OREGON HEALTH FUND BOARD – Delivery Systems Committee

January 17, 2008
9:00 am – 12:00 pm

Regence Blue Cross Blue Shield of Oregon
North & Central Sisters Rooms
100 SW Market St, Portland, Oregon

MEMBERS PRESENT:
Dick Stenson, Chair
Maribeth Healey, Vice-Chair
Vanetta Abdellatif (by phone)
Mitch Anderson
Tina Castanares, MD
David Ford
Vickie Gates
Bill Humbert
Dale Johnson
Carolyn Kohn
Diane Lovell
Bart McMullan, MD
Stefan Ostrach
Ken Provencher
Lillian Shirley, RN
Mike Shirtcliff, DMD
Doug Walta, MD, Vice-Chair
Rick Wopat, MD
Charlie Traggesser

STAFF PRESENT:
Jeanene Smith, MD, Administrator, OHPR
Ilana Weinbaum, Policy Analyst
Zarie Haverkate, Communications Coordinator

ISSUES HEARD:

- **Call to Order/Review of 11/15 Meeting Minutes/Review of Oregon Health Fund Board Staff Review Panel Policy**
- **Discussion of Framework for Delivery System Reform Diagram**
- **Discussion of Draft Integrated Health Home Recommendations**
- **Discussion of Principles to Guide Reform of Reimbursement Policies**
- **Future Meetings**
- **Update on OHFB and Committees**
- **Public Testimony**

These minutes are in compliance with Legislative Rules. Only text enclosed in italicized quotation marks reports a speaker's exact words. For complete contents, please refer to the recordings.

(Digitally Recorded)

Chair **I. Call to order/Approval of 11/15/07 Meeting Minutes/Review of Oregon Health Fund Board (HFB) Staff Review Panel Policy (see Exhibit Materials 1 and 2)**

- Meeting was called to order at approximately 1:05 pm. There is a quorum.
- Review of 11/15/07 meeting minutes. Amend to reflect that Dr. Walta was present at the 11/15/ meeting.

Motion to approve minutes as amended from November 15, 2007, is seconded. **Motion passed unanimously.**

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- The 12-12-07 minutes from the Joint Meeting of the HFB and the Delivery System Committee is pending approval by the HFB.
- Staff highlighted the review of the Oregon Health fund Board Staff Review Panel Policy, including policy surrounding workgroups, attendance and input from other committees.

Staff and Committee

II. Discussion of Framework for Delivery System Reform Diagram (See Exhibit Materials 3)

Staff reviewed diagram and sources consulted in its development.

- Concern was expressed that a basic benefit is not referenced. It was noted that the Benefit Committee will be discussing the essential benefit package and the need to focus on preventive care and disease management.
- Discussion on integrated health home and ensuring that patients have a voice.

Staff and Committee

III. Discussion of Draft Integrated Health Home (See Exhibit Materials 4 and 8 - Slide Presentation)

RECOMMENDATION 1 (See page 1 of Exhibit 4):

- **"Promote and support" –** Discussion on what it means and strengthening statement.
- Discussion concerning mandating Integrated Health Homes.
- Importance of optimizing medical care for all Oregonians and setting a timeline.
- Involving mental health, physical health, and pharmacy practices in coordinating care.
- Revisited the charge of the Delivery Systems Committee.
- Staff related that the Board will be informed of background of recommendations and debates behind the reasoning.

Call for the question.

Motion to approve recommendation 1 with changes to strengthen statement to "adopt" instead of "promote and support" and adding the need for a timeline is **seconded. Motion passed unanimously.**

RECOMMENDATION 2 (See page 2 of Exhibit 4)

- Discussion of the priority of this recommendation and the message that it sends, on incentives and accreditation, and on designation and measurement being tied to payment reform strategies.
- Decision that recommendation #2 be incorporated into #5 with reference to outcome measures and/or accountability.
- Staff will incorporate changes.

Recommendation 3 (See page 2, Exhibit 4):

- Discussion on the technology available to create interactive, secure networks.
- Make the point that this will take funding.
- Discussion on it being community owned and not organizing just around doctors, especially with the shortage of primary care physicians.

Call for the question.

Motion to approve recommendation 3 is **seconded. Motion passed unanimously.**

<u>Recommendation 4</u>

- Not just primary care workforce that needs development, but boarder health care workforce and the need for incentive.
- Agrees – Grants are good for short-term needs but not good finance mechanism for staff.
- Add financing recommendations. Suggested that this is too narrow and discussion about need for new recommendation.
- Decision to change primary care to health care workforce to wider health workforce and a subset or separate recommendation for State strategies for responding to the primary care level in Oregon.

Motion to approve recommendation 3 with the change of "primary care workforce" to "health care workforce" and make a separate recommendation to address State strategies for responding to the primary care level in Oregon is **seconded**. **Motion passed unanimously.**

<u>Recommendation 5</u>

- **Point 1** – Recommendation to Board should include promoting, acknowledging and participating in funding of pilots on an appropriate scale and develop models to test reimbursement strategies
- **Point 2** - This is a broader issue. Need outcomes, performance and data. Communication is a key issue to get people to participate
- Suggestion to change Recommendation 5 wording to: Develop strategies that promote the integrated health home including outcome incentives and system performance measures.
- Discussion of the Robert Wood Johnson Aligning Forces for Quality grant and the scope of the project in relation.
- Suggestion that the participant/consumer voice is a separate issue that should relate to effectiveness and responsiveness as opposed to rewards. Dissention that some monetary incentive may help change behavior.
- **Point 3** – A mixed model with funding for incentives to extend to network partners as well as traditional providers. Change policies to practices and compensate providers rather than promote. Include continuously evolving and improving strategies. Tie measures into population health.
- Discussion on "mixed model" and that some features would be paid for with some risk adjusted from those payments for the care management. Team basis approach for integrated health home service.
- Payment would require some sort of reporting requirements and an auditing process.
- Discussion on workforce reform.
- Request to receive update from the Benefits Committee.

Chair Stenson **V. Future Meetings**

- Do we need further discussion on how health care funds are currently spent?

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- Items for parking lot:
  - Cost transparency/containment strategy
  - February 21 – Benefits Committee
  - March 13 – Quality Institute

Chair Stenson **VI. Public Testimony**

- **Tonya Stewart, MD, for the Palliative Care Physician's Roundtable,** presented testimony on the importance of communications in health care. Written testimony provided.
- **Cindy Becker, Executive Director of the Coalition for a Healthy Oregon,** testified concerning the term medical home, coordination of care, long term care, a broader mental health workforce, as well as a workforce for Preferred Care Providers (PCP) and managed care and the lack of sharing information between providers.

Chair Stenson **VII. Adjourn**

The meeting was adjourned at 5:00 p.m.

Next meeting is February 21, 2008.

Submitted By: Paula Hird Reviewed By: Ilana Weinbaum

EXHIBIT MATERIALS:

1. Draft 11/15/07 Minutes
2. Staff Review Panel Policy
3. Framework for Delivery System Reform
4. Draft Strawperson Policy Recommendations – Promotion of Integrated Health Homes
5. Executive Summary – Harold Miller, Creating Payment Systems to Accelerate Value-Driven Health Care Full paper available at http://www.commonwealthfund.org/usr_doc/Miller_creatingpaymentsystemvalue-drivenhltcare_1062.pdf?section=4039
6. Payment Reform Examples
7. Payment Reform, Background Information Prepared by Minnesota Department of Health Staff. Available at: http://www.health.state.mn.us/divs/hpsc/hep/transform/091707documents/paymentreformfinal.pdf
8. Integrated Health Homes discussion Slides

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<u>**OREGON HEALTH FUND BOARD – Delivery Systems Committee**</u>

February 21, 2008
1:00 – 5:00 pm

Oregon Medical Association, Sommer-McLoughlin Room
11740 SW 68th Parkway Suite 100
Portland, Oregon

MEMBERS PRESENT:
Maribeth Healey, Vice-Chair
Vanetta Abdellatif
Tina Castanares, MD, (by phone)
David Ford
Bill Humbert
Carolyn Kohn
Diane Lovell
Stefan Ostrach
Ken Provencher
Mike Shirtcliff, DMD
Rick Wopat, MD
Charlie Traggesser

MEMBERS ABSENT:
Dick Stenson, Chair
Mitch Anderson
Dale Johnson
Bart McMullan, MD
Lillian Shirley, RN
Doug Walta, MD, Vice-Chair
Vickie Gates

STAFF PRESENT:
Jeanene Smith, MD, Administrator, OHPR
Ilana Weinbaum, Policy Analyst
Judy Morrow, Administrative Assistant

ISSUES HEARD:

- **Call to Order/Review of 12/12 and 1/17 Meeting Minutes**
- **Testimony from Senator Schrader on Cost Containment Strategies**
- **Description of Cost Containment Strategy Options**
- **Prioritization of Cost Containment Activities**
- **Recommendations from Safety Net Advisory Council**
- **Public Testimony**
- **Continuation of Prioritization of Cost Containment activities**
- **Invited Testimony on Role for Public Health in Health Reform: Grant Higginson, State Public Health Officer**
- **Public Testimony**

Vice-Chair Healey

I. Call to Order/Approval of 12/12 and 1/17 Meeting Minutes

- Meeting was called to order at approximately 1:00 pm. There is a quorum.
- Review of 12/12 and 01/17 meeting minutes.

Motion to approve minutes as amended is seconded. **Motion passed unanimously.**

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- Jeanene Smith provided the highlights from the OHFB February Newsletter and related committee activities including:
    - Finance – is researching and considering funding sources and identifying start up costs.
    - Exchange – has been working with Rick Curtis, Institute of Health Policy Solutions, on preliminary framework for data input into Gruber's healthcare model.
    - Health Equities – presented initial recommendations to HFB and Eligibility and Enrollment (E&E)
    - Eligibility and Enrollment—completed preliminary recommendation on affordability and presented it to the Board at the February meeting.
    - Benefits- is working on a prioritized list, has formed small review panels, and is working with the state actuary to develop a benefit package.
    - Federal Laws – is currently hearing testimony on Medicaid and Medicare issues, additional hearing on HIPAA, ERISA and other topics.
- Recommendations from the Eligibility and Enrollment and the Health Equities Committees will be sent to the Committee.

Vice-Chair Healey II. Testimony from Senator Schrader on Cost Containment Strategies

Senator Schrader sent his regrets that he was unable attend today's meeting as planned.

Vice-Chair Healey III. Description of Cost Containment Strategy Options.

The Committee focused on cost containment in the Delivery Services System. Jeanene Smith, MD, and Vice-Chair Maribeth Healy provided the committee with an overview of the new framework as updated from the last meeting. **(See Materials 3)**

What strategies do committee members think are most likely to contain costs? What other strategies should the committee consider? (See Exhibit Materials 4)

Discussion

Goal: Improve Quality and Efficiency of Care Provided Access across Oregon (See Exhibit Materials 4)

- **Paying for Quality**
- Why limit to public purchasing? More power if private sector is engaged.
- Discussion on designing the tools and mechanisms that will be used for each strategy - Regulation? Incentives? Voluntary? Will also have to think about staging strategies.
- Currently low/no reward for high performers and there is a need for incentives for improvement. Discussion on rewarding excellence versus not wanting to pay over cost, creating differential between bottom and top performers.
- If incentives are used it should be done in a cost neutral or cost reduction framework.

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- Discussion on increased transparency in hospitals, comparable service for comparable cost and engaging consumers to shop for quality and cost.

Goal: Correct Health Care Price Signals (See Exhibit Materials 4)

- Need clarification on the Medicare rate for Oregon. Noted that this was an issue Federal Laws Committee would be dealing with.
- Effects of rate regulation in New York discussed. It was suggested that it resulted in the some of the most inefficient hospitals in the country.
- **Reduce Administrative Spending**
- Discussed administrative simplification efforts in Minnesota.
- Need standard definition of administrative costs and more transparency around amount companies spend on administration. Consumers should be able to compare across health plans.
- Discussion around types of forms and processes are already standardized. Biggest hurdle for providers is multiple formats that information comes back to them in from multiple sources.
- **Health Plan Regulation**
- Some members questioned whether regulation is actually useful for bending the trend.
- Must be careful that regulation does not hurt local businesses or keep businesses out of Oregon. The more regulated, the greater the disadvantage to local companies.
- Only small percentage of market is regulated by the insurance commission – the remainder is self-funded and would not be affected by regulations.
- Must be sensitive to the ways that companies are organized – consider different regulations for for-profit vs. not-for-profit.
- Any regulation should take a long-term perspective – limits on medical loss ratios, etc. need to be taken over a few year period.
- **Hospital Regulation**
- Discussion on hospital expenses and possible effects of limiting income, while allowing for capitol investments. Some though it would be more effective to create incentives to drive prices down without limiting profits, since focus should be on finding ways to drive overall cost down.
- Discussion on responsibility of hospitals to reinvest in community given non-profit tax treatment.
- **Reduce Pharmaceutical Spending**
- Discussion on expansion of use of Oregon Prescription Drug Program and the NW Drug Consortium.
- Discussion of a statewide formulary that could be mandatory for all public programs and voluntary for private.

