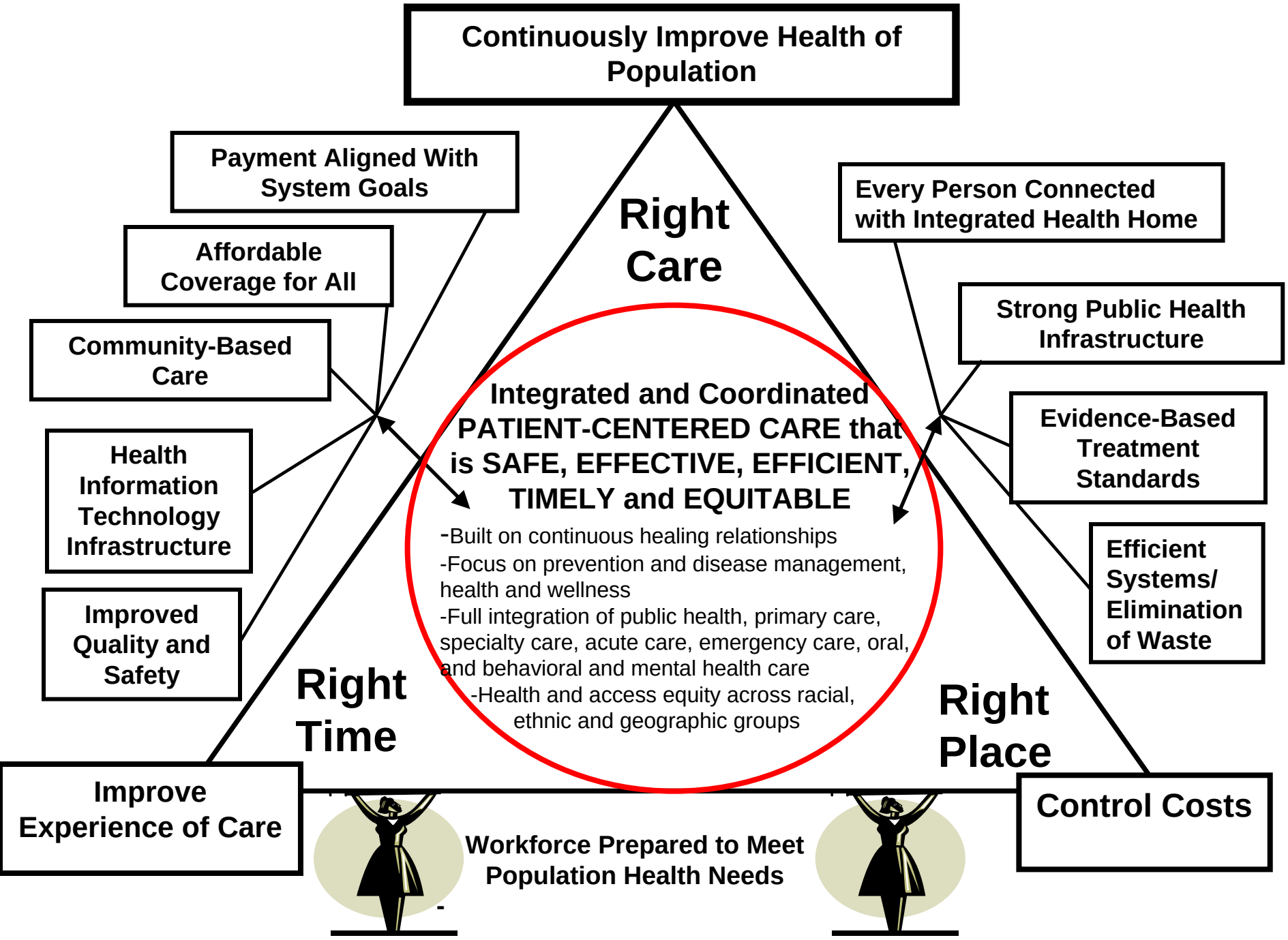
Integrated Health Homes

Oregon Health Fund Board

Delivery System Committee

Discussion 1/17/08


Continuously Improve Health of Population
Payment Aligned With System Goals
Affordable Coverage for All
Community-Based Care
Health Information Technology Infrastructure
Improved Quality and Safety
Improve Experience of Care
Right Care
Every Person Connected with Integrated Health Home
Strong Public Health Infrastructure
Evidence-Based Treatment Standards
Efficient Systems/ Elimination of Waste
Control Costs
Right Time
Right Place
Integrated and Coordinated PATIENT-CENTERED CARE that is SAFE, EFFECTIVE, EFFICIENT, TIMELY and EQUITABLE
-Built on continuous healing relationships
-Focus on prevention and disease management, health and wellness
-Full integration of public health, primary care, specialty care, acute care, emergency care, oral, and behavioral and mental health care
-Health and access equity across racial, ethnic and geographic groups
Workforce Prepared to Meet Population Health Needs

Central Goal of Delivery System Reform

Integrated and Coordinated
PATIENT-CENTERED CARE
that is SAFE, EFFECTIVE, EFFICIENT, TIMELY and EQUITABLE

-Built on continuous healing relationships
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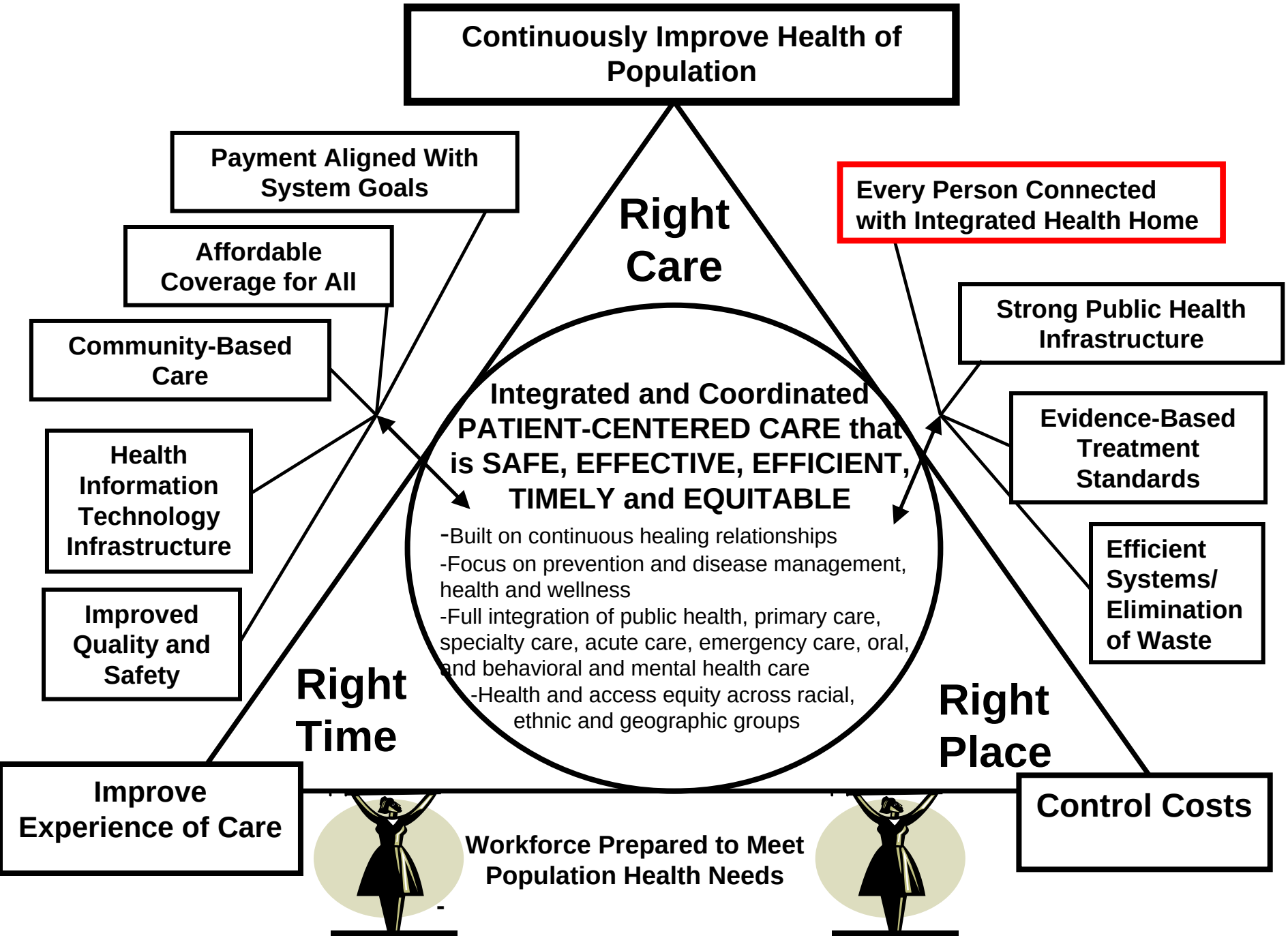
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Every Person Connected with Integrated Health Home

