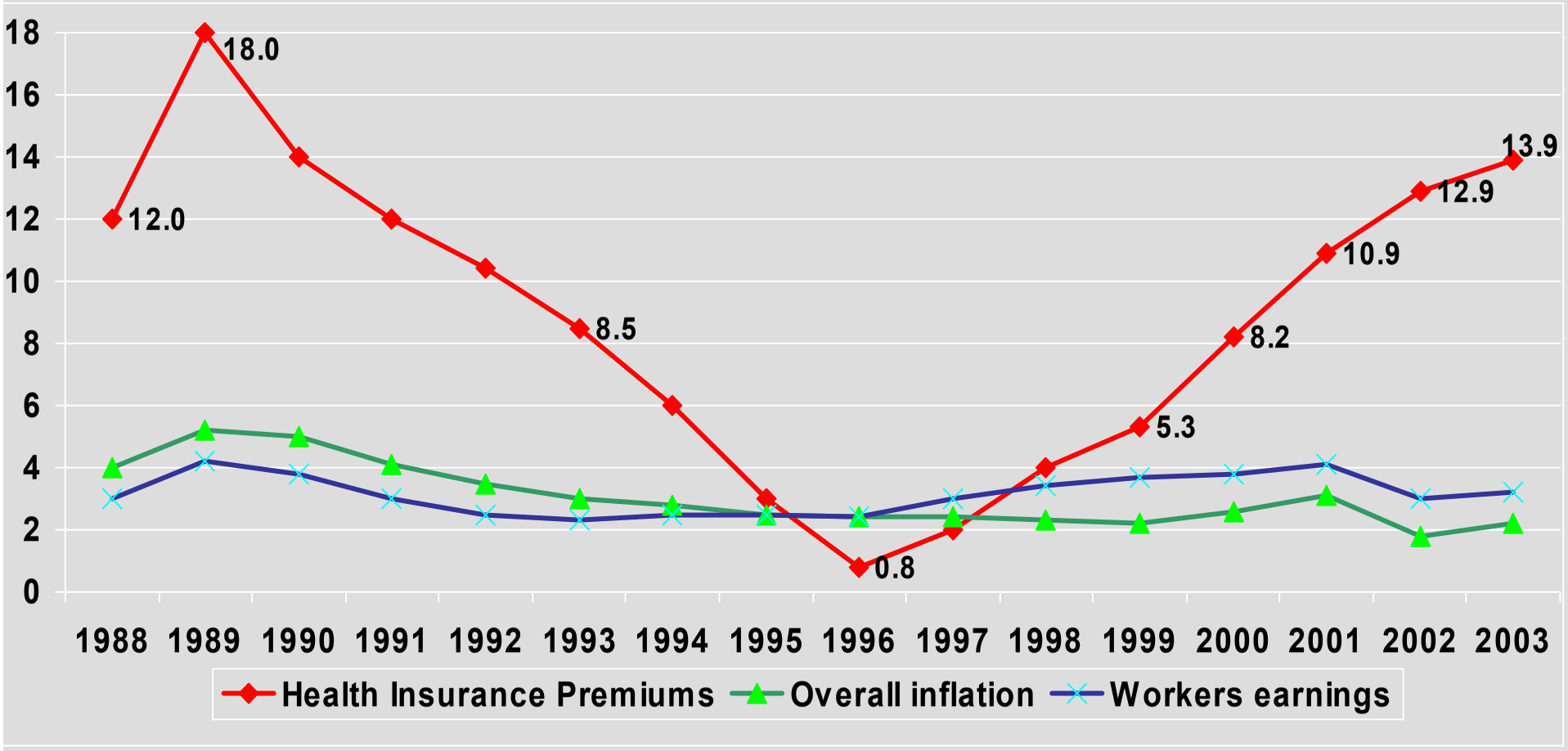
Ann Turner, MD

Jorge Yant

Cost Work Group

- A picture is worth a thousand words.