Vice-Chair Healey V. Recommendations from the Safety Net Advisory Council

Scott Eckblad, Craig Hostetler and Priscilla Lewis presented on recommendations from the Safety Net Council. (**See Exhibit Materials 8)**

Recommendations included:

- Investing in stable funding for Oregon's health care safety net
- Investing in critical infrastructure by supporting adoption of Electronic Health Technology across the safety net
- Investing in recruitment, retention and flexible strategies to grow and sustain the safety net Workforce.

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VI. Public Testimony

- Kevin Earls, Vice President, Finance and Health Policy, Oregon Association of Hospitals and Health Systems (OAHHS) spoke to the OAHHS's willingness to present to the Committee with information regarding hospital costs, profitability, regulation and financial details.
- Glen Patrino, MD, Palliative Round Table, testified on the importance of including palliative care in health reform discussions and proposed more palliative care education at the primary care level and development of palliative care nurse training programs.
- David Pollack, Mental Health Services, OHSU, testified on the integration of behavioral health services.

Vice-Chair Healey

VII. Invited Testimony on Role for Public Health in Health Reform.

Grant Higginson, State Public Health Officer, gave a presentation on the integration of public health into health reform. Committee discussion and questions followed.

Public Testimony

XI. Adjourn

The meeting was adjourned at approximately 5 pm.

Next meeting is March 13, 2008.

Submitted By: Paula Hird Reviewed By: Ilana Weinbaum

EXIHIBIT SUMMARY

1. Minutes for Review and Approval
   a. Draft Minutes from 12/12 Joint Meeting of the Health Fund Board and Delivery Systems Committee
   b. Draft Minutes from the 1/17 Delivery Systems Committee Meeting
2. Revised Framework for Delivery System Reform Diagram
3. Cost Containment Strategies Matrix
4. Companion to Cost Containment Strategies Matrix
5. J. Wennberg, E. Fisher, and J. Skinner. Feb 12 2002. Geography and the Debate Over Medicare Reform. *Health Affairs Web Exclusive.* Available: http://content.healthaffairs.org/cgi/content/full/hlthaff.w2.96v1/DC1
6. D. Shodell. 2006. Public Health Perspective – Paying for Prevention. Medscape Public Health and Prevention. 4(2).
7. Issue Paper from the Public Health Division, Oregon Department of Human Services.
8. Presentation and Report from the Safety Net Advisory Council
9. Revised Integrated Health Home Recommendations

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OREGON HEALTH FUND BOARD – Delivery Systems Committee

March 13, 2008
1:00 – 5:00 pm

Port of Portland, Commission Room
121 NW Everett St.
Portland, Oregon

MEMBERS PRESENT:
Dick Stenson, Chair
Maribeth Healey, Vice-Chair
Tina Castanares, MD, (by phone)
David Ford
Bill Humbert
Carolyn Kohn
Diane Lovell
Stefan Ostrach
Ken Provencher
Mike Shirtcliff, DMD
Rick Wopat, MD
Charlie Tragesser
Mitch Anderson
Dale Johnson
Bart McMullan, MD
Lillian Shirley, RN
Vickie Gates

MEMBERS ABSENT:
Doug Walta, MD, Vice-Chair
Vanetta Abdellatif

STAFF PRESENT:
Alyssa Holmgren, Operations Policy Analyst, OHPR
Jeanene Smith, MD, Administrator, OHPR
Ilana Weinbaum, Policy Analyst
Zarie Haverkate, Communications Coordinator

ALSO ATTENDING:
Senator Kurt Schrader
Cindy Becker, COHO
Tina Kitchen, Seniors and People with Disabilities
Eileen Brady, Oregon Health Fund Board
Bill Kramer, Consultant
Denise Honzel, Exchange Workgroup

ISSUES HEARD:

- Call to Order/Review of 2/21 Meeting Minutes
- Testimony from Senator Schrader on Cost Containment Strategies
- Accountable Health Organization Discussion
- Demand Adjustment Cost Containment Strategies
- Public Testimony
- Supply Adjustment Cost Containment Strategies
- Prioritization of Key Effective Cost Containment Strategies
- Invited Testimony and Public Testimony: Oregon Association of Hospitals and Health Systems

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Chair Stenson **I.** **Call to Order/Approval of 02/21/ Meeting Minutes**

- Meeting was called to order at approximately 1:00 pm. There is a quorum.

Motion to approve minutes is seconded. **Motion passed unanimously.**

Staff provided updates on:

- Health Fund Board meeting has moved to March 20 in Portland and requested that committee chairs be present to give reports on progress.
- New system for meeting notifications enables individual sign-up.
- Northwest Health Foundation has a blog at www.talkhealthreform.org where public will be able to post comments.
- OHSU is having a forum in April in Medford on health reform. Barney Speight, Director, OHFB, and many committee members will be participating.

Senator Scharader **II.** **Testimony from Senator Schrader on Cost Containment Strategies**

Senator Schrader commented on the points from the Committee's cost containment matrix from 02/21/08. Input included:

- Supported redesigning the Certificate of Need program and regional health planning.
- Agreed with strategies proposed under comparative effectiveness and suggested a focus on diagnostic services.
- Urged that redesigning provider payment strategies was vital.
- Discussed need reorganize the prioritized list.
- Suggested pay-for-performance should not just be considered for hospitals but for individual physicians, nurse practitioners and other providers.
- Expressed concern about reimbursement rates that include capitol investment costs.
- Discussed the employer's role in paying for healthcare costs and referred to healthcare payments that are part of workers' compensation. Suggested looking into opportunities to combine workers' compensation and health insurance markets.
- Stated that all health care providers, insurers, hospitals, doctor groups, should be required to participate in the Oregon Health Fund program.
- Suggested a review medical underwriting policies and ERISA.
- Called for more information about insurance mandates.
- Called for tort reform.

Discussion/Questions

- Discussion on the cost to small businesses.
- Discussion on certificate of need, cost of technology including oncology centers, MRI's being purchased in areas that already have several versus being able to provide basic coverage to Oregonians.
- To a question on long-term care needs, Senator Schrader asserted there was a need for integration of:
  - long term health care into current physical system
  - mental health into physical health

- To a question on what he saw as the basic health care package, Senator Schrader responded that:
  - He is concerned that the current Oregon Health Plan (OHP) will be the base plan and stated that it is not affordable.
  - He does not believe we can provide universal healthcare.
  - The state needs more data and is looking to the committees to provide information.
- Discussion on cost of bringing everyone to the level of OHP and debate on what the actual cost would be and whether or not it was affordable.
- The Senator stated that the legislature is placing a higher priority on education than on healthcare.

Chair Stenson thanked Senator Schrader for his support and for addressing the committee.

John McConnell

III. Accountable Health Organization Discussion (See Power Point presentation).

Dr. John McConnell, Oregon Health and Sciences University, discussed his experience working with the Oregon Health Policy Commission (OHPC) in estimating costs and responded to the Committee's Cost Containment Strategies. **(See Exhibit Materials 4.)**

- Defined an ACO as designed by Elliott Fisher and Jack Lindberg of Dartmouth. **(See Exhibit Materials 2.)**
- ACOs do not need to change any contractual relationships and can be created through empirical aggregation of claims data.
- Emphasized ability to compare data across ACOs.
- Can do risk adjustment of data.
- Variation of procedures utilization across ACOs can be identified.
- Discussed performance measures, local accountability and payment reform.
- Discussed the Medicare Physician Group Practice Demonstration being conducted (2004-2008) and Vermont's proposal to implement an ACO pilot project in 2011 to track performance measurement and change reimbursement **(see Exhibit Materials 3)**.
- Challenges listed.
- Highlighted advantages of model.

Discussions/Questions

- Model would enhance transparency.
- Discussion over who would provide bonuses and what percent of savings should go back to providers. Committee members felt part of savings should go back to community.
- Discussion about similarities with HMO model but would incorporate performance measures to look for overuse and underuse. Dr. McConnell responded that managed care focused on per capita cost only and ACOs would look to reduce costs while still hitting quality targets.
- ACO model can incorporate a broad set of measures.
- Three things necessary to make ACOs work:
  - Public Reporting
  - Economic Incentives
  - Community Involvement

- Discussion of current overutilization of technology.
- Value in model is in presentation of aggregated information.
- Discussion on how the integrated health home fits into the model and funding.
- Brings transparency and would allow community understanding and involvement.
- Value and limitations of quality and cost data discussed.
- Dr. McConnell old the committee that Dr. Elliott Fisher has said he would consider coming to Oregon to present to the Committee and Health Fund Board.

Chair Stenson **IV. Demand Adjustment Cost Containment Strategies (See Exhibit Materials 4)**

- Discussion of difficulties associated with merging workers' compensation and health insurance markets. Reference to previous pilots.
- Discussion of provider issues including:
  - Requiring providers to accept Medicare and Oregon Health Fund Program enrollees to spread out burden
  - Concern of creating barriers to bringing more physicians into the state.
- Public health strategies discussed including changing document language from "public health" to "population-based public health."
- Health Plan Design discussed with staff to rework 2nd statement.
- Creating Culture of Health discussed. Committee consensus that it was too vague - needs to have more teeth and be more specific. Committee comments that public health strategies are important but might not fit into cost containment strategies.
- Shared Decision Making discussion included use of patient-decision aids and need to train health care providers in how to engage patient's in decision-making processes.

Chair Stenson **V. Supply Adjustment Cost Containment Strategies (See Exhibit Materials 5)**

- Targeted Capital Investment was discussed.
  - Concern expressed in creating another bureaucracy.
  - Suggestion to make a strong statement that certificates of need currently does not work.
  - Committee was polled and staff will incorporate comments using language of ACO to encompass:
    - Aggregation of information obtained at local level
    - Transparency of information
    - Need to build framework of ACO
- Comparative Effectiveness/Medical Technology Assessment was discussed.
  - Remove the word "new" from first statement concerning "evaluation of new devices."
  - Needs stronger language.

Discussion was interrupted to allow for scheduled public testimony.

VI. Public Testimony

- Scott Kipper, Administrator for the Division of Insurance, responded to the Committee's health plan regulations document under "Goal: Correcting the Health Care Price Signal" and the five bulleted points listed below. Written testimony provided.
  - Set minimum loss ratios
    - Also discussed investments as not a part of loss ratio but used in other determinations.
  - Cap on administrative costs and/or profits and net income of insurance providers.
  - Adding investment income and insure profits as key factors to be reported and considered in the rate approval process
  - Increase transparency by defining insurance rate filings as public records
  - Expand scope of insurance rate reviews of larger groups

- Kevin Earls, Vice President, Finance and Health Policy, Oregon Association of Hospitals and Health Systems (OAHHS) and Jane-Ellen Weidanz, OAHHS Director of Public Policy, presented testimony in follow-up to Kevin Earls' comments at last Committee meeting. Powerpoint presentation and written testimony provided.
  - Discussion on increased utilization and "volume of consumption" by individuals resulting in higher costs.
  - Discussion about whether the rate of increase in uncompensated care that is absorbed by other parts of the delivery system.
  - Suggestion that despite uncompensated care, profit by hospitals is high.
  - Chair Stenson asked for Kevin Earls and Jane-Ellen Weidanz to return to the March 31 meeting.
  - Regulatory, including CON (certificate of need), has limited merit.

Chair Stenson

IX. Adjourn

Chair Stenson adjourned the meeting at 5:25 p.m.

Next meeting is March 31, 2008.

Submitted By: Paula Hird

Reviewed By: Ilana Weinbaum

EXIHIBIT SUMMARY

1. Minutes of 02/21/08 for Review and Approval
2. Fisher, Elliott S., Mar 6, 2006. *The Implications of Regional and Provider-specific Variations in Medicare Spending for Medicare Payment Reform*
3. Vermont Pilot of Community Based Payment Reform: Accountable Care Organization
4. Delivery Systems Committee Cost Containment Strategies (for discussion): Goal: Adjust Demand on Cost Containment Strategies
5. Delivery Systems Committee Cost Containment Strategies (for discussion): Goal: Adjust Supply of Care through Incentives to Encourage Provision of Effective and Efficient Care

OREGON HEALTH FUND BOARD – Delivery Systems Committee

March 31, 2008
1:00 – 5:00 pm

CCC - Wilsonville Training Center
29353 Town Center Loop East
Wilsonville, Oregon

MEMBERS PRESENT: Dick Stenson, Chair
Maribeth Healey, Vice-Chair
Tina Castanares, MD
Bill Humbert
Carolyn Kohn (by phone)
Diane Lovell
Stefan Ostrach
Ken Provencher (by phone)
Mike Shirtcliff, DMD
Rick Wopat, MD
Charlie Tragesser
Mitch Anderson
Dale Johnson
Bart McMullan, MD
Doug Walta, MD, Vice-Chair
Vickie Gates
Vanetta Abdellatif

MEMBERS ABSENT: David Ford
Lillian Shirley, RN

STAFF PRESENT: Jeanene Smith, MD, Administrator, OHPR
Tina Edlund, Deputy Administrator, OHPR
Ilana Weinbaum, Policy Analyst
Zarie Haverkate, Communications Coordinator

ALSO ATTENDING: Barney Speight, Director, Oregon Health Fund Board (OHFB)

- **Call to Order/Review of 03/13/08 Meeting Minutes**
- **Review of Cost Containment Strawperson Recommendations**
- **Invited Testimony – Oregon Association of Hospitals and Health Systems**
- **Payment Reform: Minnesota's Payment Reform Proposal**
- **Payment Reform Discussion**
- **Public Testimony**

These minutes are in compliance with Legislative Rules. Only text enclosed in italicized quotation marks reports a speaker's exact words. For complete contents, please refer to the recordings.