Characteristics: Longitudinal relationship with physician or other person trained to provide longitudinal health care services; team-based care; whole person orientation; coordinated and integrated care; engaged in continuous quality and safety improvement; enhanced access

How can we get there?

Recommendation 1: Common Definition

- Promote and support patient-centered integrated health homes to be available for all participants in the Oregon Health Fund Program and eventually widespread statewide adoption so available to all Oregonians.
- A common definition of integrated health home should be developed for Oregon that allows for innovation and encompasses a range of models.

Recommendation 1: Common Definition

- Option to consider: Endorse (with modifications) the definition of patient-centered medical home" developed by AAFP, AAP, ACP and AOA. Key aspects include:
  - Personal connection with practice
  - Team-based care
  - Whole person orientation
  - Coordinated and integrated care
  - Quality and safety improvement
  - Enhanced access

Recommendation 2: Designation and Measurement Processes

- Develop common process for designating practices across state as integrated health homes and develop (endorse) a set of common measures of integrated health home process and performance.

Recommendation 2: Designation and Measurement Processes

- The designation processes should be tiered to acknowledge various levels of progress toward evolution into full integrated health homes.
  - Option to consider: Build statewide recognition program based on NCQA PCC Patient-Centered Medical Home and/or PEBB Vision medical home criteria

Recommendation 2: Designation and Measurement Processes

- Common set of measures should build on national standards and current efforts to measure quality, cost, and efficiency in Oregon.
  - Include process and outcomes measures
  - Designed to measure longitudinal clinical outcomes for individuals as well as provider panels
  - Include measures of population health
- Measurement and designation process should be fluid and regularly updated.

Recommendation 3: Integrated Support Networks

- Create integrated networks (real and virtual) which connect integrated health homes with community, public health, behavioral health, oral health, and social services to improve population health.

Recommendation 4: Technical Assistance

- Provide Oregon's primary care workforce with technical assistance, resources, training and support needed to transform practices into integrated health homes.

Recommendation 4: Technical Assistance

- Options to consider:
  - Forums for demos and pilots to share best practices and challenges
  - Learning collaboratives
  - Funds for demonstration projects
  - Grants to practices to build infrastructure, registries, hire care managers, etc.
  - System improvement training and other technical assistance

Recommendation 5: Reimbursement Reform

- Develop reimbursement strategies that promote and sustain integrated health homes

Recommendation 5: Reimbursement Reform

Options to consider:

1) Initial pilots to encourage change and develop initial assessments of outcomes.
   - Option: Initial pilots projects that build on and coordinate current efforts

2) Consider implementing strategies directed at individual program participants tied to evaluation of effectiveness of such strategies.
   - Option: Incentives/rewards for program participants who enroll with integrated health home, get preventative services, manage chronic disease, etc.

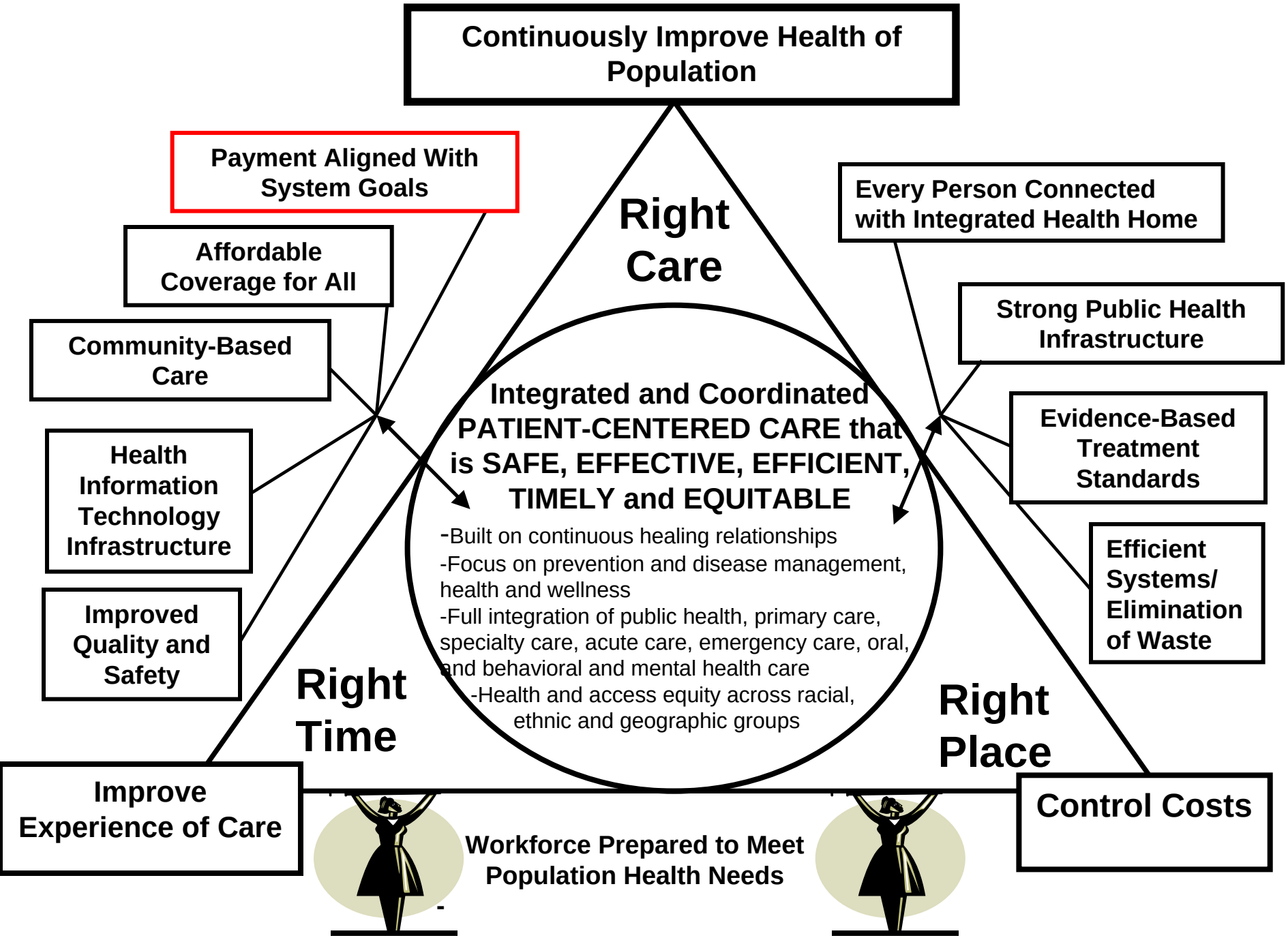
Recommendation 5: Reimbursement Reform

Options to consider (cont):

3) Develop long-term sustainable payment policies that appropriately compensate providers for developing capacity to provide integrated health home services and providing these services to Oregonians in a way that promotes quality and value.