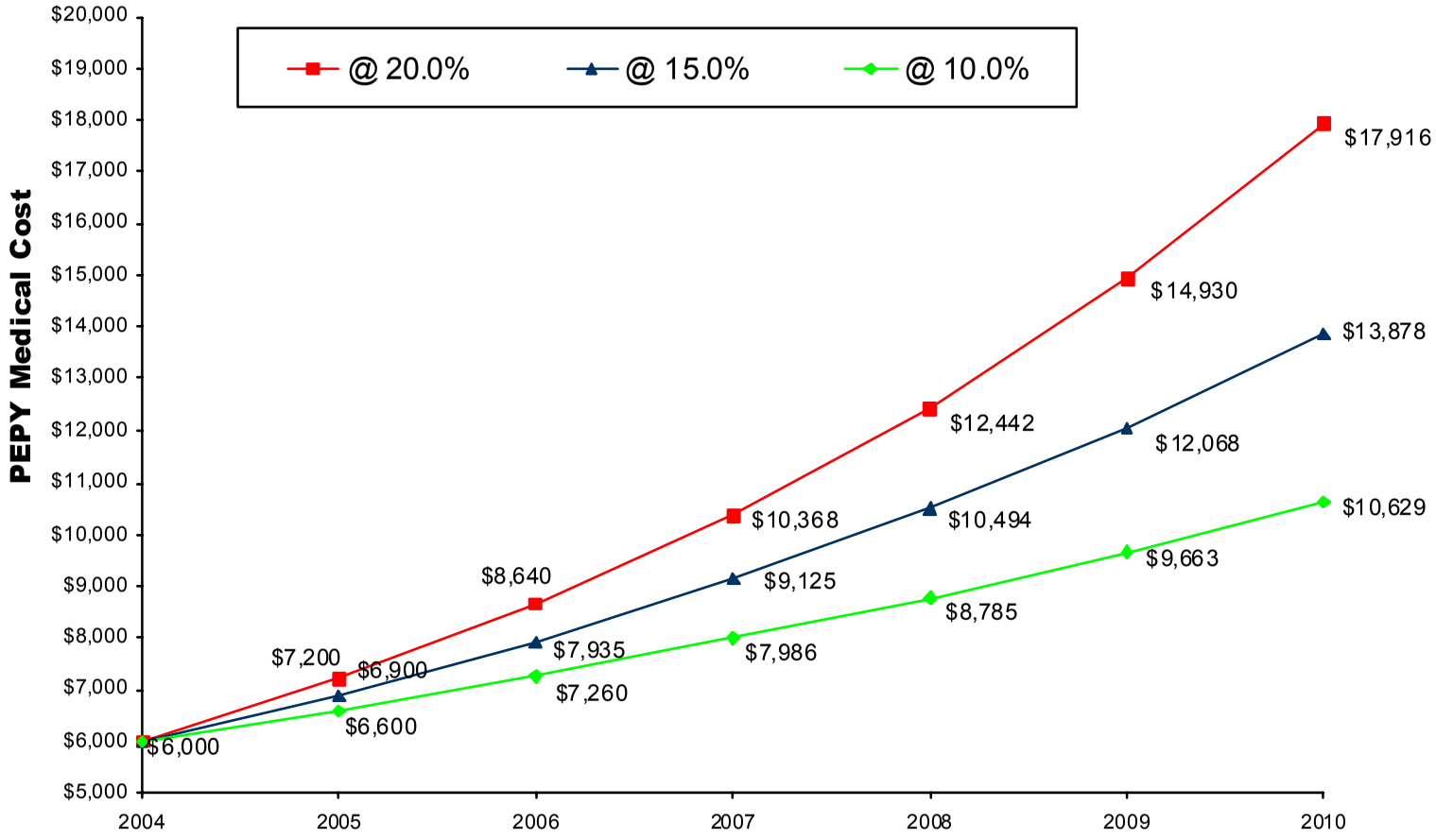
Increases in Health Insurance Premiums Compared to Other Indicators, 1988-2003



Source: National data from 2003 Kaiser/HRET Survey Summary

Is the status-quo sustainable?

Base year with various rate of increase assumptions



Cost Issues

- Misaligned financial incentives
- Multiple cost drivers
- There is no single, easy answer
- Strategies should avoid cost-shifting

GOAL - Cost

- "The health care system should be adequately financed through efficient and cost-effective operations to ensure affordability and sustainability."

Next Steps (1) - Cost

- **Investment in Prevention**
  - Health Status Work Group's Recommendations
    - Tobacco Cessation
    - Nutrition/Obesity/Physical Activity
    - Oral Health
  - Access Work Group's Recommendations
    - Access to Preventive Services
    - Children
    - Pregnant Women
    - Disease Management

Next Steps (2) - Cost

- **Accountability - Transparency**
  - Quality Work Group's Recommendation
    - Disclosure and Measurement

Next Steps (3) - Cost

- **Prescription Drugs:**

- Expand the Oregon Prescription Drug Program (ORS 414.312-414.320) to allow Oregonians without prescription drug coverage to purchase discounted drugs.

Next Steps (4) - Cost

- **Prescription Drugs:**

- Direct the Department of Human Services to establish goals to increase the prescribing of drugs on the practitioner-managed prescription drug plan through education and incentives to patients and providers -- and modify use of prior authorization if goals are not met within established timelines.

Health Status Work Group

Problem Statement:

The goal of an effective health care system is optimum health status for its population. Unfortunately the U.S. and Oregon fall short in maximizing the health of its citizens as resources are continually focused on acute care. This neglects the significant contribution of prevention activities that improve quality of life, reduce of the burden of chronic illness, and reduce of the costs of acute and chronic disease management.