Chair Stenson **I. Call to Order/Approval of 03/13/08 Meeting Minutes (See Exhibit Materials 1)**

- Meeting was called to order at 1:10 pm. There was a quorum.

Motion to approve minutes is seconded. **Motion passed unanimously.**

Staff overviewed agenda.

Chair Stenson **II.** **Review of Cost Containment Strawperson Recommendations: Improve Quality and Efficiency and Increase Accountability (See Exhibit Materials 2 and 3)**

Jeanene Smith presented updated information on the Framework Diagram from last meeting's discussion which included incorporation of Accountable Care Organizations (ACOs) which are referred to as Accountable Care Districts (ACDs) **(see Exhibit Materials 2).**

Dr. Smith reported that she, Maribeth Healey and Dick Stenson highlighted preliminary information to OHFB.

Definition and recommendations surrounding Accountable Care Districts are discussed.

- Recommendation 1 (page 1) suggestions/discussion included:
  - Expanding definition of ACDs.
  - Clarification that a financial relationship is not required between physicians and hospitals.
  - Utilizing data as a competitive tool in the marketplace.
  - Include local health authorities and mental health authorities as part of ACDs which may lead to county participation in discussion surrounding ACDs.
  - Discussion on how aggregating quality data will improve system.
  - Suggestion to accept the ACD language with broader definitions.
- Recommendation 2
  - Discussion to remove/change last sentence that refers to preference for funding pilot projects in communities that have already exhibited community collaboration. Suggested that instead should develop method to encourage participation from areas that have not benefited from organized community collaboration.
  - Who will be the facilitator/project manager in each district?
    - Different communities may have different players at the table.
    - What would the funding be covering? Recommendation 1 would be data aggregation alone and recommendation 2, would include funding for regional planning. Discussed implications on budget.
    - Recommendation for evaluating potential applicants for feasibility. The importance of early success is stated.
    - Differences between ACD models in metropolitan and rural areas.
    - Should allow other communities, especially in metropolitan areas where a pilot is being funded, to participate voluntarily.
  - Question posed: Is Committee ready to make ACDs the centerpiece of the cost containment recommendations?
    - Most members still have a lot of questions.
    - Debate on whether pilots can be accomplished through community collaboratives alone and the funding that would be required.
    - ACDs are described as economic zones.
    - Dialogue on using data to change behavior.
    - Assumption made that with data and infrastructure and with some collaboration, issues can be identified and changes affected.
    - Discussion of political implications.

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- Providers will look at data more than consumers and it will shine light on variation.
- Public transparency, economic stimulus to change and public/community involvement discussed as three necessary components.

Comparative Effectiveness Analysis and Medical Technology Assessments (see page 3)

- Recommendation 1:
  - Concern that recommendation would duplicate other work already in existence. Discussion of other efforts.
  - Transparency and neutrality as a reason for supporting involvement by Human Resource Commission (HRC).
  - Need to highlight collaboration.
- Recommendation 2:
  - May require most political involvement of the recommendations due to claims by vendors/manufacturers of their products' value.
  - Make a stronger statement regarding requiring evidence of value of new technologies and treatments.
  - Discussion and support for last sentence regarding collaboration.
- Recommendation 3
  - Similarities to Minnesota model explained, noting it relates to recommendation 1.
  - Discussion of existing efforts to create clinical guidelines. Many different sets have been created.
  - Pertains to inpatient and outpatient treatment.
  - Expand the language beyond clinical guidelines, including social support, mental illness and other chronic conditions.
  - Members were encouraged to contact staff regarding any suggestions and specific language changes.

Administrative Simplification discussed (see page 3).

- Recommendation 1
  - Bullet 3 - In citing electronic exchange in the recommendation, it was noted that the Governor has directed the formation of the Health Information Infrastructure Advisory Council (HIIAC) to research implementing electronic health records. Staff related that the simplification recommendation is in relation to billing.
  - Need for a periodic evaluation process.
  - Suggestion to separate recommendations about administrative costs from administration streamlining suggested.
  - Will transparency be required for Medicaid administrative costs?
  - Define object of administrative simplification.

Reduce Pharmaceutical Spending (see pages 3-4).

- Recommendation 1
  - Suggestion there should be one standard for all not only state health programs.
  - Effectiveness of the Oregon Prescription Drug Program (OPDP) is debated.
  - Formularies discussed. Change wording to state that the most cost-effective program should be utilized.

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Shared Decision Making (page 4)

- Need to get approval from safety net. Tina Castanares and Vanetta Abdellatif will submit language to staff.

Staff will revise recommendations incorporating member input and return to the Committee.

Kevin Earls

III. Invited Testimony – Oregon Association of Hospitals and Health Systems (See PowerPoint presentation).

Kevin Earls, Vice President, Finance and Health Policy, Oregon Association of Hospitals and Health Systems (OAHHS) returned to provide additional information with focus on issues of cost drivers of the hospital industry, competition in the market place and hospital margins.

- Cost drivers presented included aging population, increase of 8-10%/year of individuals with chronic conditions, innovation and technology, labor costs and effects of workforce shortages, uninsured and the cost shift to payers.
  - As Medicaid and Medicare drop further below actual costs, these costs are shifted directly to rates of commercial purchasers.
- Competition in the marketplace **-** Ambulatory Surgery Centers (ASCs) in competition with hospitals.
  - Regulatory inequities discussed.
  - Is the increase in ASC's profit driven or service driven? Discussion on the role of ASCs and the effect on costs.
  - Discussion of article from Health Affairs of a study on physician referral patterns to ASC's which shows populations seen by ASCs is different than that of hospitals.
- Hospital margins and growth in uncompensated care related.
  - One-third of Oregon hospitals will have a negative margin in any given year.
  - The need for margins.
  - Hospital margin statistics for 2007 provided.

Discussions/Questions

- Suggestion of more regulation on ASCs is needed to correct regulatory inequities between hospitals and ASCs.
- Discussion of range of margins among Oregon hospitals.
- Do reserves also fluctuate with the margin? Kevin Earls will get the information and provide it to the Committee.
- How does the hospital address the high cost of some procedures?
  - It's a conversation that should involve hospitals and physicians.
  - Decision is usually made by physician.
  - Preferred vendor or preferred device list and an agreed upon community standard is discussed.
- Explanation of margins, including gross margins that include areas unrelated to patient care. Patient-service margin is discussed.
- Suggestions by Kevin Earl for systemic improvement:
  - State as purchaser to pay 100-105% of cost of service.
  - Uniform drug purchasing methodology that every commercial purchaser uses for Medicaid.
  - Do you want to have investor-owned medical facilities segmenting care out of a community hospital?

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- Information was shared about the Oregon Healthcare Workforce Institute that was formed by the Association about 2 ½ years ago to address the workforce shortage.
- Discussion on payment reform.
  - Response by Kevin Earls that flat fees will not work.
  - Stated that it is necessary to Change hospitals' perception that they are cost centers and not income-generating centers. Kevin Earls responded that hospitals are efficient and judicious in utilization and discussed existing opportunities to capitalize on relations between doctors and hospitals to affect change. Stated that necessary to get healthcare providers buy-in to these changes.
- Assertion that hospitals are efficient but costly and cost is shifted to payers.
- Early discussion may be the pathway to solutions that include cost containment, transparency, evidenced-based solutions, and explicit decisions about what will be covered.
- More transparency of hospital spending and a commitment by hospital association for full participation in the accountable care districts is needed.
- The effect of anti-trust laws in interfering with the ability to collaborate is discussed.

Barney Speight **IV. Payment Reform: Minnesota's Payment Reform Proposal (See Exhibit Materials 8)**

- Prior to providing information on Minnesota's Payment Reform Propose, Barney Speight:
  - Related there is an expectation that State will be a major contributor and coverage could be expanded to 300,000 more Oregonians under Medicaid.
    - there is no State financial commitment to obtain federal matching funds; and
    - there is a fundamental suspicion by public that the current system will continue to generate at a rate of increase that is unsustainable, especially for the public sector.
- In response to Kevin Earls presentation he related:
  - Oligopoly definition of hospitals and industry implications.
  - Suppressed prices of the nineties interpreted as being artificial.
  - To dispel public skepticism, suggested absolute transparency in price increases and single price policy.
- Single price policy from Minnesota's Payment Reform Proposal restated (page 2).
- The need to relate to public on hospital operating margins, earnings before interest, tax and depreciation and reserves.
- Hospitals are not carrying the burden of uncompensated care, but pass it on to payers.
- Need candid conversation on the role of a hospital. Communities vote on new construction/changes in schools/fire departments but have no say in what hospitals do. Should be oligopoly or monopoly.
- Most essential first step is to increase Medicaid payments.

Chair Stenson **V. Payment Reform discussion**

- Do you have an example internationally on a fee-for-service transparency model that has worked?

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    - Barney responded that he did not and many of the international models are not built around fee-for-service.
    - Transparency of price does not have to be limited to fee-for-service.
- Further discussion with Committee on transparency and value performance dimension resulting in informed purchasers.
- Value performance dimension related to price may result in informed purchasers.
- Discounting and bundling of services discussed.
- Legality of a single price without a single payer will be researched.
- Chronic underpayment by Medicaid/Medicare discussed. Will increasing Medicaid population through Oregon Health Plan (OHP) drive up costs?
    - Below costs payments vs. charity care related.
    - What mechanism do we put in place that gives the public confidence that costs are being monitored?
- Possibility of a global cap encompassing all pieces is hindered by the many "mini-budgets" that exist and possible use of John McConnell's Accountable Care District pilot recommendation in this area.
- Discussion on limiting coverage and effects on quality. What are the tradeoffs? Public's perception of healthcare is through marketing efforts and need information/transparency to make decisions.
- Demographics of Minnesota and Oregon compared.
- Consensus to carry to single-price proposal forward.
- Staff will look at regulations on ASCs and acquire model legislation.
- Three tier model overviewed **(Exhibit Materials 6)**. Staff review panel will work on it coupled with price transparency.

Future Meetings and directions were discussed:

- Two more meetings remain, April 17 and April 28. Next meeting will include Quality Institute Workgroup recommendations, fleshing out of public health wellness initiatives, and palliative care.
- Recommendations to be finalized at last meeting. Board seeking recommendations by early May.
- Suggested that palliative care be tied into Tier 2, Care Coordination Payments.
- Staff Review Panel for the payment reform proposal will consist of Vanetta Abdellatif, Bart McMullan, Rick Wopat and Dale Johnson.
- Other members of the committee are urged to email staff to contribute language for recommendations discussed.
- Committee expressed it would welcome the opportunity to interact with other committees on how the recommendations will fit together.

VI. Public Testimony

- No public testimony offered.

Chair Stenson **IX. Adjourn**

Chair Stenson adjourned the meeting at 4:45 p.m.

Next meeting is April 17, 2008.

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Submitted By: Paula Hird   Reviewed By: Ilana Weinbaum

EXIHIBIT SUMMARY

1. Minutes from 03/13/08.
2. Diagram of Framework for Delivery System Reform - Revised 03/18/08
3. Cost containment strawperson
4. Comparative Effectiveness Summary
5. Minnesota Administrative Simplification Act
6. Payment Reform Proposal
7. Payment Reform and Provider Reimbursement
8. Minnesota Payment Reform

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OREGON HEALTH FUND BOARD – Delivery Systems Committee

April 17, 2008
1:00 – 5:00 pm

CCC - Wilsonville Training Center Room 111- 112
29353 Town Center Loop East
Wilsonville, Oregon

MEMBERS PRESENT:
Dick Stenson, Chair
Maribeth Healey, Vice-Chair
Doug Walta, MD, Vice-Chair
Mitch Anderson
Tina Castanares, MD
Vickie Gates
David Ford
Bill Humbert
Dale Johnson
Carolyn Kohn
Diane Lovell
Bart McMullan, MD
Stefan Ostrach
Ken Provencher
Lillian Shirley, RN
Mike Shirtcliff, DMD
Charlie Tragesser
Rick Wopat, MD

MEMBERS ABSENT:
Vanetta Abdellatif

STAFF PRESENT:
Jeanene Smith, MD, Administrator, OHPR
Tina Edlund, Deputy Administrator, OHPR
Ilana Weinbaum, Policy Analyst
Zarie Haverkate, Communications Coordinator

ALSO ATTENDING:
Quality Institute Work Group Members:
Jim Dameron, Administrator, Oregon Patient Safety Commission
Gwen Dayton, Oregon Association of Hospitals and Health Services
Ralph Prows, Chief Medical Officer, Regence of Oregon

Others:
Susan Tolle, Center for Ethics in Healthcare, OHSU

- Call to Order/Review of 03/31/08 Meeting Minutes
- Invited Testimony – American Health Association/American Stroke Association
- Recommendations from the Quality Institute Work Group
- Review of Additional Strawperson Recommendations
- Public Testimony

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These minutes are in compliance with Legislative Rules. Only text enclosed in italicized quotation marks reports a speaker's exact words. For complete contents, please refer to the recordings.