Reimbursement Reform: Next Steps

- Committee will need to discuss specific reimbursement models targeted at promoting integrated health homes, as well as options that can be applied to primary care and across wider delivery system
  - Will most likely have to be mixed model including some fee for service and risk-adjusted bundled payments for integrated health home services
  - Payment tied to reporting requirements
  - Common auditing process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Criteria for Analyzing Alternative Reimbursement Reforms (1)

- Payment systems should enable and encourage providers to deliver accepted procedures of care to patients in a high-quality, efficient, and patient-centered manner.
- Payment systems should support and encourage investments, innovations, and other actions by providers that lead to improvements in efficiency, quality, and patient outcomes and or/reduced costs.

H. Miller, Creating Payment Systems to Accelerate Value-Driven Health Care: Issues and Options for Value-Based Healthcare Payment Systems, The Commonwealth Fund, September 2007.

Criteria for Analyzing Alternative Reimbursement Reforms (2)

- Payment systems should not encourage or reward overtreatment, use of unnecessarily expensive services, unnecessary hospitalization or re-hospitalization, provision of services with poor patient outcomes, inefficient service delivery, or encouraging choices about preference-sensitive services that are not compatible with patient desires.

H. Miller, Creating Payment Systems to Accelerate Value-Driven Health Care: Issues and Options for Value-Based Healthcare Payment Systems, The Commonwealth Fund, September 2007.

Criteria for Analyzing Alternative Reimbursement Reforms (3)

- Payment systems should not reward providers for undertreatment of patients or for the exclusion of patients with serious conditions or multiple risk factors.
- Payments systems should not reward provider errors or adverse events.

H. Miller, Creating Payment Systems to Accelerate Value-Driven Health Care: Issues and Options for Value-Based Healthcare Payment Systems, The Commonwealth Fund, September 2007.

Criteria for Analyzing Alternative Reimbursement Reforms (4)

- Payment systems should make providers responsible for quality and costs within their control, but not for quality or costs outside of their control.
- Payment systems should support and encourage coordination of care among multiple providers, and should discourage providers from shifting costs to other providers without explicit agreements to do so.

H. Miller, Creating Payment Systems to Accelerate Value-Driven Health Care: Issues and Options for Value-Based Healthcare Payment Systems, The Commonwealth Fund, September 2007.

Criteria for Analyzing Alternative Reimbursement Reforms (5)

- Payment systems should encourage patient choices that improve adherence to recommended care processes, improve outcomes, and reduce the costs of care.
- Payment systems should not reward short-term cost reductions at the expense of long-term cost reductions, and should not increase indirect costs in order to reduce direct costs.

H. Miller, Creating Payment Systems to Accelerate Value-Driven Health Care: Issues and Options for Value-Based Healthcare Payment Systems, The Commonwealth Fund, September 2007.

Criteria for Analyzing Alternative Reimbursement Reforms (6)

- Payment systems should not encourage providers to reduce costs for one payer by increasing costs for other payers, unless the changes bring payments more in line with costs for both payers.
- Payment systems should minimize the administrative costs for providers in complying with payment system requirements.
- Different payers should align their standards and methods of payment in order to avoid unnecessary differences in incentives for providers.

H. Miller, Creating Payment Systems to Accelerate Value-Driven Health Care: Issues and Options for Value-Based Healthcare Payment Systems, The Commonwealth Fund, September 2007.

How the Oregon Health Fund Board can improve the quality of care and slow the rate of cost growth

John McConnell, PhD
Oregon Health & Science University

Familiar problems…

- A complex, fragmented, & confusing system
- Very little coordination
- Very little or no incentive to limit care
- Inadequate data to assess cost-effectiveness (or even cost growth or utilization trends)
- Current innovations too incremental to really “bend the cost curve”?
  - Pay for performance?
  - Certificate of Need?
  - Encouraging patient decision aids?
  - Etc etc

A “bigger picture” approach

- Define Accountable Care Organizations
  - Elliot Fisher & Dartmoth Group have worked on these extensively
  - See e.g., Fisher et al. *Health Affairs* 2006.
- Use the ACO to report outcomes, utilization rates, and spending
- Three rationales:
  - Performance measurement
  - Local accountability
  - Payment reform

Defining the Accountable Care Organization: Empirical Observations

1. Almost all physicians work within or around a single hospital and can be directly affiliated with that hospital using claims data
2. Patients cared for by these empirically defined medical groups can be identified through claims
3. Most of the care for these patients is provided by the empirically defined medical group or a referral hospital and its staff that are readily identified

- Thus: these empirically defined hospital / medical staff groups (Accountable Care Organizations) provide care to relatively large and stable populations (providing statistical precision in both outcome and cost measures)

Defining the Accountable Care Organization: How to

- Step 1: Assign physicians to hospitals
- Step 2: Assign patients to hospitals

- The resulting “network” of physicians and patients assigned to a particular hospital may be treated as an ACO and provides a region for providing quality measurements (and perhaps rewards)
  - No formal contracting agreement binds the physicians or patients assigned to an ACO.

Now you've defined your ACO(s)

- What does that get you?
- First, let's look at performance measurements
- It could get you this…

	ACO #1	ACO #13
Number of beneficiaries	50,000	60,000
Quality of ambulatory care		
Colorectal cancer screening	12.0%	15.0%
Diabetic eye exams	41.0%	44.2%
Hospital utilization and outcomes (per 1000 beneficiaries)		
Emergency department visits	800	700
Short-stay hospital discharges	400	307
Acute care institutional days	5	4
In-hospital mortality, CABG	0.02	0.01
MRI scans	54	27
Measures of coordination		
Concentration of medical staff at primary hospital	60.7%	84.3%
Different physicians seen (average)	5.1	4.3
Spending per beneficiary		
Physician services	$3000	$2200
Acute care hospital	$2600	$2200
Total	$5600	$4400

ACO Rationale #1: performance measurement

- Opportunities for comparing outcomes among high intensity sites vs. low intensity sites
  - Not just outcomes among individuals undergoing a selected procedure
- Measures spending per beneficiary
  - Not just hospital prices
- Measures and promotes coordination between physicians, clinics, and hospitals
  - Not just silos
- New set of aggregated data to improve the ability to do technological assessments *and* outcomes assessments

ACO Rationale #2: local accountability

- We know that cost growth is a major challenge to health reform
- Local decisions (MRI purchases, ICU wings, high-tech devices) are a first step in the chain to more-intensive practice patterns and the overuse of services
- ACO-level measures of quality and costs would bring the impact of such decisions to light
- The effects of expansions of acute care facilities or recruitment of additional specialists would be more easily identified
  - The good and the bad
  - Not just a vague pass-through that is built into future premiums