One third of deaths in Oregon can be attributed to just three unhealthy behaviors: tobacco use, lack of physical activity and poor eating habits. These behaviors often result in and exacerbate chronic disease. Heart disease, cancer, stroke, respiratory disease and diabetes account for two of every three deaths. Furthermore, one out of every three years of potential life lost before the age of 65 is due to a chronic disease. Beyond mortality, these chronic diseases reduce the quality of life of individuals, have an impact on families and friends, and are responsible for massive health care expenditures.

In addition, severe health disparities exist among racial and ethic groups. Such disparities are reflected in differences in length of life; rates of disease; disability and death; severity of disease; and access to treatment. For example, American Indians and Alaska Natives are 2.6 times more likely to have diagnosed diabetes than whites. Deaths rates from heart disease are close to 30 percent higher among African American adults than among white adults.

With a statewide effort, these unhealthy behaviors and disparities can be changed.

Goal:

Improve the health status of Oregonians by fostering supportive environments that are conducive to healthy lifestyles through effective state policy, education, preventive services, incentives and collaboration.

Preamble:

HEALTHY OREGON

The Health Status Work Group proposes the establishment of a *HEALTY OREGON* initiative that will serve as a catalyst to improve the health status of all Oregonians. It will coordinate communication both statewide and nationally of, 1) the short-term goals that Oregonians are pursuing to address immediate health-related issues, and 2) the long-term goals of transforming physical and social environments to assure that all Oregonians attain their optimum health status and to promote Oregon as the healthiest state in the country.

The focus of *HEALTHY OREGON* will incorporate state and local governments, hospitals and healthcare providers, educational institutions (especially K-12), and other

human services organizations like churches, families and individuals. The predominant health issues facing Oregonians today are in large measure a combination of life-style related factors and how our health system is designed. There is a dire need for more appropriate resource allocation to better meet the needs of Oregonians in the 21st century.

PROGRAMMING

HEALTHY OREGON will address current and future health issues facing Oregon and work to design programs and legislation to address them. It will include the priorities of the Governor and Legislature – as well as the priorities identified by the Commission's work groups. In addition, *HEALTHY OREGON* will work to develop coalitions among independent organizations through collaboration.

Ultimately, the over-arching goal of *HEALTHY OREGON* is to create an effective initiative to improve the health of Oregonians. This will be accomplished by fostering collaboration among all related agencies and institutions, and raising the consciousness level within Oregon as to issues of health and how they can be most effectively addressed.

The following list outlines recommended legislative and non-legislative strategies.

Recommended Next Steps:

TIER I - IMMEDIATE

Legislative Strategies	Non-Legislative Strategies
Tobacco Use	
Cigarette Tax Reinstate the cigarette tax of 10 cents that was repealed as part of Measure 30 to fund the Oregon Health Plan.	**Multifaceted Prevention** Support the state's multifaceted approach to tobacco prevention programs
Master Settlement Agreement Revenue Allocate 10 percent of unallocated Master Settlement Agreement revenue for the Tobacco Prevention and Education Program (TPEP).	**Local Policies** Promote local policies prohibiting smoking around building entrances, in parks, public transit, and other public places.
Tobacco Prevention and Education Program Return the TPEP to voter-mandated funding level.	**Cost-Effective Programs** Research, promote and implement cost-effective population-based tobacco cessation programs.
Clean Indoor Air Law Support amending the Oregon Clean Indoor Air law to protect all workers from secondhand smoke.	**Cultural Strategies** Implement culturally appropriate youth strategies.
	Education Environment Increase the percentage of school districts, colleges, and universities with comprehensive tobacco use prevention policies and programs.
	Public and Private Sector Task Force Convene a task force charged with encouraging public and private sector employers and employees and labor unions to secure cessation benefits for employees and families.
	Disseminate Disparities Information Disseminate the results of the Centers for Disease Control and Prevention disparities planning project.
	Five-Year Plan Determine necessary resources for adequate funding to implement the five-year plan.