Chair Stenson **I. Call to Order/Approval of 03/31/08 Meeting Minutes (See Exhibit Materials 1)**

- Meeting was called to order. There was a quorum.

Motion to approve minutes is seconded. **Motion passed unanimously.**

Beth Gebstadt **II. Invited Testimony – American Heart Association/American Stroke Association**

Beth Gebstadt, MPH, MS, with Phil Donavan, both of the American Heart/American Stroke Association and Dana Kaye, Executive Director of the American Lung Association presented testimony. (See Exhibit Materials 2).

Focus on two areas: Tobacco Use and Obesity

- Tobacco Use
  - Noted that funding was lost in 2003 in Oregon for tobacco prevention programs and was recently reinstated in 2007. Members and presenters discussed diversion of the funds between 2003-2007 and requests that some of these unobligated funds be used for tobacco prevention although none have been.
- Obesity
  - Related skyrocketing rates of obesity in Oregon.
  - Stakeholders are developing an obesity prevention program using the CDC best practices model.
  - Approaches include setting minimum minute standard for PE requirements but funding needs to be designated for this.
  - Progress made in removing junk food from schools.
  - Adult onset of diabetes and costs to healthcare are discussed.
- Both of these areas contribute to the five major diseases that impact healthcare spending.
- Question about other partners that could be included in efforts to prevent and reduce obesity.
  - Public health program would start at the Division of Health Services of Public Health Division.
  - Funding could go to county level, county health departments, nonprofit agencies, community health partnerships, before and after school programs, and is also looking at childcare.
  - Connecting young people with the physical environment and partnering with outside entities, e.g. Department of Forestry. Related reports that connection with physical environment leads to more physical exercise (e.g., hiking, walking, camping).
- Difficulties of developing effective strategies for obesity are discussed. Difficult to create environmental change and a cultural shift toward walking/bicycling.
- Debate over whether appropriate for employers to charge employees who smoke or are overweight more for their premiums.

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Vickie Gates
Maribeth Healey

III. Recommendations from the Quality Institute Work Group (See Exhibit Materials 3 (PowerPoint presentation) and 4).

Quality Institute (QI) members Vickie Gates, Chair, and Maribeth Healey, Vice Chair overviewed the group's recommendations

- Overviewed the process and inputs that were provided to the group during the development of their recommendations.
- Page 11 - Overview of the definition of quality.
- Page 12 - Transparency definition related.
- Page 12-13 – Problem statement discussed.
- Strategies for increasing transparency (page 14) related.
- Quality Institute roles (pages 14-15).
- Quality Institute funding and structure
  - Would be chartered as a public-private corporation, not a State agency.
  - Board members would be appointed by the Governor and would not be State employees.
  - Funding from private and public entities discussed. Must be stable and substantial public funding, supplemented by private funding.
  - QI will partner with another organization to reduce administrative costs.
  - Funding request explained.
  - Collaboration with other stakeholders and strategic investments in collaborative initiatives.
- Logic model presented.
- Reference to letters from Patient Safety Commission **(See Exhibit Materials 5)** and the Quality Corporation **(See Exhibit Materials 6)** is related.
- **Gwen Dayton, Oregon Association of Hospitals and Hospital Systems** discussed her experience working with the group.
  - Explanation of National Surgical Quality Improvement Project. Presented as an example of a strategic partnership that could be expanded with state support.
  - Dialogue on maintaining public and private stakeholders, looking at what is being done in others states, leveraging information from both public and private sectors.
  - Appreciation to Jeanene Smith, M.D., of the OHPR staff for the efforts and results produced.
  - Assertion that this is a long-term process that will take time.
- **Jim Dameron, Administrator of the Oregon Patient Safety Commission**, outlined his involvement in the work group and how the Patient Safety Commission provided a model for the work group to consider. Discussed the structure and funding of the Commission.
- Stable and significant public funding and a state commitment to long term funding is necessary.
- Need to look outside of the U.S. to see what other countries are doing in quality improvement. It was related that part of the Institute's role would be to bring the best of all work to the state.
- Breadth of the Quality Institute in relation to value, cost and transparency of expenditures discussed.
- Committee member questions why we need a new organization and new board when there is the Oregon Health Policy Commission, Health Policy Research Office, the Health Fund Board, etc? Suggested that will not be able to get ten-year funding from the legislature.

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- Quality Institute Work Group believes there needs to be a well-funded, dedicated organization to lead and coordinate efforts. These responsibilities cannot be given to an existing organization without the funds and resources to support the work.

- Questions regarding simplification: What is the standard that quality is being measured against? (Is that something you see the QI establishing?) How will you compel and who will you compel? How will QI relate to Accountable Care Organizations (ACOs)?
  - Compelling is about the submission of data and about the ability to have the kind of decisions to make improvements in a transparent way.
  - The ACOs would be part of the commitment to use data to improve quality.
- Member suggests that in business, when one finds a better use of funds, something is "turned off" in another area. Suggestion to look at opportunities to redirect funds. Several members comment that state government is not currently investing enough funds in quality improvement to allow for redirection.
- Recommendation that Quality Institute must be closely linked to accountable care organizations. Report should relate that efforts of the Quality Institute shouldn't just focus on giving the healthcare system the data and support it needs to evaluate itself, but needs to create a system that supports community evaluation of performance.
- Recommendation that role of the consumer is made stronger in the document.
  - Definition of transparency needs to include "understandable to general public."
  - It was observed that statements in the recommendation regarding consumers are always the last bullet point and it comes across as an afterthought. Recommendation that bullets should be reordered to reflect higher priority.
- Discussion about whether Committee is comfortable having an organization driven by political appointments.
- It was suggested that Quality Institute has to play a significant role in setting standards for how data is collected to reduce duplication.
- Quality Institute will use the best of the work out there to develop and set standards. Discussion of Hospital Association initiatives to develop common measures, as an example of work that might be endorsed by the Quality Institute rather than replicated.
- Discussion on lack of program evaluation around OHP. Measuring effectiveness of changes of reform once it is implemented is necessary.

Motion to recommend QI report is seconded.

Chair Stenson — **IV. Public Testimony**

- Dan Klosterman, from Wilsonville, provided testimony on using a systems approach and the need to identify measurement goal first or money will be wasted. Testified on needing to educate and linking measure to well-being of state.

Call for the Question. Motion to approve QI recommendations is passed unanimously.

Presentation by Dr. Susan Tolle, OHSU, on the 18th Annual Kinsman Ethics Conference in Medford, Oregon (See Exhibit Materials 10).

- Susan Tolle presented background on the Kinsman Conference and an overview of the conference paper.
- Committee discussion on ethics of health care reform
  - o Setting limits and making decisions about what won't be covered.
  - o The rising cost of health and need to identify ineffective care currently delivered.
  - o Universal access can only be achieved if tough decision-making is done.
  - o Aggressive treatment at end-of-life.
  - o Individual mandate (page 8).
  - o Health care for immigrants (page 8).
  - o Shifting funds for societal gain.
  - o Universal access vs. universal care, shared responsibility vs. individual responsibility and issue of payment based on severity of illness.
  - o Paying for research through patient care dollars.
  - o "Too emotionally difficult" for providers to tell patient/family that something will not be funded. It was debated, however, that patients are frequently told they cannot have a procedure because they don't have the money. It was asserted that having the line defined would allow providers to be able to communicate this with patients.
- Members expressed difficulty in defining delivery system without having the Benefits Committees' recommendations on what would be covered.
  - o Dissention on the role of Committee in addressing limits and priority setting.
  - o Staff will provide the Benefits' Committee draft report.

Jeanene Smith **V. Review of Additional Strawperson Recommendations (See Exhibit Materials 7 and 8).**

Decision support recommendations **(See Exhibit Materials 7)**

- **Recommendation 1**
  - o Debate on suggestion in 2nd sentence to add "within the defined evidenced-based benefits package" after "alternate treatments and patient preferences" to add "within the defined evidenced-based benefit package." Decision to leave as written.
  - o Add advanced directives to last sentence.
- **Recommendation 2**
  - o First sentence - remove "codes" from first sentence and replace with "methods."
  - o First sentence – make entire statement apply to both public and private health plans and purchasers.
  - o Dissention on using incentives expressed. Treatments at end-of-life discussed. Current system penalizes providers for having conversations with patient.
- **Recommendation 3**
  - o Rationale for stressing advanced chronic illnesses is related to the high costs involved.
- **Recommendation 4** – Question as to whether registry should include advance directives.
- Further testimony by Susan Tolle, MD:

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- Philanthropic dollars are being used to create a POLST registry with emergency communications system housed at OHSU.
- Other models that use advance directives are not working.
- HIPAA and privacy rules limit access to registry.
- Studies related that 25% of the time POLST information is not available when needed.
- Registry could be implemented by July 2009.

Motion to support the concept of the decision making recommendations with the changes discussed is seconded.

Further discussion on POLST:

- Four sections of the POLST form are overviewed including the 2nd section as being most powerful for impacting care as it guides intervention efforts.
- Difference between advanced directive and POLST form. POLST form is for persons with advanced illness. POLST includes physician orders and allow EMTs to follow patient wishes.
- Staff will provide members copies of advanced directive and POLST forms.
- POLST program (not registry) is being replicated in 15 other states.

Call for the question. **Motion passed unanimously.**

Payment Reform Recommendations **(See Exhibit Materials 8)**

- **Recommendation 1** stated.
- **Recommendation 2**
  - Legality of a single price for all purchasers. Does this imply price fixing?
  - Suggestion to change to more general statement requiring transparency of prices.
  - Debate around effectiveness of posting prices, price competition and regulatory measures.

Motion to remove recommendation #2. **Motion rescinded.**

Motion to retain first sentence of recommendation #2 and remove remainder of recommendation is seconded.

Discussion:

- Assumptions are being made and the impact of requiring greater price transparency is not known.
- Complexity of changing compensation structure of delivery system and strategy to be permissive rather than prescriptive. First line is permissive.
- Must align with work of the QI (see recommendation 1).

  Call for the question. **Motion passed** by majority with two dissenting votes.

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- **Recommendation 3**
    - Example of an MD who changed his practice to include more contact through email, etc. is related. Did not change payment structure and was able to save money.
    - Concern expressed that it is framed around primary care rather than a holistic approach.
    - Several members expressed concern about move to global budgets.
    - Committee consensus that payment recommendations need additional work but agreed on the basic principles. Agreement that need to be more permissive and less prescriptive.
    - Concern that just setting up another commission, without changing the way things are done.
    - Staff to reconvene payment reform staff review panel.
    - Members are asked to submit comments to staff.

Chair Stenson **VI. Public Testimony**

- **Craig Hostetler, Oregon Primary Care Association (OPCA),** encouraged the Committee to explicitly identify goals of payment reform and related that he has been working with a national group on defining patient-centered medical homes.
    - Discussion on capitated payments to community health care clinics and moving away from the visit-based mentality.
    - Payment incentives should be available to all members primary care team and not just the physician.
    - Build towards process and outcome measures and then establish global payment. Global payment without the right measures for accountability would be difficult.
    - Culture shift in primary care discussed.
    - Mr. Hostetler will send letter with information and suggestions to Committee.

Chair Stenson **IX. Adjourn**

Chair Stenson adjourned the meeting.

Next meeting is April 28, 2008.

Submitted By: Paula Hird Reviewed By: Ilana Weinbaum

EXIHIBIT SUMMARY

1. Minutes from 03/31/08.
2. Reducing the Demand for Healthcare
3. Quality Institute Recommendations (PowerPoint)
4. Quality Institute Recommendations (Written)
5. Letter from Jim Dameron of the Oregon Patient Safety Commission
6. Letter from Nancy Clark, Executive Director, Quality Corporation
7. Decision support strawperson
8. Payment reform strawperson
9. Public Health Strawperson
10. 2008 Kinsman Ethics Conference Summary

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OREGON HEALTH FUND BOARD – Delivery Systems Committee

April 28, 2008
1:00 – 5:00 pm

Portland State Office Building, 1st Floor Room 1D
800 NE Oregon Street
Portland, Oregon

MEMBERS PRESENT:

Dick Stenson, Chair
Maribeth Healey, Vice-Chair
Tina Castanares, MD
Bill Humbert
Carolyn Kohn
Diane Lovell
Ken Provencher
Mike Shirtcliff, DMD
Rick Wopat, MD
Charlie Tragesser
Mitch Anderson
Dale Johnson
David Ford
Bart McMullan, MD (arrived late)
Doug Walta, MD, Vice-Chair
Vickie Gates
Lillian Shirley, RN

MEMBERS ABSENT:

Stefan Ostrach
Vanetta Abdellatif

STAFF PRESENT:

Jeanene Smith, MD, Administrator, OHPR
Tina Edlund, Deputy Administrator, OHPR
Ilana Weinbaum, Policy Analyst
Judy???

These minutes are in compliance with Legislative Rules. Only text enclosed in italicized quotation marks reports a speaker's exact words. For complete contents, please refer to the recordings.