ACO Rationale #3: linking ACOs and reimbursement

- Lots of ways to do this – a future consideration
- Reward ACO providers who achieve quality targets while reducing the growth of *overall* costs?
- Oregonians: “We think costs should grow at 6% per year, not the current 8%”
  - That’s the target
  - Give providers a bonus (e.g. 80% of savings) if they come in lower (4% growth)

Putting these together…

- ACOs are relatively easy to define
  - Does not mean abandoning or changing any reform options for covering the uninsured
  - Does not require new contractual agreements with physicians or hospitals
  - Does not need to be conducted on a statewide basis
    - E.g., could be piloted in selected regions in Oregon
- ACOs & performance measurement:
  - Broad, diverse set of measures possible (public health, too!)
  - Captures the entire continuum of care
  - Allows for assessment of investment of expensive & high intensity treatments
- ACO & local accountability
  - "Virtual home" - encourages coordination of care
  - Could foster the use of care management protocols
- ACOs & payment reform
  - Opens up possibilities of reforming the payment system
  - Providers could be given incentives to control total spending
  - Generate savings to the state/employers/individuals
  - Could be designed to have smaller relative impact on provider revenues
  - Deterrent to the "Medical Arms Race"

What are the potential savings?

- What's at stake?
- Assume that we spend this much in 2009 (rough numbers):
  - State spending (OHP) :$1B
  - Employer spending: $6B
  - Individual spending: $3B
  - ----------
  - Total: $10B

How does $10B grow? 8% vs. 6%

Year	Spending (8%)	Spending (6%)	Savings
2009	$10B	$10B	**$0**
2011	$11.6B	$11.2B	**$0.4B**
2013	$13.6B	$12.6B	**$1.0B**
2015	$15.9B	$14.2B	**$1.7B**
2017	$18.5	$15.9B	**$2.6B**
2019	$21.6	$17.9B	**$3.7B**

Other experiences

- Medicare Physician Group Practice Demonstration
  - Early results: some groups able to achieve higher quality and slower expenditure growth (currently contingent on performance payments)
- Vermont – under way?

Challenges?

- Current market/reimbursement system
  - Rewards the use of expensive, high intensity services
  - ACO is not a panacea
- Cultural challenges
  - Providers may resist accepting a degree of responsibility for the care of all of the patients within their ACO
- Legal obstacles to physician-hospital collaboration
  - Especially with regard to sharing potential financial gains/rewards
- Concentration of care in Portland?
  - Many physicians admit to multiple hospitals

Hospital	Concentration of care: Percent of all Evaluation and Management billing to assigned physicians in designated ACO
Willamette Falls	67%
Emanuel	51%
Providence Milwaukee	64%
OHSU	57%
Adventist	67%
Good Sam	61%
Providence Portland	73%
St. Vincent's	70%
Meridian Park	69%
AVERAGE	64%

Rest of state ranges between 54% (Providence Medford) and 88% (Merle West)

How do we get there?

- Step 1: Define ACOs using Medicare, Commercial, and/or OHP claims data
  - Dartmouth group has already done this!
  - ACOs can be flexible;
    - if empirical definition does not work, physicians can suggest/create their own ACOs
    - ACO could include 2 or 3 hospitals
- Step 2: Use what we have started…
  - OHPR: Hospital Quality/Outcomes
    - Uses hospital discharge data
  - OHPR: Hospital Pricing
    - Uses commercial insurance claims
  - QualityCorporation: Ambulatory Quality/Outcomes
    - Uses commercial & Medicaid insurance claims
- …but provide public performance at the ACO level
- Step 3: Encourage/incentivize controlling long-term cost growth

Exploring this model

- Builds on (and coordinates!) ongoing attempts to provide more public reporting
- Provides a framework for the State and Health Fund Board to align incentives and encourage desirable behaviors
  - E.g., encourage providers to focus on “planning” instead of “expansion”
- Aligned with models currently under consideration
  - Compatible with Medical Home model
  - Compatible with Medicare’s Physician Group Practice Demonstration
  - Compatible with recent MEDPAC report on pay-for-episode reimbursements
- Opportunities to learn from:
  - Medicare demonstrations
  - Vermont proposal
  - Dartmouth group

Thank you…

…and questions?

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Presentation to the Delivery Systems Committee of the Oregon Health Fund Board

Oregon Association of Hospitals and Health Systems – Representing Oregon's Community Hospitals

Presented by Kevin Earls
Oregon Association of Hospitals & Health Systems
March 13, 2008

Objectives

- **Identify ways to modify the delivery system to:**
  - **Improve access**
  - **Contain costs**
  - **Improve quality and outcomes**

Overview

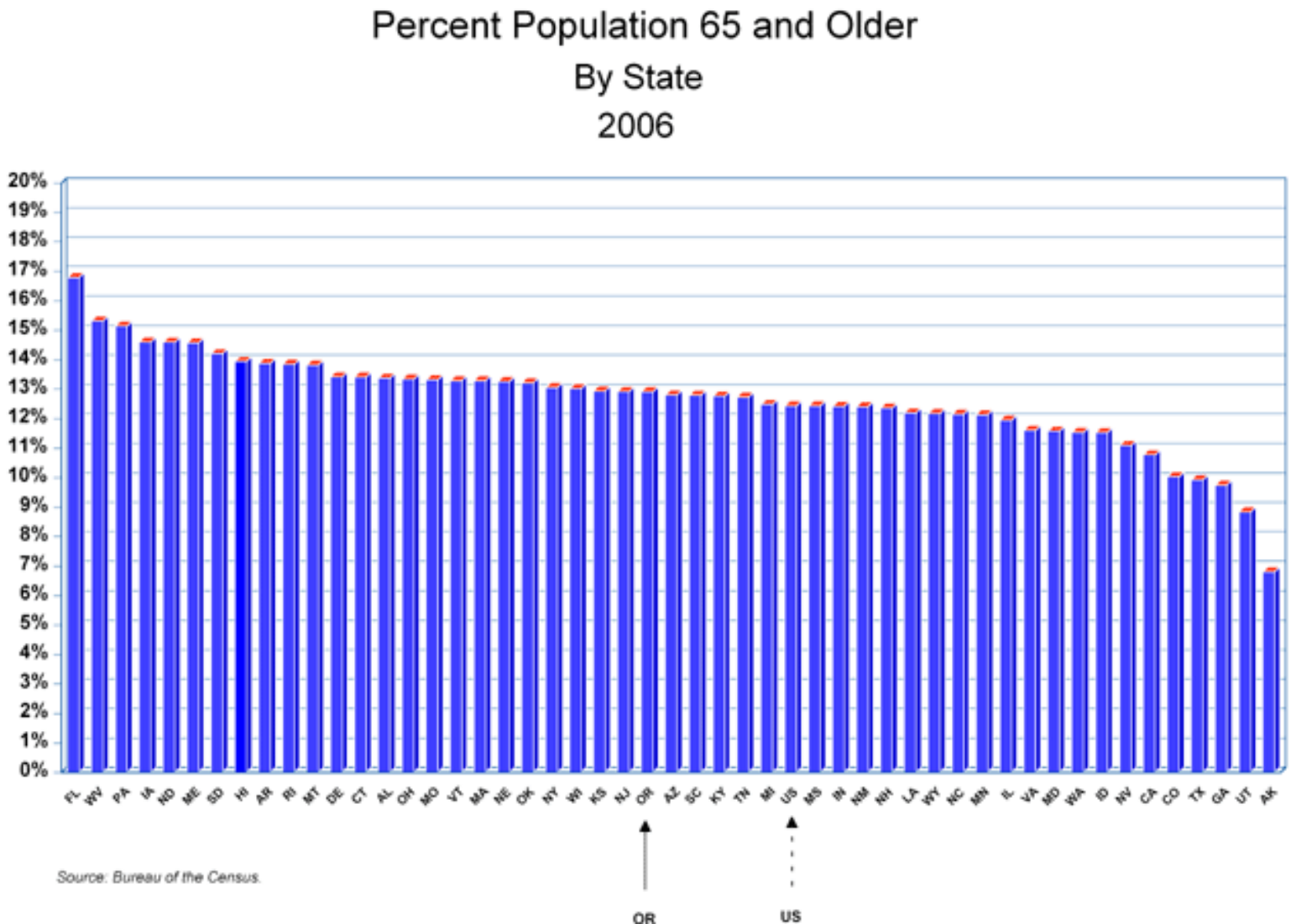
- Context Setting

- Where we think we can help
- Where we think you can help
- What we think won’t help