Obesity / Nutrition / Physical Activity	
Advisory Council on Wellness Establish an Advisory Council on Wellness within the Department of Education.	**Community Resources** Link with other community resources to support and encourage families to raise healthy children.
School District Advisory Committees Assist school districts in convening advisory committees to develop policies on access to nutritious foods and appropriate exercise for students.	**Center for the Study of Weight Regulation and Associated Disorders** Support the work by the Center for the Study of Weight Regulation and Associated Disorders administered by the Oregon Health and Science University.
Non-USDA Guidelines Set guidelines for non-USDA foods and beverages sold in schools.	**Wellness Oriented Coalitions** Support the efforts of the Oregon Health District, Oregon Coalition for Promoting Physical Activity, and Active Community Environments.
Student Health Status Report Cards Direct the Department of Education to develop and implement a pilot project for selected schools to send "student health status" report card home which reports body mass index and an explanation of the health effects of body mass index, nutrition and physical activity.	**Cardiovascular Health** Support the efforts of the Cardiovascular Health Advisory Council
Physical Activity Requirement Support establishing a minimum for required minutes of physical education	**Diabetes** Support the efforts of the Oregon Diabetes Prevention and Control Program
Subsidies for Farmers' Markets Continue to appropriate moneys to Department of Human Services for provision of fruits and vegetables from farmers' markets to individuals eligible for Women, Infant and Children Program, and for older adults eligible for food stamps.	**Health Professional Workforce** Prepare health professionals to respond to the needs and challenges of the 21st century through prevention-based programs.

Oral Health	
Water Flouridation Require the fluoridation of all public water systems in Oregon.	**Parent and Child Education** Teach parents and children the importance of good oral health habits to prevent tooth decay and gum disease.
Dental Hygienists Support expanding the number of sites dental hygienists can practice to increase access to services necessary to meet the oral health care needs of medically underserved Oregonians	
Out-of-State Dentists Support removing barriers for licensed out-of-state dentists who want to practice in Oregon	

TIER II – INTERMEDIATE to LONG-TERM

Tobacco Use	
Tobacco tax Raise tobacco taxes 50 cents with revenue directed for health care purposes.	
Obesity / Nutrition / Physical Activity	
Senior Meals Support and expand funding for Senior Meal programs to assure access to healthy meals for underserved seniors	
Community Assessment Require a community assessment of walkability and potential for healthy activities during their planning processes to assure access to recreational/activity resources for older and disabled citizens.	

Health Status Work Group Roster

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Access Work Group

Assurance of access to affordable basic healthcare services is the foundation to preventing disease and disability and improving the health and productivity of the population. There are many components necessary to assure access to affordable healthcare services.

Problem Statement:

1) Insurance Coverage: Health insurance coverage is very important in assuring access to necessary care in a way that doesn't lead to financial hardship and having to make the choice between healthcare and the other necessities of life such as food and shelter.

The impacts of uninsurance and underinsurance are clear and severe. A recent Kaiser Family Foundation survey found that 47% of those without health insurance postponed seeking care within the past year because of costs and 35% had needed care but had not been able to obtain it.

Since those without insurance receive less care – and receive it later than those with coverage, they are on average less healthy and less able to function effectively in their daily lives. In addition, this pattern of delayed treatment shifts costs to those who do have coverage, creating a vicious cycle by increasing costs and making health care unaffordable for even more Oregonians.

Approximately 500,000 Oregonians are currently without health insurance.

2) Other Access Barriers: Coverage does not always mean access.
Access to care is further compromised when health services are unavailable or inappropriate. Hundreds of thousands of Oregonians are known to have unmet health care needs due to such factors as geographical isolation, health professional workforce shortages, scarcity of providers accepting public insurance, lack of enabling services such as transportation and interpretation.

3) The Financing and Delivery of Health Care does not create incentives to prevent disease.
Health care financing rewards and perpetuates a delivery system geared primarily toward specialized care of conditions once they have become advanced or critical. There is a significant lack of incentives for providers and systems necessary to provide public health safeguards and preventive and primary care services. This absence of incentives exacerbates health professional workforce shortages and other access barriers. This situation represents poor stewardship of public and private resources.

Goal:

Assure all Oregonians access to essential health care services.

Preamble:

The Access Work Group acknowledges the fiscal realities the state must work within. In an ideal world, every Oregonian would have access to essential health care services that would ensure their optimum health.

However, in order to effectively use existing resources, society and policymakers must first define a minimum standard of what every Oregonian should have access to. The Access Work Group believes that the prioritization of any services should maximize the use of limited funds by improving society's overall health.

The following services apply to medical, dental and behavioral health services and are listed in priority order. For all categories, necessary pharmaceuticals, equipment, supplies, diagnostic services and enabling services such as transportation and interpretation are included. Evidence-based guidelines, which include consideration of potential cost savings, are to be utilized.

1. Preventive services (U.S. Public Health Services Task Force on Prevention - Category A & B Services)
2. Reproductive healthcare including
    a. Contraception
    b. Preconception counseling
    c. Prenatal, peri-natal and postpartum care
3. Outpatient healthcare (to cover both emergent/urgent services and services that will lead to worsening and avoidable loss of function or death if not treated)
    a. Diagnostic services
    b. Treatment of diagnoses where failure to treat leads to avoidable loss of function or death – examples include treatment of acute conditions such as bacterial pneumonia, severe depression or fractures and treatment of chronic conditions such as diabetes, heart disease, or schizophrenia.
4. Inpatient services (as currently defined for the Oregon Health Plan Standard population where hospital services are necessary to avoid loss of function or death).