- **Call to Order/Review of 04/17/08 Meeting Minutes**
- **Architecting World quality Care for Oregon**
- **Review and Possible Approval of Recommendations: Public Health, Health Promotion and Wellness; Payment Reofrm; Cost Containment (Comparative Effectiveness Analysis and Medical Technology Assessments)**
- **Review and Possible Approval of Revised Recommendations: Integrated Health Home; Shared Decisions; Cost Containment (Accountable Care Districts, Administrative Simplification; Reduce Pharmaceutical Spending; Patient Decision Aids)**
- **Public Testimony**

Chair Stenson — **I. Call to Order/Approval of 04/17/08 Meeting Minutes (See Exhibit Materials 1)**

- Meeting was called to order. There was a quorum.

Motion to approve minutes is seconded. **Motion passed unanimously.**

Dave Ford/ Jack Friedman — **II. Architecting World Quality Care for Oregon (See Exhibit Materials 2)**

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Introduction of presentation with clarifying "world class quality" in individual service on a population basis as opposed to high cost accessibility of treatments.

- Globalism affecting health care costs.
  - Less than competitive health care costs.
  - Trade imbalances and exporting of jobs.
- Visualizing the future and looking at Oregon in global context.
- CareOregon's look at world-class organizations including:
  - Alaska's South-Central Foundation health care system after 15 years.
  - U.S. low standing in world-class care outcomes. Highest in cost.
  - Swedish system of the county of Jonkoping overviewed. It is funded through county tax with increase limits. Representatives will be visiting Oregon in July.
- Related from book, "To Err is Human," from the Institute of Medicine including:
  - Pointing to unsafe factors in the U.S. system, harm done and deaths caused.
  - It is measured from a systems' perspective.
- "Crossing the Quality Chasm" was written a year later and related:
  - a "whole system transformation strategy."
  - Instead of perception of "cost containment," there should be a fundamental public strategy with embedded qualities for keeping costs down.
- Don Berwick, MD, President of the Institute for Health Care Improvement, referenced.
  - Current system is built for convenience of those giving care, not for dignity and "patient centricity."
  - Inherent factors for quality defined. Related care specifications: "Don't kill me . . ., Don't hurt me. . ., Don't make me feel helpless. . ., Don't make me wait. . ., Don't waste money. . ."
- Overarching goal is to achieve world class quality care.

Discussion/Questions

- Concern expressed that providing care for everyone will result in increased indigent population.
  - Dave Ford related other states with similar plans and doesn't believe that would be a driver.
  - Could be seen as a model for other states and could actually be an economic stimulus for companies to come to Oregon.
- Question on how this translates to the Delivery Systems Committee recommendations and those from other committees that might not be a fit. Is this a vision for the next generation?
  - This can be used to view how recommendations align with a vision.
  - Suggestion for staff review panel to include some of the concepts in the final recommendations, if that is the will of the Committee.
  - It provides is a different way of talking about the reform.
  - Quality Institute recommendation are consistent with this vision.
  - Support expressed for a system that automatically includes control of costs rather than cost containment as a separate issue and viewing the system as a whole.
  - How is the shift in the system actually made? What is the timeline for achieving goal?

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- Dave Ford responded that it will take time and will not shift all at once. He noted that Oregon is rated 38th out of the 50 states and in health care then compounded further by the low ranking of U.S. in world.
- Waste needs to be identified.
- Rallying public by sharing data would facilitate shift shift.

- Question: How does the rest of Sweden compare with the county in the presentation?
  - County has a learning approach to how they organize their change and are spreading that through Sweden. Sweden is a good system overall. They have gradations of care, but it is better than the States. No system is a perfect system.

Chair Stenson **III.** **Review and Possible Approval of Recommendations**

Jeanene Smith, M.D., announced that there is one more meeting on May 14 and presented the recommendations.

Public Health, Health Promotion and Wellness
Recommendation 1
- Rural?? health and behavioral health to be clarified as part of the recommendation.
- Suggestion that there needs to be glossary for clarification.
-

Recommendations 2
- First page, last sentence, clarification stated that it addresses removing
- Suggestion to include an evaluative process for accountability of strategic plan. (44:50)
- Tie-in recommendations with Accountable Care Organizations.
- Discussion on removing the sentence from recommendation 2, third unbolded sentence regarding ". . .seek to use existing resources . . ."
  - Lack of current existing mental health resources in Oregon noted.
  - Suggestion to use stronger language, meaning of existing resources means "all healthcare resources" while the recommendation implies just to use what is in existence now.
  - Suggestion that it was to provide direction to do things differently priorities are different
  - Language suggestion: "use a larger percentage of the healthcare dollar on prevention" which is using healthcare dollars effectively.
  - Debate between doing things right/differently and not getting carried away spending money and setting a dynamic that implies additional resources are not needed to utilize this plan.
  - It was noted that recommendation 3 addresses funding.

Recommendation 3
- Dovetails with recommendations 1 and 2.
- Support for local funding mechanism. Use the existing taxing authorities that can receive state funding and also have ability to raise money locally.
  - Will need to be regional in rural areas that include small towns.
  - Level of implementation involvement discussed.

- o Local and county funding, including mechanisms, discussed. (54:20)
- Include Medicare/Medicaid in recommendations.

- **Recommendation 1** – Question asked on the need to specifically identify tobacco and obesity with suggestion that issues around drug addiction and mental health need stressing.
  - Response by staff indicated that identifying tobacco and obesity are objectives for preventive health issues.
  - Dave Ford related that tobacco and obesity are the top two leading causes of preventable health care. Suggestion to earmark for flexible activities.
  - Discussion to address why individuals choose these behaviors. Concern expressed that it would be limited to these two things.
  - Suggestion to link to mortality and for more inclusive language.
  - CDC recommendation of level of funding is noted.
- Concern expressed in perception of more funding, stating that there are "layers" of spending that could be redirected.

Recommendation 3 – No further comments.
Recommendation 4 – Encouraging healthy behaviors among state employees discussed.

Payment Reform
Recommendation 1
- #2 under goals, clarification by staff stated that it addresses removing incentives for providers that patient's may not want done. (GO Back to 1:08)
- Debate on who is included as the "providers" in recommendation 1 and if it should include insurance companies as healthcare providers are paid for processes not outcomes.
  - Examples of hospital incentives for wrong care, patient not adequately being informed, including costly end-of-life questions.
  - Regional differences in regards to appropriate use of ERs (rural vs. urban).
  - Interpreted as making purchasers and payers to take incentives out of the system which will make providers more accountable.
- Incent to use right tools at right time and caution against micro-managing. (1:17:50)
- Practicalities and effecting change. Discussion regarding purchasers deciding what they want.
- Recommendation as prescriptive vs. based on principles is discussed. Prescriptiveness may translate into a future possible barrier. Achieving desired outcomes, encouraging system shift by providing principles suggested. Suggestion that there will be improvement as it becomes more focused.
- Suggestion to use a series of examples. (1:27:50) Put principals forward.
- Responsibility is discussed. Community based healthcare system, people trapped into a system, trouble with this section talks about how it should be not what the community would like it to be.
- Suggestion: Paragraph under rec #1. Accept and delete specifics (change them to background material). Recommendation paragraph only.

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- Keep the main recommendation and the numbered sentences only below, removing the bullet points. (1:32)
- Design principles
- Piloting terminology and whether it is needed as there are pilots in existence and there is consensus in what is working??(1:35:20)
- Demonstrated by (1:36:40)

Cost Containment

Staff related that a small workgroup composed these recommendations.

Comparative Effectivenes Analysis and Medical Technology Assessments
Recommendation 1
- Clarification that technology is only part of the recommendation. Suggestion to include in glossary the definition of comparative effectiveness.

Recommendation 2
- Discussion on creating guidelines.

Recommendation 3 – No comments.
(1:40)

Financial Transparency
Recommendation 1
- Opposition to recommendation.
- Question why it should just be hospitals, ambulatory and imaging centers included in recommendations? Suggestion to make to broader to include all healthcare providers.
- Intention of the recommendation was described as an attempt to bring transparency in relation to funding that public has no say in. (1:48)
- Needs community discussion (1:49)
- GO BACK 1:52:40 – Public disclosure in major change with details.
- Something more about reporting by everyone,
- Insurance transparency and requiring disclosure is suggested as inclusion.
- How can you talk about cost containment when information is private. Importance to community support cited.
- Language suggestion:

Staff related goal to have (1:56:30)

Jeanene Smith **IV.** **Review and Possible Approval of Revised Recommendations.**

Suggestion to change. (1:59)
Integrated Health Home

Motion to approve recommendation with amendment is seconded.
Motion passed unanimously.

Shared Decision Making
- Question raised as to who is included in the Decision support process termed and who is included. Assertion that it would vary.

Motion to approve recommendation.

Discussion
- Make language stronger by Question if it is worded strongly enough.

Motion seconded with amendments. Motion passed unanimously.
(2:02)
Document from chairs of this and other OHFB committees related.

<u>**Accountable Care Districts**</u>
- (2:03)
- January 20, 2020??? (2:05)

- Question on when legislature will be acting on the recommendations. It was related that (2:06)
- If passes in house implementation could be January 2009, otherwise January 2010.
- (2:07)   Addressing issues raised by data and public input.   (2:09)
- Discussion on pilot project.
- Discussion on collecting data and standardizing across the state. (2:14)
- Boundaries that will determine ACOs discussed.
- Suggestion to include Public Health.
- Clarify that it is top down????(2:15)
- Question if this is part of the data is collected by the Quality Institutes – would probably find it useful, but is separate.
- Question regarding data currently being collected and concern expressed over the "gigantic feat" and what it would impact in terms of infrastructure (2:17) Suggestion on need to clarify purpose ....
- Suggestion that what is being said is that this is a way of aggregating data for planning purposes and decision-making, these are the users of the data, not the producers. QI would be where set of issues???(2:18)
- The ACO concept should be considered as part of the long-view. The application and data analysis. Same is true in the transparency piece and should go together, e.g., capitation decision would need data to support health policy decisions.
- Need clear coordination and need to have a clear vision on where you are going.(2:24) (2:25)

Motion to adopt recommendations as amended is seconded. **Motion passed by majority vote. Two absentions.???(2:27)**

Administrative Simplification
Recommendation 1

Motion to approve recommendation is seconded.

Discussion
- (2:29)

Call for the question. Motion passed with amendments by????
(2:32:00)
Reduce Pharmaceutical Spending
- (2:33)

DRAFT

- Plans subject to control by state and insurance agency and things controlled through ERISA, do you need to distinguish between the two.
  - It was related that this is just (2:34)

- Giving to consumers???(2:35)
- Formularae discussed including one state formula. – they get to pick their own formula.
- Do we really need that recommendation then?
- (2:38) Suggestion that recommendatuion #2 is not
- Forularies discussed noting that each insurance company may have a different formulary
- Suggestion to have insurance companies collude on a single formula. (2:43)
- It was observed that there is a lot of discussion on transparency.
- Language suggestion (2:44:15)
- Oregon Prescription Drug Program (OPDP) does this??(2:45)
- There may be reluctance by insurance company to turn over information they have in this area (2:49)

Question to eliminate #2

- Language suggestion: Encourage the development of a consistent evidenced-based pharmaceutical formulary for Oregon.
- Need wording for private stakeholders???(2:52)
- Concern over misinterpretation expressed.
- Should include provision for encouraging development of a simplification.
- Suggestion to include it under Health Home.
- Concern over administrative process.
- Regarding: **Shared Decision Making** regarding options for patients.
- Is it providers and patients or just patients?
- (3:06) Truth of the options.
- Following protocols adopted statewide.
- Encourage legislature

Motion to move recommendation as amended to Simplicity recommendation is seconded. **Motion passed unanimously**.

Motion to strike recommendation 3.

- Value in physicians and other healthcare professionals to follow an established set of guidelines that should, by in and of itself, should reduce negligence and unwanted and frivolous lawsuits.
- Can this be done in another place?
- (3:15) Trying to bundle many things together. Very few available decision aids and this may spur some ideas. Use what is available, in regards to, ---- We are at a very early stage of using something that we want to encourage but to require, right now, is not relevant. Wanting to encourage the (1) use of good evidence-based tools as they emerge, health plans have a big role in that area, (2) another

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thing is to allow interjection of cost discussions on the medical front with the patients which is not happening at all.

- In trhstPut under ??? based effectiveness (3:17:40) with intent to invent a community standard to provide Oregonian with a degree of protection. Standard of world class care.
- Under consideration is to: 1) change recommendation 1 along lines of clinical guidelines and not having anyone to require (3:19) then working toward a hospital standard.
- Staff will rework recommendations and bring back to committee.

Workforce issues are being brought up in several committees.

Chair Stenson **V. Public Testimony**

Rob Schwartz, Executive Director, Oregon Ambulatory Centers Association (ASCs), Senior Vice President of the National Association, provided testimony on ASC's provided detailed report of ownership to committee members. Testified on the safety, ease, accessibility of these centers and refuted testimony based on an article . Physician ownership and driving utilization, which has met with a lot of controversy because of research assumptions. (1) Concerns regarding article.