Oregon's Hospitals

- **57 community acute care hospitals**
  - **32 Type A/B hospitals**
    - 25 are Critical Access Hospitals (25 or fewer beds)
    - 7 are small and rural (26-50 beds)
  - **25 Larger hospitals (DRG)**
- **Ownership**
  - **55 are not-for-profit**
    - 15 are local government hospitals
  - **2 are for-profit**

Oregonians are Older Than National Average...

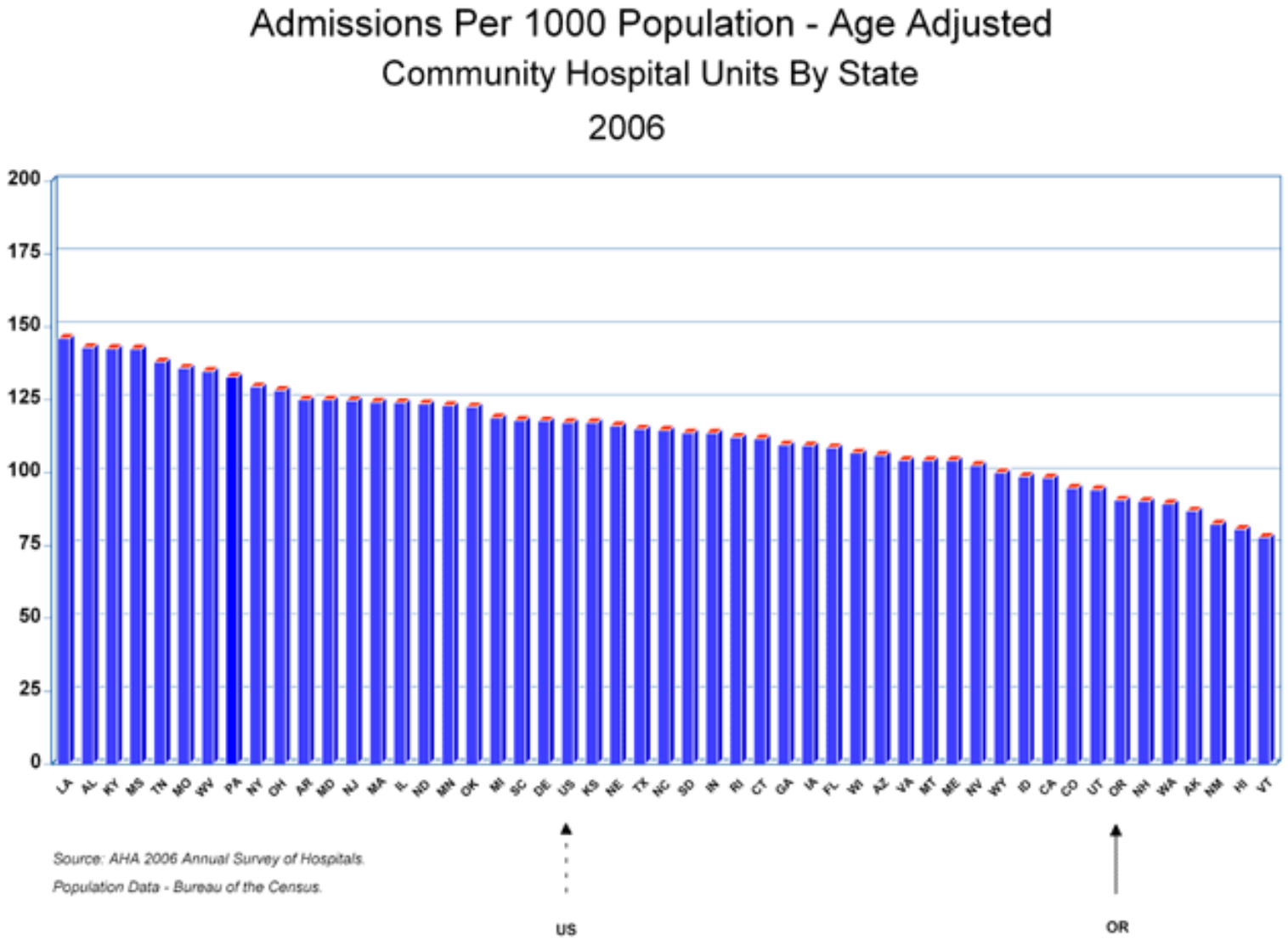


Efficiency Metrics:

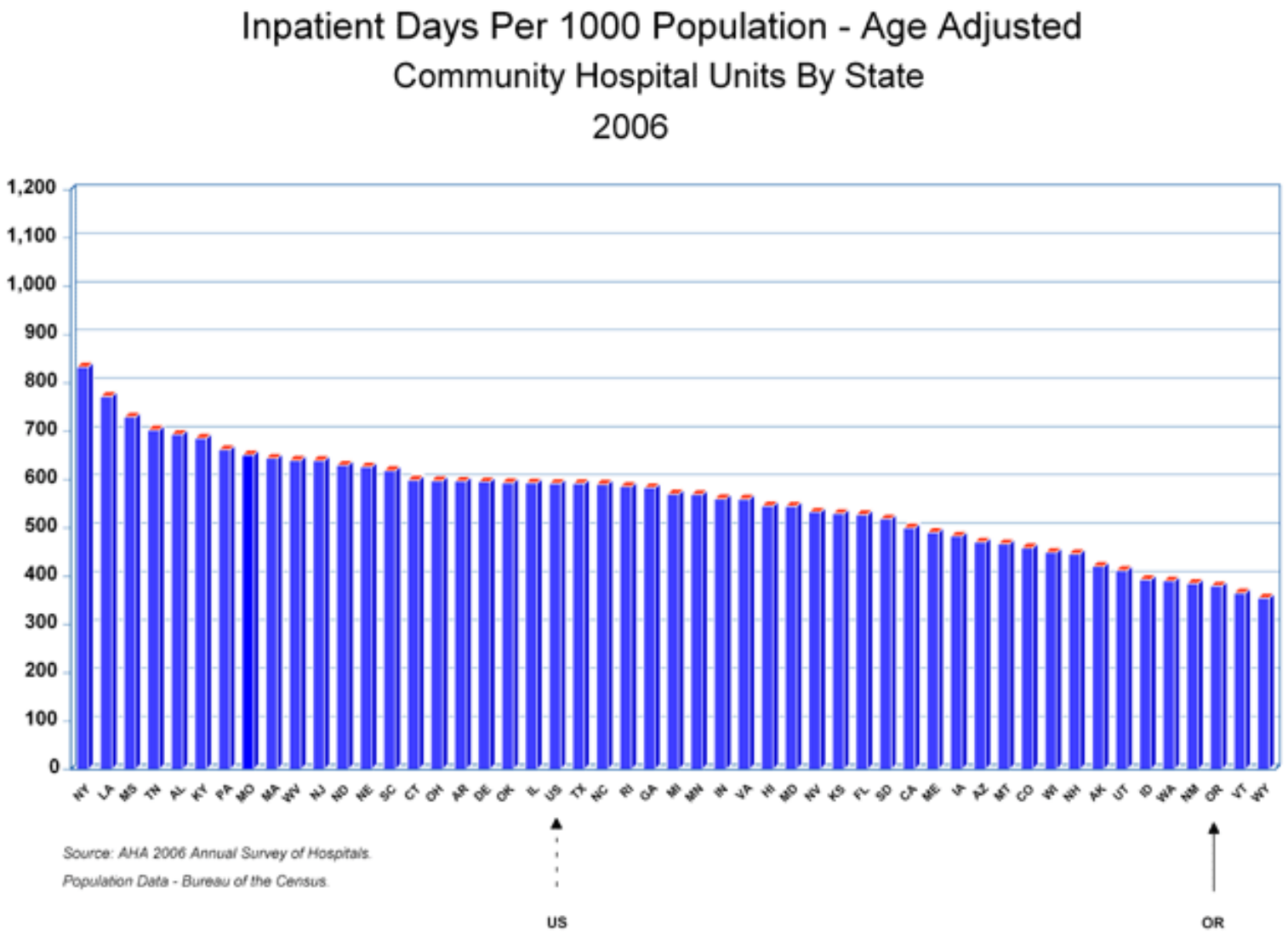
Criteria	Oregon's Rank*
Admissions per 1,000 – Age Adjusted	7th lowest
Inpatient Days per 1,000 – Age Adjusted	3rd lowest
Average Length of Stay	3rd lowest
Beds Per 1,000	3rd lowest
Expenses per Capita - Age Adjusted	16th lowest
Medicare Discharges per 1,000 Population	3rd lowest
Medicare Days per 1,000 Population	2nd lowest
Medicare Length of Stay	2nd lowest
Medicare Billings per Capita	3rd lowest
Medicare Receipts per Capita	5th lowest