The following list outlines recommended legislative and non-legislative strategies:

Recommended Next Steps:

TIER I – IMMEDIATE

Legislative Strategies	Non-Legislative Strategies
Assessment of Current Resources	
Assessment Tool Direct the Office of Health Policy and Research to create and implement a point-in-time statewide assessment of health services and resources to determine the availability of health services and resources and amount of unmet need.	
	Future Planning Use assessment data for future planning of a comprehensive statewide strategy to increase access.
Access to Preventive Services	
Children Expand health services offered under the Oregon Health Plan to uninsured children with incomes no more than 300 percent of federal poverty guidelines.	
Pregnant Women Expand health services offered under the Oregon Health Plan to uninsured pregnant women with incomes no more than 250 percent of federal poverty guidelines.	
Immunizations Expand the Immunization Program operated by the Department of Human Services to offer immunizations that have been proven effective to individuals not currently served by the program.	

Chronic Disease Management Direct the Department of Human Services to develop and implement a pilot program that screens uninsured individuals with incomes no more than 300 percent of federal poverty guidelines for chronic disease risk factors based on information developed by United States Public Health Services Task Force on Prevention, category A and B services and provides those individuals with chronic disease management services.	
Oral and Mental Health Preventive Services Direct the Department of Human Service to develop and implement a pilot program for uninsured individuals with incomes no more than 300 percent of federal poverty guidelines for oral and mental health preventive services.	
Access to Safety Net Providers	
	Safety Net Task Force Awaiting recommendations from the Governor's Safety Net Task Force.

TIER II – INTERMEDIATE to LONG-TERM

Access to Private Coverage	
	State Contracts Evaluate the possibility of requiring health insurance as a condition of state contracts.
	Statewide Reinsurance Program Investigate the possibility of establishing a statewide reinsurance program for small businesses and individuals.
	Tax Incentives Assess the possibility of providing tax incentives to encourage employers to offer coverage
	Association Health Plans Assess the option of allowing group purchasing arrangements for small employers
	Expansion of PEBB Investigate the possibility of allowing other groups to join the health plan offered by the Public Employee Benefit Board
	Employer Mandate Review the possibility of enacting an employer mandate provision for minimal coverage.
Access to Public Coverage	
	OHP Buy-in Analyze the feasibility of allowing uninsured individuals to buy into the Oregon Health Plan.
	Essential Services for all Oregonians Assess the possibilities of providing essential health care services to all Oregonians.

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Quality Work Group

Problem Statement:
The quality of health care provided in any society is measured by the results achieved across the population.

A series of landmark reports from the Institute of Medicine (IOM) brought wide spread attention to and documented the existence of a "quality chasm" in our health care system – a wide gulf between the care that patients should receive and the care that is actually delivered. As the IOM noted in this landmark report "*just because outstanding care is available does not mean that it is always provided or that everyone has access to such care."*

The health care system has serious systemic problems which must be addressed in order to improve the quality of health care. Here are some examples:

- Recent research on the quality of health care delivered to adults published in the New England Journal of Medicine showed that Americans receive recommended care about 55 percent of the time. The study covered 439 quality of care indicators for acute and chronic conditions as well as preventive care.

- A recent Dartmouth study found that close to one third of our healthcare expenditures goes to care that is duplicative, fails to improve patient health, or may even make it worse. Dartmouth research has for many years documented variation between regions in medical care that is not explained by differences in health status or conditions.

- A recent study by the Commonwealth Fund found the United States health care system the most inefficient in duplicating tests, repeating medical histories, and not having medical records available at the time of the visit. A recent study in California found that one of every five lab tests and x-rays were done just because previous results were not available.

- The Center for Information Technology Leadership has estimated that standardizing health information exchanges will save $86.8 billion annually by performing fewer tests and achieving administrative savings from automated data.

- Ninety percent of health information still moves by fax, phone, or mail

- A recent study by the Agency for Healthcare Research and Quality found that hospitals with high Registered Nurse (RN) staffing levels had lower rates of five adverse patient outcomes (urinary track infections, pneumonia, shock, upper

gastrointestinal bleeding, and longer hospital stay) than hospitals with low RN staffing levels.

- The IOM has estimated that between 44,000 and 98,000 Americans die each year from preventable medical errors in hospitals.