- Addressed concerns asserted at meeting of 03/13/08 of ASCs in competition with hospitals and an article presented that indicates hospitals are in competition with ASCs and raises q re physician ownership and driving utilization. Counter Concerns about assumptions of article expressed. 1991 study Commission by Florida Healthcare ??? commission found higher utilization by some physican with clinical laboratories.
- It found no correlation and no evidence of (3:24:20)
- Value of these centers to working individuals.
- Expressed that there is fear in the public about losing healthcare coverage.
- ASCs are a resource.

Ellen Pinney, Oregon , member of Eligibility and Enrollment Committee, testifies on the individual mandate, accountability and transparency and the importance of this in ______. (3:27:40) What would it take for you to know that the health plan that you are enrolled in is accountable to your needs? Asked at community meetings. Repeatedly answered that they need options. Supported pharmaceutical benefit managers are lack regulation and transparency and urged including reference to this in recommendations. Testified to individuals changing medication due to health plan.

.

Jeanene Smith **III. Review and Possible Approval of Recommendations**

Staff overviewed the

Public Health, Health Promotion and Wellness

- xxx
- xxx

Payment Reform

- xxx
- xxx

Cost Containment
Accountable Care Districts
- xxx
- xxx

Administrative Simplification
- xxx
- xxx

Reduce Pharmaceutical Spending
- xxx
- xxx

Patient Decision Aids
- xxx
- xxx

Chair Stenson **VI. Public Testimony**

- **Rob Schwartz, Executive Director, Oregon Ambulatory Association**
- 1991 Study
- Discussion on payments to community health care clinics and

Chair Stenson **IX. Adjourn**

Chair Stenson adjourned the meeting.

Next meeting is April 28, 2008.

Submitted By: Paula Hird Reviewed By:

EXIHIBIT SUMMARY
1. Minutes from 04/17/08.
2. "Architecting World Quality Care for Oregonians" (PowerPoint)
3. Quality Institute Recommendations (PowerPoint)
4. Quality Institute Recommendations (Written)
5. Letter from Jim Dameron of the Oregon Patient Safety Commission
6. Letter from Nancy Clark, Executive Director, Quality Corporation
7. Decision support strawperson
8. Payment reform strawperson
9. Public Health Strawperson
10. 2008 Kinsman Ethics Conference Summary

OREGON HEALTH FUND BOARD – Delivery Systems Committee

May 14, 2008
1 – 5 pm

Portland State Office Building, 1st Floor Room 1A
800 NE Oregon Street
Portland, Oregon

MEMBERS PRESENT:
Dick Stenson, Chair
Maribeth Healey, Vice-Chair
Doug Walta, MD, Vice-Chair
Vanetta Abdellatif
Mitch Anderson
Tina Castanares, MD
Vickie Gates
Bill Humbert
Dale Johnson
Carolyn Kohn
Bart McMullan, MD
Stefan Ostrach (by phone)
Ken Provencher (by phone)
Lillian Shirley, RN
Mike Shirtcliff, DMD
Charlie Tragesser
Rick Wopat, MD

MEMBERS ABSENT:
David Ford
Diane Lovell

STAFF PRESENT:
Jeanene Smith, MD, Administrator, OHPR
Tina Edlund, Deputy Administrator, OHPPR
Ilana Weinbaum, Policy Analyst, OHFB

These minutes are in compliance with Legislative Rules. <u>Only text enclosed in italicized quotation marks reports a speaker's exact words</u>. For complete contents, please refer to the recordings.

- **Identify Key Area of Draft Report for Discussion**
- **Discuss Key areas of Draft Report**
- **Public Testimony**

[DISCLAIMER: There was a malfunction of the digital recorder used to record this meeting. As a result, only a portion of the beginning of the meeting was recorded. However, every attempt has been made to recreate an accurate summary of what occurred at this meeting.]

Chair Stenson **I. Call to Order/Approval of 04/28/08 Meeting Minutes (See Exhibit Materials 1)**

- Meeting was called to order. There was a quorum.

Motion to approve minutes is seconded. **Motion passed unanimously.**

Chair Stenson **II. Identify Key Areas of Draft Report for Discussion**

Chair asked members to identify areas that need further discussion. Members responded suggesting the following areas:

- Wordsmithing document headed **<u>Public Health, Prevention and Wellness</u> (See Exhibit Materials _______)**
- Accountable Care Districts (ACDs)

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- Written comments from Carolyn Kohn, Stefan Ostrach and Mitch Anderson will be considered.
- Cost Containment

Staff related that Chair of the Safety Net Advisory Council will address the Committee regarding their submitted comments.

Chair Stenson **III.** **Discussion of Key areas of Draft Report (See Exhibit Materials 3)**

Vision Statement (page 7)

- Lead Staff Jeanene Smith related that statement includes attempts to capture comments from presentation by Dave Ford at last meeting and principles discussed over series of meetings. Have not received any email feedback on the statement.
  - Suggestion to add definition of mental health care in Vision Statement and Glossary of Terms. Discussion on definition of health care as including physical, mental, dental, etc.
  - Third hollow bullet (Institute of Medicine's Six Aims): Suggestion to put in the systems and footnote Institute of Medicine reference.
  - Equitable referencing piece not strong enough, needs statement emphasizing it is for all.
  - First hollow bullet: "medicalizing" things that are not medical and not related to the delivery system by nature noted.
  - Committee recommended that Vision Statement is actually just the first paragraph. It should be succinct.
    - Separate first paragraph (minus last line) and bold for Vision Statement.
  - Top of page 8, first full statement, wordsmith adding to ". . . rates higher in efficiency" and add "a position that could easily erode if supply of services increases too quickly." Need to be clear that we are not performing well and need to change.
  - Define what is meant by access suggested.
  - High unit prices for hospital and low utilization. Suggestion that instead of talking about rank
    - Delete first part of statement to begin with "There is still a great deal that Oregon can . . ." and do not use any comparisons. ILANA NO-YES SOUNDS LIKE HE TOOK IT BACK????

Accountable Care Districts (page 32)

- Actual recommendations are in bold on page 33.
- Deals with what data collection and aggregation could do.
- Debate on detail of accountability, with some members asserting document reflects no sense of true accountability and does not prescribe how the data is governed or used. In opposition, importance of collecting data for transparency and in driving policy is asserted. Specificity on governance and accountability vs. providing guidance that others will need to create model.
- Support for community use of data.
- Page 32, last paragraph, statement in parentheses should be expanded to include "shared accountability of quality across the community" that also will include school systems, other agencies, etc., relating it should be honed by communities recognizing that it may be different from region to region.

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- Related study to be published in public journal comparing ER use by OHP patients regionally. Indications are that it will be dramatic.
- Do we need a second recommendation or just an extra sentence?

Payment Reform

Others identified by Committee

Chair Stenson **IV.** **Public Testimony**

Chair Stenson **V.** **Adjourn**

Motion to adjourn is seconded. **Motion passed unanimously.** Chair Stenson adjourned the meeting.

Next meeting is May 28, 2008.

Submitted By: Paula Hird Reviewed By:

EXIHIBIT SUMMARY

1. Agenda
2. Minutes from 04/28/08.
3. Delivery Recommendations
4. Oregon Primary Care Association
5. Safety Net Advisory Council Recommendations
6. Safety Net Advisory Council Testimony

DRAFT

OREGON HEALTH FUND BOARD – DELIVERY SYSTEMS COMMITTEE

May 28, 2008 — **Portland State Office Bldg., First Floor, Room 1B**
1:30 p.m. to 3:30 p.m. — **800 NE Oregon St.**
Digitally Recorded — **Portland, Oregon**

ATTENDANCE NEEDS TO BE CHECKED

MEMBERS PRESENT:
Dick Stenson, Chair
Maribeth Healey, Vice-Chair
Doug Walta, MD, Vice-Chair
Vanetta Abdellatif
Mitch Anderson (by phone)
Tina Castanares, MD
David Ford (did he leave?)
Dale Johnson
Carolyn Kohn
Bart McMullan, MD
Stefan Ostrach
Charlie Tragesser
Rick Wopat, MD

MEMBERS ABSENT:
Vicki Gates
Bull Humbert
Ken Provencher
Diane Lovell
Lillian Shirley, RN
Mike Shirtcliff, DMD

STAFF PRESENT:
Jeanene Smith, MD, Administrator, OHPR
Ilana Weinbaum, Policy Analyst, OHFB
Judy Morrow, Assistant, OHPR

- **Call to Order. Approval of 05/14/08 Meeting Minutes**
- **Brief Update of Delivery Systems Presentation to Board**
- **Public Testimony**
- **Review and Vote on Revised Committee Report**

These minutes are in compliance with Legislative Rules. <u>Only text enclosed in italicized quotation marks reports a speaker's exact words</u>. For complete contents, please refer to the recordings.

Digitally Recorded

Chair Stenson **I. Call to Order/Approval of 05/14/08 Meeting Minutes (See Exhibit Materials 1)**

- Meeting was called to order. There was a quorum.

Motion to approve minutes is seconded. **Motion passed unanimously.**

Chair Stenson **II. Brief Update of Delivery Systems Presentation to Board**

Jeanene Smith reported that she, Dick, Maribeth, and Ilana presented the Committee's recommendations to the Oregon Health Fund Board (OHFB) last week.

- Next steps to be taken by the Board were discussed. Final report will be available soon with changes highlighted. Related the integration of Health Equities Committee (HEC) recommendations into the plan.
- Next Board meeting will focus on Finance Committee
- Stefan Ostrach stated there are fundamental problems with the recommendations and that he will be voting no. Will distribute written issues of concern.
  - Staff noted discussions in the recommendation that relay varying member opinions. Stefan responded that it does not go far enough.
- Tina Castanares stated that the last bullet on page 1 of the Member Comments that was attributed to her is incorrect. **(See Exhibit Materials 3)**
- At the request of the Chair, Stefan summarized his concerns stating:
  - SB 329 is flawed,
  - By taking the single payer off of the table, the real reform needed is not even under consideration and a world class system cannot be built on private insurance.
  - In the short term, Integrated Health Care Homes (IHH) will be more costly, and there is no evidence of long-term savings or that people want them.
  - Agrees with data collection but sees the Quality Institute (QI) as a duplicative bureaucracy and the work should be done by Oregon Health Policy and Research (OHPR).
  - No serious cost containment in recommendations.
  - Incentives for health care quality and outcomes is not needed.
  - Holding increase in costs to CPI is related as "lip service."
- Chair asked if there were objections to Stefan writing a minority report. No objections presented.
  - Support for Stefan's concern on the viability of the health home, but views work as a directive and supports pilots/ experiments.
  - Linking health care costs to CPI supported.
  - Further support that not everyone wants a health home.
  - Maribeth Healey questioned whether the objective of cost containment had been addressed and stated that the Board wants *"more meat"* around it.

Chair Stenson **III.** **Public Testimony – (Moved to end of report review)**

Chair Stenson **IV.** **Reivew and Vote on Revised Committee Report (See Exhibit Materials 3 and 4)**

Using Committee Members Comments **(see Exhibit Materials 3)**, Chair related them to the Committee's recommendations **(see Exhibit Materials 4).**

- First comment from Ken Provencher related. No action required.
- **Vision Statement**: Agreement to include Tina Castanares comments.
- **Primary Care/IHH sections**: First Bullet (Recommendation 8, page 28 of plan)
  - Discussion on removing statement that safety net providers may not be needed with debate on safety net clinics as part of the system and their role in a reform system as changing. Statement that under universal care, 5% of population is still uninsured.
  - Debate on if there has been a lobbying effort by safety net people to get protection. Chair proposed to say "may" not be needed from "would" not be needed. Tina Castanares, who submitted

safety net language, denied lobbying efforts, asserted it is in the public's interest to support. Commonwealth report related Oregon ranks 43rd on children's healthcare and 47th in equity in the nation.

Motion to change remove discussion on safety nets is seconded.

Discussion

- Arguments against the motion, stating that it was important that the report to the Board include the Committee's deliberations.

Call for the Question. **Motion fails 5-8.**

On page 28, further discussion should be stricken.

Opposition to the motion and supports leaving in the discussion. Support expressed.

Motion to change recommendation 8 to add "and integrate" to read "Recognize and strengethn <u>and integrate</u> the role of the safety net . . . " is seconded..

Discussion

- Suggestion to include language of "until no longer necessary," with discussion following.
- Statement that this is only the first step for this document and it will be changed by others. Suggestion to leave it as it is.
- Assertion no other states are debating the value of the safety net.

Call for the question. Motion passed unanimously.

- **Primary Care/IHH sections.** Second/Third Bullet overviewed.
  - **Plan recommendation 2 on page 74 (Appendix H)** – Suggestion to move from Appendix to be included in **Recommendation 5 (page 26).**
  - Opposition stated that it is not just safety net providers and should not be changed.
  - Suggestion to recommend ensuring adequate safety net workforce to the OHFB.
  - Discussion of bolded language constituting Recommendation 5 should call out the safety net workforce.
  - What about those that are not defined as safety net?

Motion to change Recommendation 5 from ". . . especially those serving vulnerable populations" to "especially the safety net workforce and those serving vulnerable populations" is seconded.

Discussion

- Objection to calling out specific groups which may adversely affects others serving those populations.
- Prioritizing and importance of safety net providers as a subset is discussed.
- Assertion that the safety net designation is broad and that should be stated.