2006 AHA Annual Survey of Hospitals

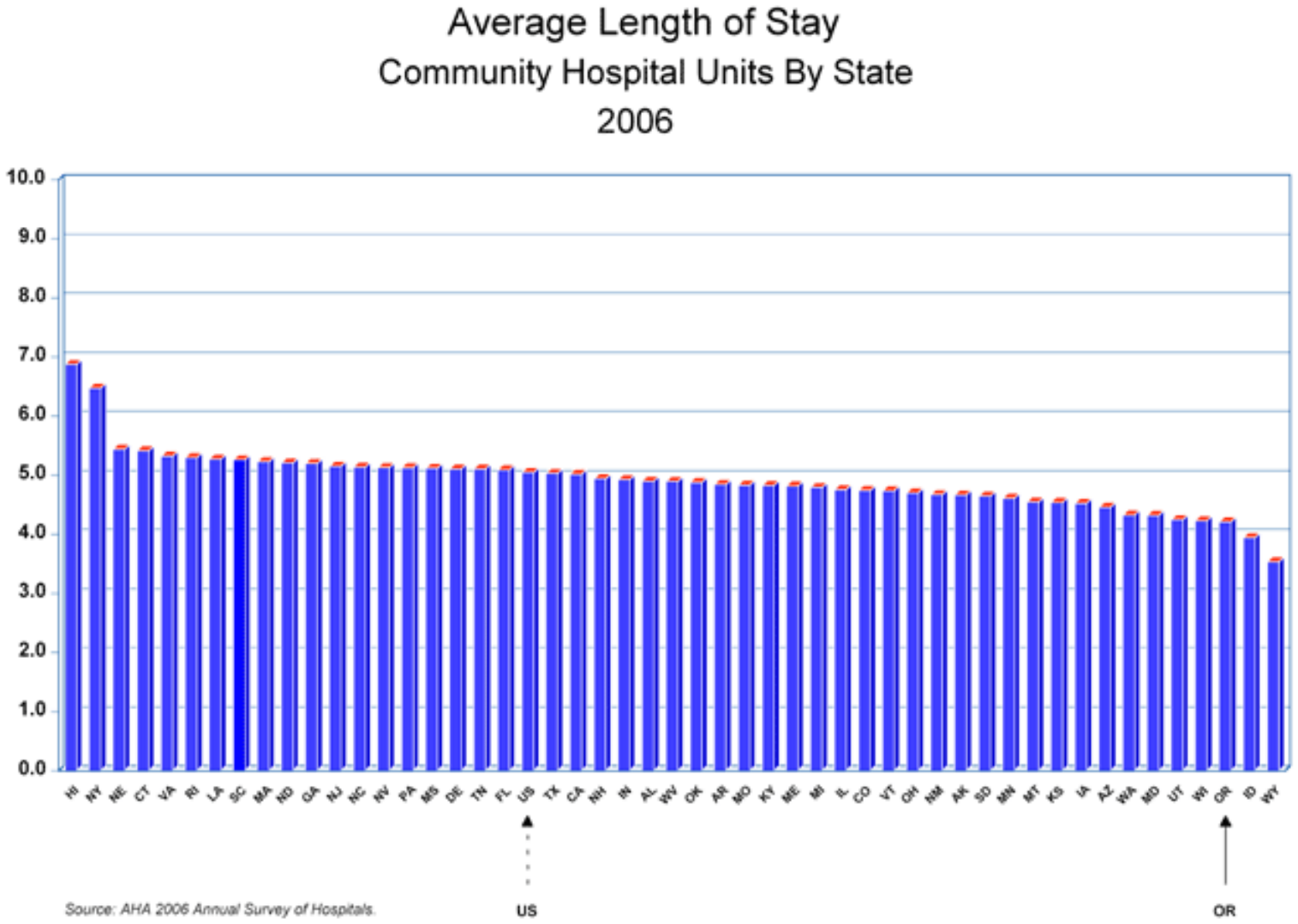
Oregon Admits Less Frequently…



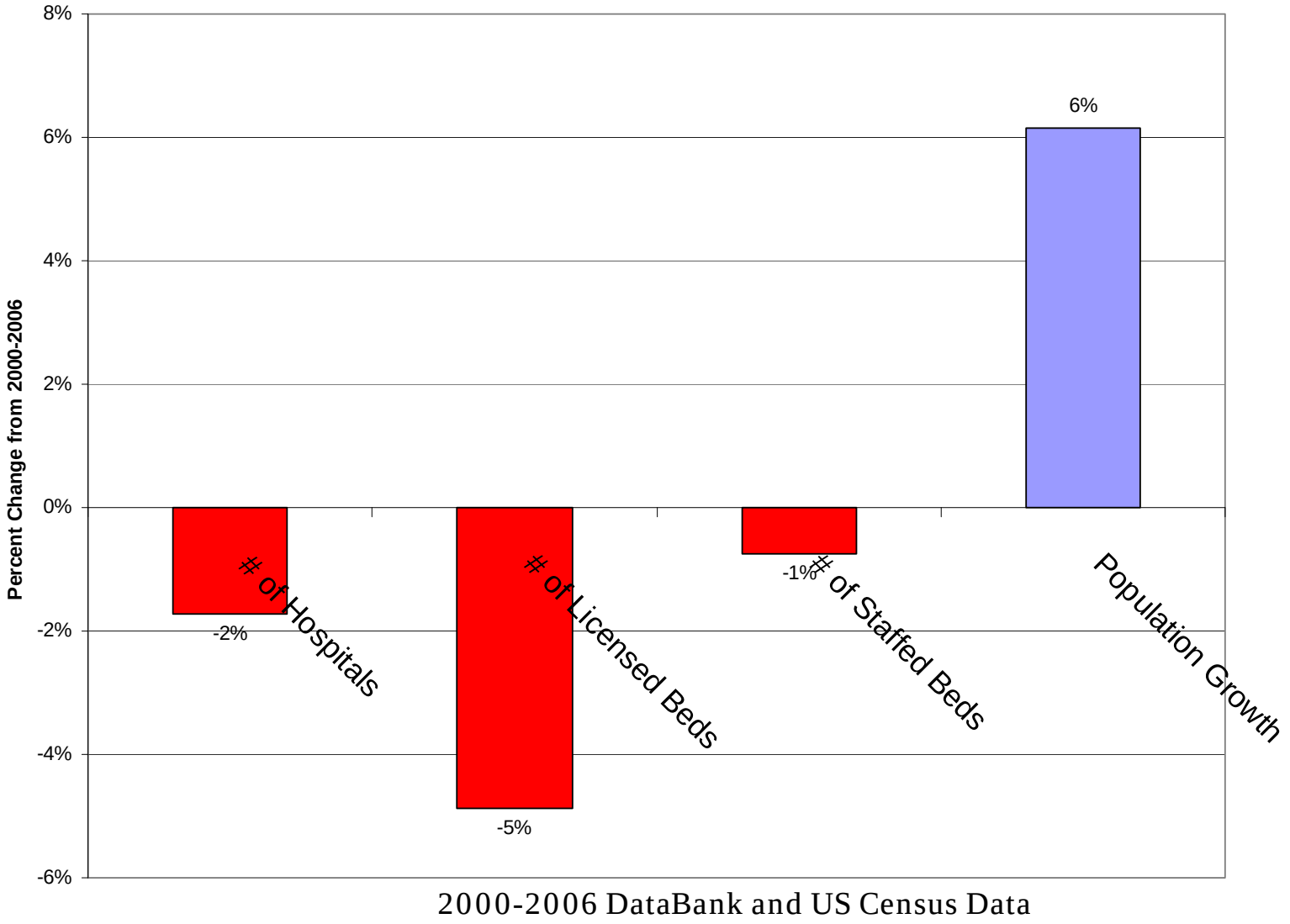
Oregon Treats More Efficiently…



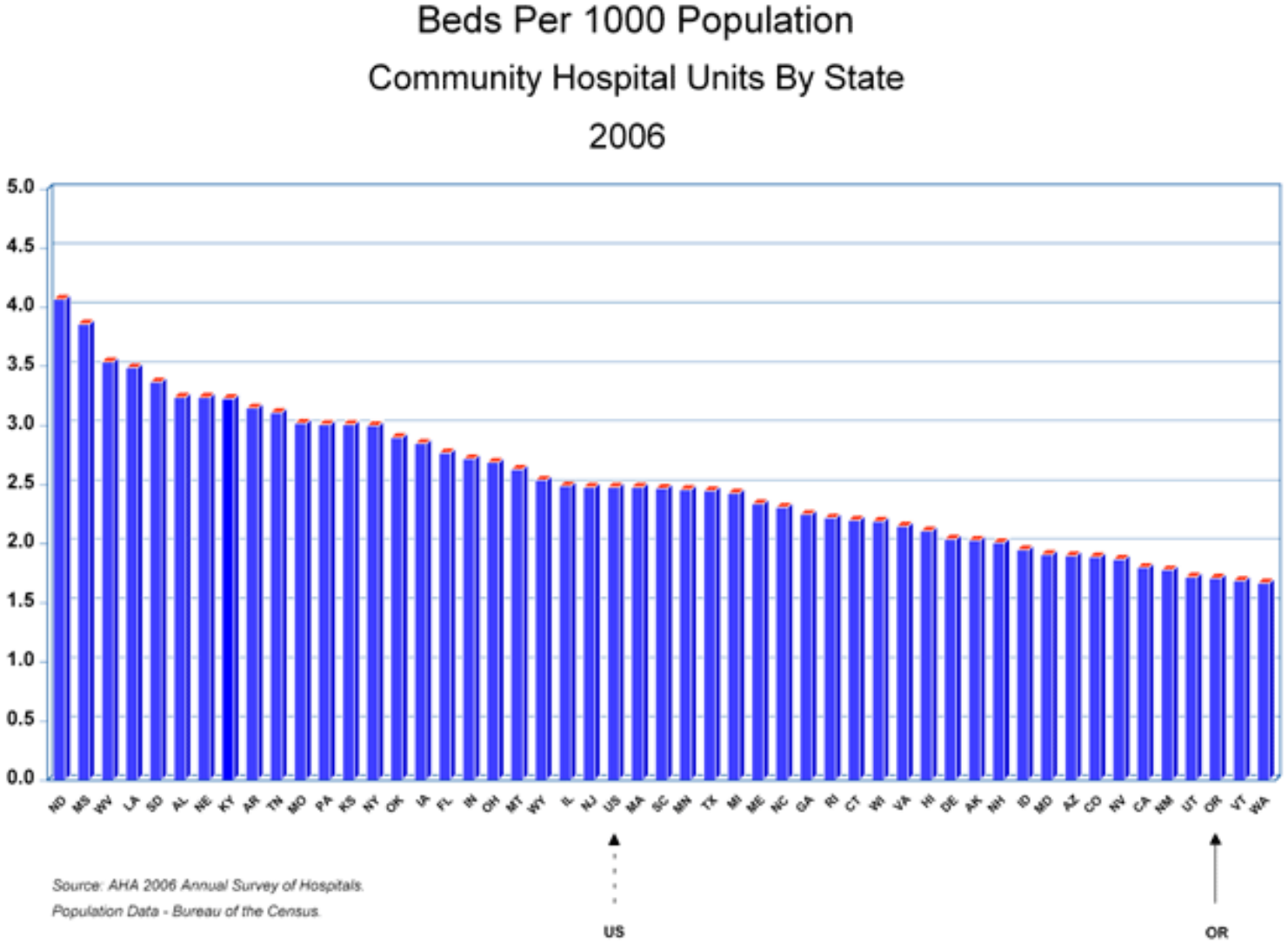
…Oregon has shorter patient stays



2000-06: Population vs. Hospital Capacity…



We've reduced excess hospital capacity…



Where we think we can help…

- Clarifying and standardizing policies and practices
  - Financial assistance policies
  - Community Benefits reporting
  - Quality reporting
  - Patient Safety – Medical errors
  - Non-payment for serious adverse events

Where we think we can help…

- **Administrative Simplification**
  - **OAHHS convening Summit**
  - **Involving physicians, hospitals, plans**
  - **Focus on the business office processes**
  - **Create efficiencies to drive more of the health care dollar to patient care**