There is a critical need to develop appropriate tools and infrastructure and measure and monitor data to ensure the optimum health of Oregonians and the consistent provision of care that meets safety and quality guidelines. The Quality Work Group believes that more money is not currently the answer. The United States currently spends more than any other developed country without achieving results that justify the difference in spending. The International Working Group on Quality Indicators of the Commonwealth Fund produced performance data on 40 quality indicators for five developed nations (Australia, Canada, New Zealand, the United Kingdom, the United States) and found that no country consistently scored the best or the worst on all of the indicators and each had at least one area where it could learn from international experience.

Precious health care resources are wasted with every unneeded lab test or surgery, every duplicative procedure, and every complication, or lost life resulting from medical error or the failure to provide needed care. Using those health care dollars more efficiently will help make care affordable for those with insurance and provide health care coverage for those Oregonians and Americans who rely on emergency rooms and care that is often too little and too late.

Goal:

Improve the results achieved by Oregon's health care system by promoting changes in processes, cultures and payment systems necessary to improve health care outcomes, improve system efficiency, and control costs. To this end, reliable, common, and transparent information is mandatory.

Preamble:

The Quality Work Group acknowledges that transitioning the health care system to produce better outcomes is a long-term process involving many steps.

A beginning point is to promote the development of a health information infrastructure, decrease barriers to adopting health information technology and improve gathering and reporting of health care information for providers, purchasers and policymakers.

A system-wide effort to improve quality should:

- Increase investment in useful information about effectiveness and cost-effectiveness – to improve recommendations and choices among options for care.

- Develop and make widely available measurements of progress and outcomes – to facilitate choices among plans and providers by payers and consumers and inform state policy makers.
- Support evidence-based medicine and help reduce variability across regions, providers and practice patterns.
- Provide for the efficient creation, storage and sharing of electronic medical records, including prescription drugs.
- Link payments for care to measured quality of care and provide incentives for high quality care.
- Provide information to patients and involve patients in shared decision making.

The state can initiate this effort as a provider, purchaser, regulator, educator and convener. In the following tables, the Quality Work Group identifies an agenda for immediate and mid-term actions by which the State can promote a systemic move towards improved quality.

Recommended Next Steps:

TIER I - IMMEDIATE

Legislative Strategies	Non-Legislative Strategies
System Performance: Disclosure and Measurement	
Lack of Information Direct the Office of Health Policy and Research to collaborate with state agencies to use existing FTE within the state for the creation of a state web site that: • Connects citizens to a wide range of information on the cost and quality of health care in the state • Compares providers, health plans, hospitals on quality and cost • Provides information about being a wise health consumer and how best to manage health care dollars.	
	Patient Safety Commission Encourage the participation of all hospitals in the Patient Safety Commission's voluntary reporting process of hospitals' "never events."
	Streamline Regulations Review the options of streamlining regulations to increase efficiency and reduce administrative burdens on providers and payers.
Building the Health Care Information Infrastructure	
	Electronic Medical Records Identify barriers to the adoption and implementation of electronic health record systems in Oregon; Identify core components of an electronic health record and standards for interoperability; Assess the status of current implementation of electronic health records in Oregon; Assess the costs for primary and acute health care providers, including safety net clinics and hospitals, to implement electronic health records systems; Identify partnership models and collaboration potential for implementing electronic health records systems; Monitor the development of federal standards, coordinate input to the National Health Information Infrastructure Process, and ensure that Oregon's recommendations are consistent with emerging federal standards; and

	Identify barriers and develop a plan to develop a unified record system among public hospitals and clinics.
Supporting Purchasers: Incentivizing Quality	
	Medicaid and PEBB Contracts Assess current Medicaid and Public Employees Benefit Board (PEBB) contracts for possible pay for performance strategies.
	State Health Care Purchasing Contracts Encourage all state health care purchasing contracts to include incentives for physician participation in provider recognition and pay-for-performance contracts.

TIER II – INTERMEDIATE to LONG-TERM

System Performance: Disclosure and Measurement	
	Leapfrog Project Encourage the participation of all eligible hospitals in the Leapfrog Group project.
	Health Plan Data Encourage the collection and publication of Health Plan Employer Data and Information Set and Consumer Assessment of Health Plans Survey data for all insurance carriers and hospitals.
	Medical Court System Analyze the potential of creating a medical court system or no fault system instead of current malpractice environment.
Supporting Purchasers: Incentivizing Quality	
	PEBB Leadership Use PEBB as a leader with other purchasers for development of pay for performance strategies.
	Convene Other Organizations Work with other organizations to improve Oregon purchasers' knowledge of strategies to incentivize quality and build a coalition of purchasers committed to purchasing quality.
	Anti Trust and Fraud Evaluate antitrust and fraud and abuse laws to stimulate more private investment and payment incentives
Building the Health Care Information Infrastructure	
	State-wide Collaboration Support state wide collaborative efforts (ex: Oregon Medical Peer Review Organization

	collaborative on diabetes)
	Financial Incentives Evaluate the possibility of providing financial incentives through Medicaid and PEBB for electronic medical records and other safety and quality tools.
	Tax Incentives Evaluate the possibility of providing tax incentives for the implementation of electronic medical records and other quality and safety investments
	Anti Trust and Fraud Evaluate anti trust laws that may make it difficult for hospitals to develop specialties and jointly purchase expensive equipment