Call for the question. Motion ???????? – couldn't tell if it passed or not. (56:20)

- **Quality Institute sections**: First Bullet
  - Discussion on electronic health records not being included in recommendations due to this being assigned to the newly formed Health Information Infrastructure Advisory Committee (HIIAC).
  - The need for these systems to be integrated.
  - Issue identified on page 33 of recommendations.

Motion for Committee to "visibly" reflect and explain to HIIAC that this Committee will fully and strongly support the development of electronic health records, that interoperability needs to be high on the agenda and there should be special attention to safety net providers and those that may have more difficulty in attaining that standard. Motion seconded.

Staff related that the recommendations will be related to HIIAC tomorrow as they want to make ensure recommendations intertwine with this Committee's recommendations.
Motion passed unanimously.

- **ACD Sections –** Suggestion to add Safety Net Advisory Council (SNAC) recommendation 3 of Appendix H (page 74) to C. Accountable Care Districts (ACDs) on pages 35-37. Suggestion to add a third recommendation.
- Related that it is included under Further Discussion of Recommendation 1 on page 37.

Motion to add bullet on page 37 to include safety nets and "others serving vulnerable populations" is seconded. **Motion passed unanimously.**

- **Payment Reform Sections:** Tina Castanares related that she did not make the statement at the bottom of page one of the Member Comments document that a dollar amount be attached and supported not including an amount. Discussion on SNAC recommendation .

Motion to include SNAC's recommendation #1 to establish a Safety Net Integrity Fund is seconded.

Discussion

- Concern expressed about asking for money for the safety nets, money for QI, the CCHI fund and how does it interlink with the broader reform?
- Important distinction is noted that access is the Committee's charge, not coverage. It was noted other states have a similar fund.
- Joel Young, Oregon Department of Human Services, staff to SNAC, described the concept of a Safety Net Integrity fund as a new fund to Oregon that would help where gaps may exist and to sustain entities. It is to be used to help establish and meant to be a constant flow of funds.
  - It would help entities with financial trouble with discussion on poor management.
  - Criteria would establish who would be eligible for the fund.

Call for the Question. Motion fails.

- Other Comments: Suggestion does not require action but meant to make OHFB aware stating that they have received an email on it.
- Importance in cost containment asserted.
- Debate on whether insurance companies should be allowed to make profit or have profit limited on basic plans.
- If they have a loss, are we obligated to make up the loss?
- Maribeth Healey asked that it be noted on the record that the Committee did not meet its objective on cost containment.
- **Recommendation 5 on page 13** – Relates to "higher standards of immunity from litigation." Has not been voted on nor fully debated. Suggestion of a liability fund, or other options to recommend that protect patients more than limiting ability to sue.
- Staff related that on page 43, more detailed recommendation, discussion includes acknowledgement that there was inadequate time to form a recommendation in this area.
- Other options need to be suggested.

Motion to remove Recommendation 5 on pages 13 and 43 on the creation of a professional liability fund as part of these recommendations.

Discussion
- Support for motion against recommending any immunity from litigation. Needs more study and deliberation.
- Concern expressed for physicians with no claims paying high premiums. Suggestion that it would not get to trial if the physician follows evidenced-based procedures.
- Reiteration that it is a recommendation that takes away patient rights.
- Issue of immunity discussed.

Board met

Friendly amendment to retain discussion with suggestion of protections for providers and patients.

Amendment Accepted.

Call for the Question. Motion carries 9-4.

Motion to approve the report as amended is seconded. **Motion passed 10-1???**

- Request to see minority report. Report will be circulated.

Chair Stenson **VIII** **Public Testimony**

- **Dr. Gina Nichol, Director of Association of Community Mental Health**, **Addictions and Development Disabilities programs and member of HIIAC**. Complimented the Committee on their process while being faced with short timeline. Suggestion to include in report: (1) statement referring to world class organization needs to be broader and stronger, it is a culture change; and 2) on page 14 and primary care could add that ½ of the people who die from smoking have a serious mental illness (provided supporting information).
  - Stronger emphasis on integrating mental health, addictions and dental care.
  - Related that jails are the largest health provider for mental health.
  - Related information on SB 1087.

  - Agrees that report needs more on cost containment and cost shifting.
  - Testifies to the importance of safety net clinics.

- **Mallen Kear, Portland**, challenged some assertions relating to minority report. Asserts that there are public-private health systems in other countries as opposed to a single-payer system. States that reforms can be made on a state-by-state basis.

- **Don Klosterman, citizen**, related that the report could be strengthend by identifying essential recommendations that would give greater guidance. Support for strong state audit system.

Submitted By: Paula Hird

Reviewed By:

Exhibit Materials

1. **Agenda**
2. **Delivery Systems meeting minutes of 05/13/08.**
3. **Member Comments**
4. **Delivery Recommendations with no Quality Institute report**

OREGON HEALTH FUND BOARD

December 12, 2007 CCC, Wilsonville Training Center, Room 111-112
1:00pm (Digitally Recorded) Portland, OR

MEMBERS PRESENT: Board

William Thorndike, Chair
Jonathan Ater, Co-Vice Chair
Eileen Brady, Co-Vice Chair
Thomas Chamberlain
Charles Hofmann, M.D.
Raymond Miao
Marcus Mundy

Delivery
Dick Stenson, Chair
Maribeth Healey, Co-Vice Chair
Doug Walta, MD, Co-Vice Chair
Vanetta Abdellatif
Mitch Anderson
Tina Castanares, MD
Dave Ford
Vickie Gates
William Humbert
Dale Johnson, Jr.
Carolyn Kohn
Diane Lovell
Bart McMullan, Jr., MD
Stefan Ostrach
Ken Provencher
Lillian Shirley, BSN
Mike Shirtcliff, DMD
Charlie Tragesser
Richard Wopat, MD

OTHERS PRESENT: Ellen Lowe, Chair, Eligibility and Enrollment Committee
Ella Booth, Chair, Health Equities Committee
Senator Ben Westlund

STAFF PRESENT: Barney Speight, Executive Director, OHFB
Jeanene Smith, M.D., Administrator, OHPR
Tina Edlund, Deputy Administrator, OHPR
Sean Kolmer, Research Analyst
Heidi Allen, Program Manager, OHREC
Tami Breitenstein, Executive Assistant, OHFB
Nora Leibowitz, Acting Director, Health Policy Commission
Darren Coffman, Director, Health Services Commission
Nathan Hierlmaier, Policy Analyst
Brandon Repp, Research Analyst
Illana Weinbaum, Policy Analyst
Alyssa Holmgren, Policy Analyst

ISSUES HEARD:

- Call to Order/Introductions/Review and Approve Meeting Agenda

- **Review and Approval of Revised Committee Charters and Design Principals and Assumptions**
- **Call Joint Meeting of Board and Delivery Systems Committee to Order**
- **Characteristics of a Patient-Centered Medical Home**
- **Panel: What are Oregon Health Insurers Doing to Promote Medical Homes? Dave Labby, CareOregon; Ralph Prows, Regence Blue Cross Blue Shield; and Thomas Hickey, Kaiser Permanente**
- **Presentation: Efforts to Unify Primary Care Providers around Medical Home Model, by Chuck Kylo, Greenfield Health, David Dorr, OHSU**
- **Invited Testimony and Public Testimony**
- **Other Business**

These minutes are in compliance with Legislative Rules. <u>Only text enclosed in italicized quotation marks reports a speaker's</u> exact words. For complete contents, please refer to the recordings.

(Digitally Recorded)

Chair Thorndike **I. Call to order the meeting of the Oregon Health Fund Board/Review and Approve Meeting Agenda.**

There is a quorum. Board, Committee Members and staff introduced themselves.

Chair Thorndike **II. Review and Approval of Revised Committee Charters and Design Principles and Assumptions**

Barney Speight overviewed "A Comprehensive Plan for Reform: Design Principals and Assumptions" as amended with previous suggestions from the Board incorporated.

- Concern regarding Assumption H as it appears to lock in the existing business model of employers funding much of the health care reform.

Motion to adopt the document, "A Comprehensive Plan for Reform: Design Principals and Assumptions" is seconded.

Discussion

- Agreement that Assumption H is too limited and suggests a program is being designed only for the uninsured, when it is a program for all Oregonians.
- Cost containment statement should be related not only to the health coverage for the uninsured but also to employer-based costs.
- Under Assumption A include the wording "cost containment" and more flexibility in H; and Assumption I regarding revenue should be changed to "new funding mechanisms."

The plan will be amended to add cost containment to Assumption A, change Assumption I to new funding mechanisms, and, in regards to the concern of Assumption H, a new Principal will be added stating that this plan not only looks at systems to bring the uninsured into coverage but also to reform the existing delivery system and financing system for those who have coverage.

The question is called for to approve the Comprehensive Plan as amended. Motion passed unanimously.

The Director will rework the document and send it out for comment.

Review and Approval of Revised Committee Charters presented by Barney Speight

- Four charters for consideration:
  - **Delivery System Committee**, highlighting changes made to:
    - Principals: efficiency, economic sustainability, use proven models, fund a high quality and transparent health care delivery system and ensuring costs do not exceed cost of living increases.
    - Scope concepts were highlighted, including adding to Public Health and Prevention and End-of-Life Care.
  - **Quality Institute Work Group**
    - This group will look at the issue of information transparency. The Governor's office will probably form a Health Infrastructure Advisory Committee (HIAC) that will look at information and technology.
    - Question regarding the Quality Institute and composition of group – doctors, health systems, insurers, providers, counselor, it was ask
  - **Eligibility and Enrollment Committee** charter points were highlighted. Ellen Lowe, Chair of the Committee, responded to questions concerning the timeline for submitting reports and information that will be needed from the Benefits Committee to complete some reports.
  - **Federal Laws Committee** charter was reviewed.

Motion to adopt the charters for the Delivery System, Eligibility and Enrollment, Quality Institute and the Federal Law Committees is seconded. **Motion passes unanimously.**

The Chair welcomed Senator Kurt Schrader who addressed the committees.

Dick Stenson

III. Call to order the Joint Meeting of the Board and the Delivery Systems Committee

Barney Speight reviewed meeting schedules and discussed finalizing arrangements with The Institute of Health Policy and Solutions, which has been working with Massachusetts and California on reforms, and James Matheson, an independent actuary, which has been working on the Boston Health Policy and Research, as consultants.

Representative Tina Kotek is welcomed.

Jeanene Smith, MD

IV. Characteristics of a Patient-Centered Medical Home

Presented a brief overview of The Medical Home Model of Primary Care (see exhibit materials).

- Definition of primary care includes general pediatrics, general internal medicine, family medicine and OB-GYN.
- Statistics from the Board of Medical Examiners states there are 3,964 primary care physicians, if you include all OB-GYN's.
- Background of primary care, integrating behavioral, mental and public health, and community collaborative activities.

- The importance of other key health care professionals, e.g. Nurse Practitioners.
- Emergency room use.

Presentations **V. Panel: What are Oregon Health Insurers Doing to Promote Medical Homes?**

Panel Members David Libby, MD, PhD, CareOregon; Ralph Prows, MD, Regence Blue Cross Blue Shield; and Thomas Hickey, MD, Kaiser Permanente (see exhibit materials for copies of Power Point presentations).

Each panel member gave a presentation on medical homes including research and pilot programs.

Discussion

- Some topics discussed included:
  - Integrating care for individuals and families
  - Panel sizes and implementation of these type of models
  - Medical homes cost, cost methodology and administrative costs
  - Lack of primary care physicians
  - Chronic care
  - Customer focus
  - Health Information Technology
  - Primary Care Home collaboratives

Presentation **VI. Efforts to Unify Primary Care Providers around Medical Home Model**

Presentations by David Dorr, MD, OHSU and Chuck Kilo, MD, Greenfield on the benefits and challenges of medical homes in primary care.

Bill Thorndike **VII. Invited Testimony and Public Testimony**
The following were invited to provide testimony:

- Rick Wopat
- Mike Grady
- Craig Hostetler

Public testimony was given by:
- David Pollack, OHSU

Bill Thorndike **VIII. Other Business - None**

Bill Thorndike/ Dick Stenson **IX. Adjourn**

The meeting was adjourned at approximately 5:05 p.m.

The next meeting for the Oregon Health Fund Board will be January 15, 2008, at the Port of Portland Commission Room in Portland.