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Joint Legislative Committee on
Information Management and Technology

H-178 State Capitol
Salem, Oregon 97301
Phone 503-986-1828 Fax 503-373-7807

June 24, 2004

Honorable Theodore R. Kulongoski, Governor
Oregon State Capitol
900 Court Street NE
Salem, Oregon 97301

Dear Governor Kulongoski:

This Committee heard testimony in support of a legislative concept directed toward standardization and sharing of medical records electronically. Testimony was provided by representatives of independent physicians, a hospital, an insurer, and the Director of the Oregon Health Policy Commission and it convinced this Committee of the need for the ability to access and share medical records electronically. The concept (LC 832 enclosed) was developed for consideration by the 73rd Legislative Assembly to facilitate development of a platform for the sharing of electronic medical records. The concept calls for the establishment of a task force to develop suggested legislation for the 74th Legislative Assembly. The task force would be staffed by the Oregon Office for Health Policy and Research.

This Committee is very supportive of this concept. During our deliberations, the possibility of an Executive Order was raised. An Executive Order along the lines of the enclosed LC 832 would "get the ball rolling" much earlier than a yet-to-be-passed bill from the 2005 legislative session. The Committee discussed this with staff of the Oregon Office for Health Policy and Research. That staff was supportive of the concept and felt the work could be accomplished within existing resources. It was felt also that providing this support could minimize, if not eliminate, duplicative efforts on this issue.

The Joint Legislative Committee on Information Management and Technology asks that you consider such an Executive Order.

Sincerely,

Senator David Nelson, Co-Chair

Enclosure

Cc: The Honorable Peter Courtney, President of the Senate
The Honorable Karen Minnis, Speaker of the House
Dallas Weyand, Legislative Fiscal Office

August 2, 2004

The Honorable David Nelson
Co-Chair
Joint Legislative Committee on Information Management and Technology
1407 NW Horn Ave.
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Dear Senator Nelson:

My thanks to you and to the Joint Legislative Committee on Information Management and Technology for bringing the issue of electronic medical records to my attention. I agree that the development of a common platform for the sharing of electronic medical records will be a keystone to the future of our health care system.

In regard to the Committee's suggestion that an Executive Order be issued to create a task force to facilitate the development for a common platform, I believe such a group already exists. After discussing this concept with Bruce Goldberg, administrator of the Oregon Office for Health Policy and Research, as well as Mike Bonetto, director of the Oregon Health Policy Commission (OHPC), I have recommended that the duties you highlighted for a task force be conducted by the OHPC. Since the OHPC currently has a Quality Work Group, comprised of experts from around the state on health care quality and medical informatics, I am confident this group will accomplish this task in a timely manner with existing resources.

I have asked Mike Bonetto to follow up with you to keep you and interested committee members apprised of the OHPC's progress on the issue. Again, thank you for your suggestion and I look forward to working with you and the Committee in the future.

Sincerely,

THEODORE R. KULONGOSKI
Governor

TRK:EKS/ejb
c: The Honorable Peter Courtney, President of the Senate
The Honorable Karen Minnis, Speaker of the House
The Honorable Rob Patridge, Co-Chair
The Honorable Mary Gallegos, Vice-Chair
Bruce Goldberg, Administrator, Office of Health Policy and Research
Kerry Barnett, Chair, Oregon Health Policy Commission
Mike Bonetto, Director, Oregon Health Policy Commission

Cost Work Group

Problem Statement:

The lack of affordable health care is a crisis in Oregon and across the nation. The following list illustrates some dramatic examples of escalating costs:

- Health insurance premiums have risen every year since 1998. In 2003, the 13.9 percent increase was nearly four times the increase in 1998. These increases in health care costs cut across all layers – individuals, employers, state and federal government.

- A variety of independent studies and surveys anticipate that premiums will continue to increase at double-digit rates over the next several years. A recent Mercer report projected that the average annual premium for an Oregonian will surge from $6,000 in 2004 to $13,878 in 2010 (based on a 15% annual increase).

- What makes these recent increases especially concerning is that they have occurred during a period of low inflation. Last year's increase, in comparison to the net increase of the Consumer Price Index was more than five times greater.