Submitted By:
Paula Hird

Reviewed By:

EXHIBIT SUMMARY

1. Agenda
2. Revised Committee Charters
3. Reform Design Principles and Assumptions
4. The Medical Home Model of Primary Care, Draft Report Prepared for Office for Oregon Health Policy and Research
5. Joint Principles of a Patient-Centered Medical Home, American Academy of Family Physicians, American Academy of Pediatrics, America College of Physicians and American Osteopathic Association, February 2007.
6. Beal A, et al., Closing the Divide: How Medical Homes Promote Equity in Health Care, The Commonwealth Fund, June 2007
7. Jeanene Smith Presentation Slides – Characteristics of a Patient-Centered Primary Care Home
8. Speaker Bios
9. Insurer Panel Materials
   a. Ralph Prows Presentation Slides – Primary Care Home: Overview of Collaboration
   b. Thomas Hickey Presentation Slides – Kaiser Permanente Vision
   c. Goodson J, Unintended Consequences of Resource-Based Relative Value-Scaled Reimbursement, JAMA, November 2007, 298(19):2308-2319
   d. David Labby Presentation Slides
10. Provider Panel Materials
    a. Summary of Better Health Initiates Meetings
    b. David Dorr Presentation Slides – Medical homes in primary care: policy implications from Care Management Plus

OREGON HEALTH FUND BOARD (OHFB) – DELIVERY COMMITTEE

November 15, 2007 **CCC-Wilsonville Training Center**
1:00 PM (Digitally recorded) **Room 112, Wilsonville, OR**

MEMBERS PRESENT:
Dick Stenson, Chair
Maribeth Healey, Vice-Chair
Doug Walta, MD, Vice-Chair
Vanetta Abdellatif (by phone)
Mitch Anderson
Tina Castanares, MD
David Ford
Vickie Gates
Bill Humbert
Dale Johnson
Carolyn Kohn
Diane Lovell
Bart McMullan, MD
Stefan Ostrach
Ken Provencher
Lillian Shirley, RN
Mike Shirtcliff, DMD

MEMBERS EXCUSED:
Rick Wopat, MD
Charlie Traggesser

STAFF PRESENT:
Jeanene Smith, MD, Administrator, OHPR
Barney Speight, Executive Director, OHFB
Ilana Weinbaum, Policy Analyst
Zarie Haverkate, Communications Coordinator

ISSUES HEARD:

- Approval of Agenda and 10/18 Minutes
- Introduction of New Committee Members
- Review of Public Meeting Laws
- Update on OHFB and Other Committees
- Appointment of Health Quality Institute Workgroup
- PEBB Vision and Oregon Purchasers Coalition Efforts to Promote Accountable Health Plans
- Governor's Office Update on Health Information Infrastructure Advisory Committee (HIIAC)
- Review Committee Charter and Draft Work Plan
- Public Testimony

(Digitally Recorded)

Dick Stenson, Chair

I. Call to order at 1:04 pm - There is quorum.

II. Approval of Agenda and 10/18 Minutes

Governor's Office presentation by Ree Sailors will be after the PEBB presentation. Agenda approved.
The Committee unanimously approved the October 18, 2007 minutes as submitted.

III. Introduction of New Committee Members

Mitch Anderson, Bill Humbert, Carolyn Kohn, Stefan Ostrach and Charlie Tragesser (not present) were introduced as new members to the Committee.

IV. Review of Public Meeting Laws

Summary of Public meeting laws reviewed. All meetings will follow these guidelines and the public is encouraged to provide testimony.

Barney Speight — **V. Update on OHFB and Other Committees**

Barney summarized OHFB and Committee activities since the last meeting. December 12 with be a joint meeting of the Delivery Committee and OHFB.

The Committee asked to be included on emails regarding other OHFB-related meetings.

VI. Appointment of Health Care Quality Institute Workgroup

Bios for proposed members of the Delivery Committee Quality Institute members were reviewed. It was suggested adding quality experts if possible in the dental and mental health areas. Mitch Anderson will provide a name of mental health quality expert and Dr. Shirtcliff will provide a name of dental quality expert to serve on the Exchange Workgroup to Jeanene Smith.

The Committee unanimously approved the Health Care Quality Institute Workgroup membership as submitted, subject to possible additional representatives from the mental health and dental quality control fields.

Jean Thorne — **VII. PEBB Vision and Oregon Coalition of Health Care Purchasers Efforts to Promote Accountable Health Plans**

Jean Thorne, Administrator of PEBB and Oregon Educators Benefit Board stated that she will be retiring next month from all of her public duties.

PEBB is the largest purchaser of employer-based health insurance and implemented a value-based purchasing program in 2006. She advised the Committee to not recreate the wheel, but look to PEBB's report, build on it, and recognize that state government as a purchaser can impact the delivery system. She encouraged the Committee to work alongside others who are trying to do make delivery system changes to ensure a consistent message across the plans. She also discussed the role of PEBB's Council of Innovators, which is comprised of representatives from the plans that contract with PEBB to provide benefits to state employees.

Ms. Thorne also presented information on efforts of the Oregon Coalition of Health Care Purchasers to use the Evalu8 tool to assess health plan quality.

Discussion

- Dr. Castañares concerned that PCPs are threatened now because of having to practice medicine and reporting, that adding to the paperwork takes away from practicing medicine.

- Dr. McMullen stated purchaser collaboration around developing standard reporting requirements will help reduce the burden, but still a lot of work for health plans.

- Ken Provencher stated it would be good to measure results from initiatives, such as purchaser coalition. Too soon to tell.

Ree Sailors

VIII. Governor's Office Update on Health Information Infrastructure Advisory Committee (HIIAC)

Ree Sailors stated that HIIAC has been formed to replace the Health Information Security and Privacy Collective (HISPC) which was tied to a former grant. HIIAC will be funded by a Medical transformation grant. The Governor felt it may serve the public better by looking at electronic health records beyond privacy and security. The primary goal of HIIAC is to make the patient the owner of the information. Will bring technical and policy people together on HIIAC to look into these issues and initial record development for the OHP population. Ms. Sailors plans to report to the Committee each meeting about activities. She asked the Committee to please contact her if they have recommendations of people to appoint to HIIAC.

VII. Review Committee Charter and Draft Work Plan

Chair Stenson asked for a subgroup of committee members to assist him, the vice-chairs, and staff in developing a "straw person" set of policy proposals for the committee to discuss in January. Dave Ford, Bart McMullan, Dale Johnson and Stefan Ostrach indicated they would like to participate. Vanetta Abdellatif followed up with an email to express her interest in participating.

The draft work plan and charter were reviewed. Discussion followed regarding elements and key issues to be addressed in the work plan. Mr. Speight stated we need a framework before get into scope of work plan and committee members suggested the framework should be based on the Institute of Medicine, Institute for Healthcare Improvement and CMS Four Cornerstone reform principles. Staff will draft a framework and bring to Committee for review.

Discussion

- Cost containment for future sustainability through an efficient and effective delivery system.
- Concern with shortage of certain health specialties which increases burden on PCP.
- Look at work force, epidemiology, forecasting demand, not just cost containment. Need reformed system.
- Create a safer, simpler, more efficient, more equitable health care system.
- Health care currently operates in silos, need to address integration.
- Cover the working poor.
- Address impact of mental health, methamphetamine, and addictions on delivery system.
- Develop accessible system for mental health and special needs clients.
- Health Equities Committee appointed to look at special populations and needs.
- Build in preventive care into delivery system to address additional public health system such as alternative care (acupuncture, chiropractic), and not just traditional health services. Preventative programs to address obesity in kids, i.e., physical education.
- Value based benefit design – how incentives or disincentives to evidence based care?
- Delivery system streamlining – for example, not requiring co-pays for persons needing insulin.

VIII. Public Testimony

Fred Matthies, MD, Portland OR: Dr. Matthies stated he is a retired family practice doctor who is concerned about the PCP and family doctor practices, especially in Eastern Oregon rural areas and due to doctors retiring. He distributed a "Selected Reading List on Primary Care Physician Resources" (Public Testimony Item #1) for the Committee's review.

Jonathan Ater, Chair of Oregon Health Fund Board: Gave overall background on the OHFB and the work the various committees will need to do. Asked Committee to keep eye on prize and remember significant role in affecting change in Oregon and across the nation.

Ellen Lowe: Reported that the Enrollment and Eligibility Committee is dealing with affordability.

Next Meeting

December 12 from 1-4 pm, Wilsonville Training Center, Rooms 111 and 112. This will be a joint meeting with the Oregon Health Fund

The meeting adjourned at approximately 4:20 pm.

EXHIBIT MATERIALS:

1. Draft Agenda
2. Oct 18 Draft Minutes – Delivery System Committee
3. Summary of Public Meeting Laws
4. OHFB October Newsletter
5. Draft Charters for Other OHFB Committees
6. Bios for Proposed Members of Health Care Quality Institute Workgroup
7. Jean Thorne's Presentation Handout
8. Minimum Requirements and High Rating Criteria from the PEBB Vision Matrix
9. PEBB Guiding Principles and RFP Preferences
10. Value-Driven Health Care Purchasing: Four States that Are Ahead of the Curve, The Commonwealth Fund Available for download: http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=515778
11. Final Delivery System Committee By-Laws
12. Revised Draft Delivery System Committee Charter
13. Draft Delivery System Committee Work Plan

Citizen written materials received:

1. "Selected Reading List on Primary Care Physician Resources" submite4d by Fred Matthies, MD, Portland OR

OREGON HEALTH FUND BOARD (OHFB) – DELIVERY COMMITTEE

October 18, 2007 **CCC-Wilsonville Training Center, Room 112**
3:00 PM (Digitally recorded) **Wilsonville, OR**

MEMBERS PRESENT: **Vanetta Abellatif (by phone)**
Mitch Anderson
Tina Castanares, MD
David Ford
Vickie Gates
Maribeth Healey
Diane Lovell
Bart McMullan, MD
Ken Provencher
Dick Stenson
Doug Walta, MD
Rick Wopat, MD

MEMBERS EXCUSED: **Dale Johnson**
Steve Sharp
Lillian Shirley, RN

STAFF PRESENT: **Jeanene Smith, MD, Administrator, OHPR**
Tina Edlund, MS, Deputy Administrator, OHPR
Barney Speight, Executive Director, OHFB
Ilana Weinbaum, Policy Analyst
Zarie Haverkate, Communications Coordinator

ISSUES HEARD:

- **Review & Adoption of By-laws**
- **Nomination & Election of Chair and Vice Chair**
- **Review Draft Committee Charter, Workgroups and Timeline**
- **Future Meetings**
- **Public Testimony**

(Digitally Recorded)

Jeanene Smith, MD **I. Call to order - There is quorum.**

Barney Speight **II. Review and Adoption of By-laws**

Discussion

- Article I, bullet 4 states that Committee members are not entitled to reimbursement of expenses for serving on the Committee as funding is limited. However, if this is a hardship, please discuss with Barney Speight and special arrangements can be made.
- The intent of Article III, bullet 5 is that a majority of Committee Members shall constitute a quorum for the transaction of business. A majority of members present may act on behalf of the committee.
- Article III, bullet 3, will be clarified to state that a preliminary Agenda will be sent to the Committee and posted on the

website, with the final Agenda to be approved at the beginning of meetings as an action item to allow for additions/changes.

The Committee unanimously approved the By-Laws as amended above.

III. Nomination and Election of Chair and Vice Chair

The Committee unanimously approved Dick Stenson to serve as Chair. Dr. Doug Walta and Maribeth Healey were unanimously approved as co-Vice Chairs.

Barney Speight

IV. Review Draft Committee Charter, Workgroups and Timeline

Discussion

- Mr. Speight reviewed Design Principles and Assumptions document in formulating Charter and gave an overview of work to be done. He discussed timelines, Committee charter, public meetings, and public outreach required before OHFB will present comprehensive reform plan to the Governor and Legislature by October 2008.
- The OHFB held its first meeting on October 2. There are six committees to the Board: Finance, Delivery Systems, Eligibility and Enrollment, Benefits, and Federal Policy and Health Disparities Committee. Committee chairs will serve as non-voting members to the OHFB. The Benefits Committee held its first meeting October 17 and elected Susan King as Chair, and has yet to elect a Vice Chair.
- Question as to how Delivery System Committee should approach health information technology recommendations. Discussion of possible role for Governor's Health Information Infrastructure Advisory Committee to inform Delivery Committee recommendations.
- Mr. Speight is working to hire consultants such as Dr. Gruber for actuarial expertise and economist John McConnell. Only have approximately $400K for consultants and are also applying for grants as well to fund consultants. Discussion about how any modeling has to be able to take into account changes in costs from year to year.
- Dr. Castanares stated the work needs to also be future based to take into account chronic disease burden, MH additions, future epidemiologic/economic projections and workforce sustainability.
- Mr. Ford asked that committee have commitment to data driven reform and to look at what other states have done.

IV. Future Meetings

Discussion

- Plan to meet in November and December, 4 hours each meeting. Look at 3rd Thursday. Committee members to be polled and future committee meetings set.
- Next meeting set outline / structure of work to be done.
- Each Board member to have a liaison to the Committees.

- Will circulate contact information to Committee members.
- All meeting materials will be posted to the website along with the digital sound recording of the meeting. Future meeting dates will be posted as soon as they are set.

V. Public Testimony

No guests present wished to provide testimony. At future Committee meetings, 20 – 30 minutes will be set aside for public testimony.

Meeting adjourned at approximately 4:45 p.m.

Submitted by:	**Reviewed by:**
Zarie Haverkate	Ilana Weinbaum
Communications Coordinator	Policy Analyst

EXHIBIT SUMMARY

1 – Agenda
2 – OHFB Committee Members List
3 – OHFB Organizational Documents
4 – OHPC Roadmap for Health Care Reform
5 – Oregon Business Council Policy Playbook
6 – Description of OHPR Programs
7 – Draft Charter
8 – Draft By-laws
9 – OHFB Design Principles & Assumptions
10– OHFB Timeline