- Similarly, public sector health care spending has outpaced incoming revenue and budget priorities for health care. The Oregon Health Plan budget has averaged approximately 10-12% annual increases over the past 10 years, while increases in the General Fund have only averaged 5 to 6%. This rate of medical inflation will continue to make it exceedingly difficult for the state to serve an increasing number of uninsured while also funding essential services like education and public safety.

All Oregonians are being affected by increasing health care costs. Increasing costs to business and private sector employers reduce their ability to be competitive. The public sector is impacted both as an employer and in its responsibility for the uninsured. Increased costs burden insured Oregonians who are on fixed incomes. Complicating the issue are data showing that the reasons for increased costs are complex and are not dominated by a single factor such as an aging population, defensive medicine, expensive technologies or drug costs.

Without a change, our health care system will become increasingly unaffordable for Oregonians and will significantly decrease their access, jeopardize their health status and dampen the state's economic growth.

Goal:

The health care system should be adequately financed through efficient and cost-effective operations to ensure affordability and sustainability.

Preamble:

The current health care system operates with misaligned financial incentives. This misalignment includes federal tax subsidies that favor employer-sponsored coverage and provider payments that reward the number of services provided and not performance outcomes. This misalignment has led to some excessive cost drivers that exist today. The Cost Work Group realizes that the most sustainable system ultimately must realign incentives to improve efficiency and maximize the value of our health care dollars.

The Cost Work Group acknowledges the limitations federal policy has on state reform. However, this should not deter Oregon from pursuing cost-saving actions or laying the foundation for future cost management strategies.

The Cost Work Group set out to identify health care cost drivers at the state level. This process is ongoing and entails assessing the state's ability to affect various cost drivers and determine how various strategies might affect different groups.

It is important to note that the Cost Work Group has been focused on cost management approaches that do not lead to cost-shifting. For example, if cuts in reimbursement rates or in a type of service lead to greater use of another more expensive service, total costs are not contained, but merely shifted or even increased. Avoiding cost shifts occurs when:

- Needed services are delivered using appropriate techniques and technologies that reduce costs without reducing quality of outcomes.
- Unnecessary services are cut without creating the need for other even more expensive services.
- Health care dollars are prioritized on improving individual health and effective preventive services (both for those with and without medical illness) – that offset the need for expensive care and services later.

In addition, *no one strategy identified by the Cost Work Group is the magic pill.* Reform that will make health care safe, affordable and accessible must be a collaborative, coordinated, and incremental effort on many fronts, between many parties in the public and private sectors, and is best implemented at the community level.

The following list outlines recommended legislative and non-legislative cost containment strategies.

Recommended Next Steps:

TIER I - IMMEDIATE

Legislative Strategies	Non-Legislative Strategies
Investment in Prevention *(Health Status & Access Work Groups)*	
Accountability & Transparency *(Quality Work Group)*	
Prescription Drugs	
Prescription Drug Purchasing Pool Expand the Oregon Prescription Drug Program (ORS 414.312-414.320) to allow Oregonians without prescription drug coverage to purchase discounted drugs.	**Prescription Drug Purchasing Pool** Encourage all eligible purchasing groups, including Oregon's Public Employees Benefit Board, to participate in the state's prescription drug purchasing pool.
Oregon Health Plan Direct the Department of Human Services to establish goals to increase the prescribing of drugs on the practitioner-managed prescription drug plan through education and incentives to patients and providers -- and modify use of prior authorization if goals are not met within established timelines.	**Drug Information** Publish comparative information on drug cost-effectiveness.
System Inefficiencies	
	Oregon Health Plan Evaluate the options for restructuring Medicaid operations to improve claims and utilization management.
	Evidence-Based Medicine Support initiatives that increase the use of evidence-based medicine by physicians and health care institutions

TIER II - INTERMEDIATE to LONG-TERM

Health Care Market Opportunities	
	Realigning Incentives Encourage the state and business community to enter into health care contracts that include incentives for physician participation in provider recognition and pay-for-performance contracts.
	Purchasing Pool Evaluate the possibility of establishing a health insurance purchasing pool for selected employer groups.
	Reinsurance Program Investigate the possibility of creating a statewide reinsurance program for small businesses and individuals.
	Streamline Regulations Review the options of streamlining regulations to increase efficiency and reduce administrative burdens on providers and payers.
	Provider Incentives Evaluate the possibility of providing incentives for providers to serve in under-served areas.
Defensive Medicine and Medical Malpractice Costs	
	Patient Safety Commission Encourage the participation of all hospitals in the Patient Safety Commission's voluntary reporting process of hospitals' "never events."

Aging Population	
	Immunizations for Seniors Support programs aimed at increasing immunizations and reducing fractures among seniors.
	Senior Education Teach seniors (and others) how to be informed consumers in buying services from the medical care delivery system.
	Disease Management Programs Support disease management programs.

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