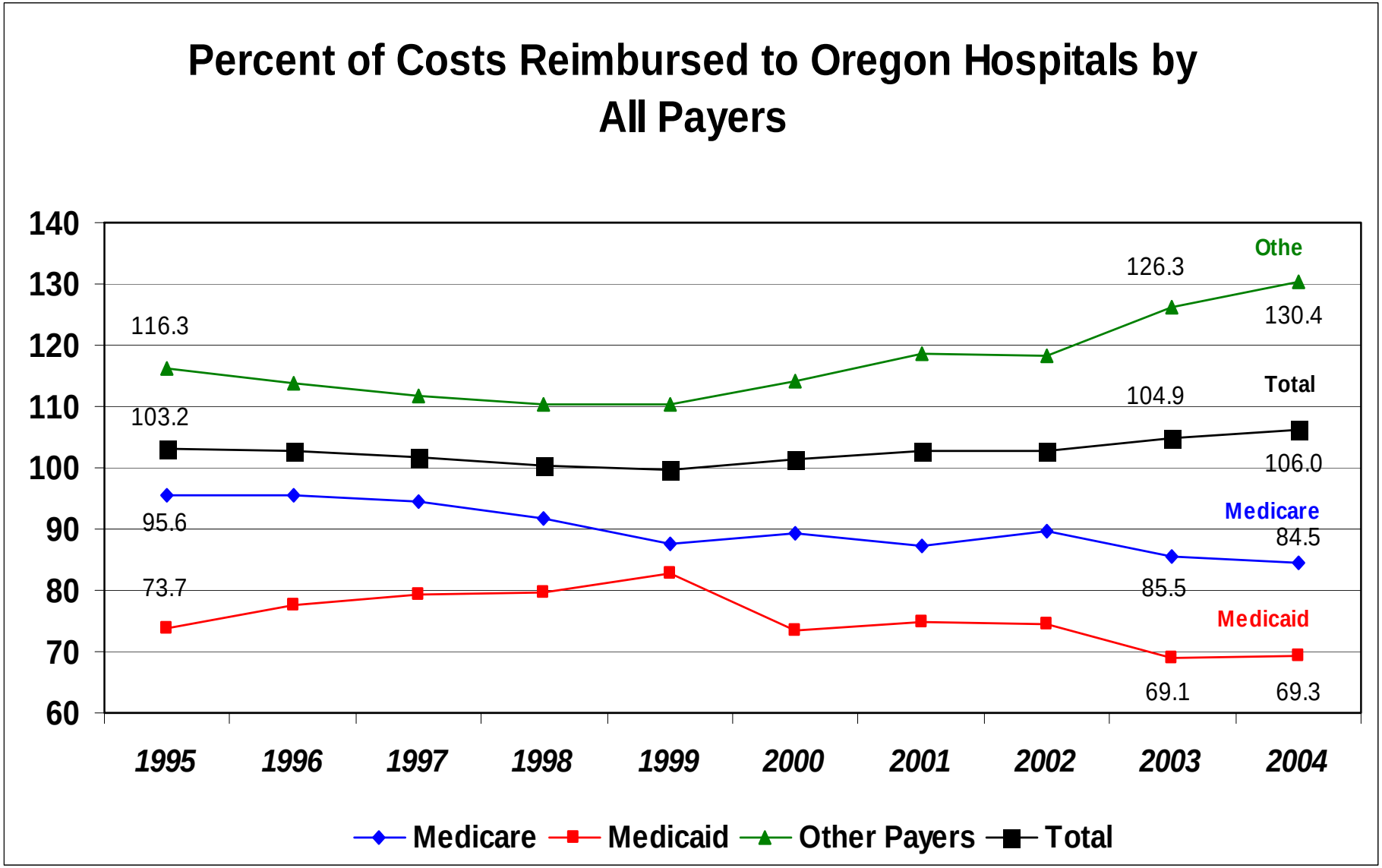
Where we think we can help…

- **Working with physicians on utilization**
  - **Aligning hospitals and physician incentives will continue to be important**

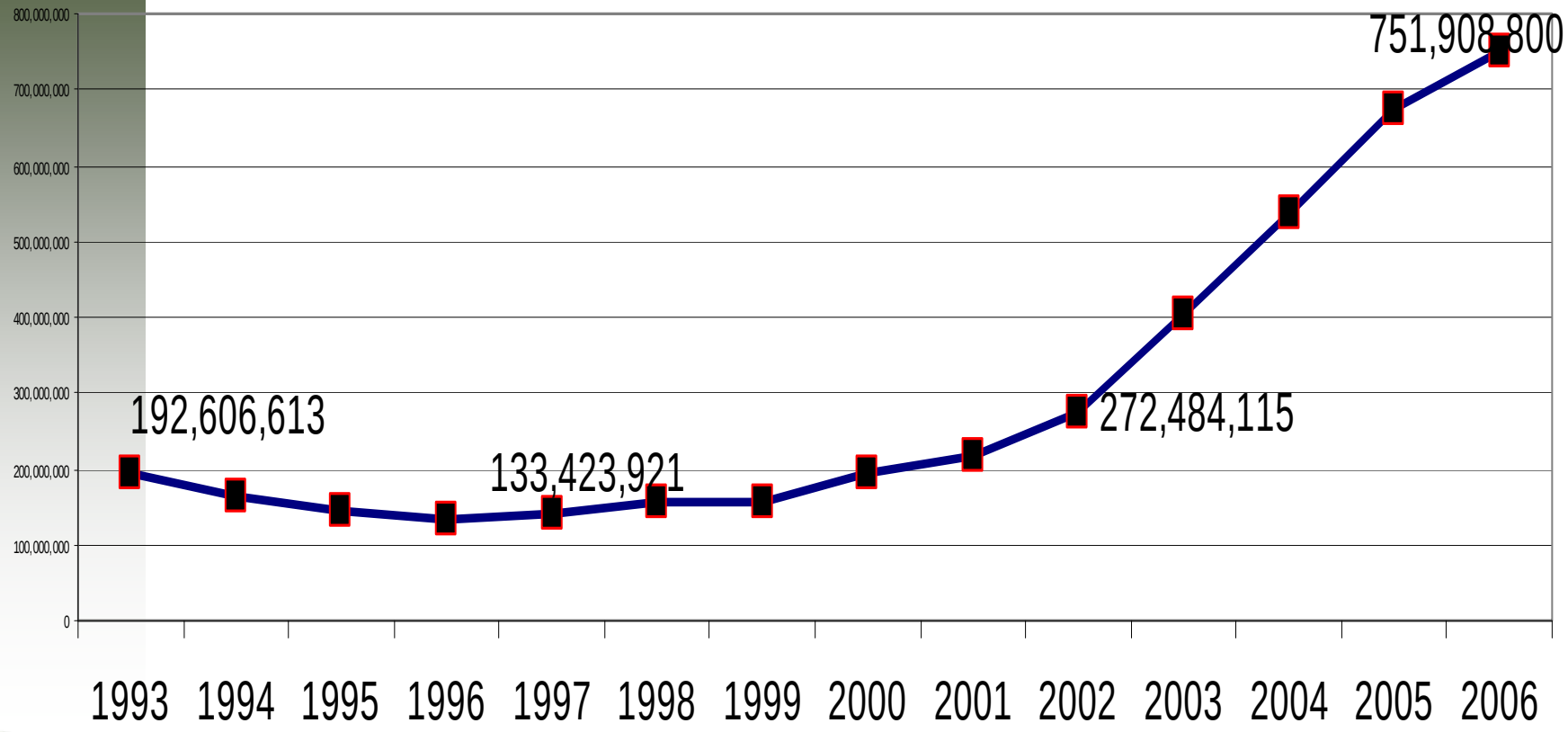
Where We Think You Can Help:

- **Reduce barriers to insurance**
  - **Explicit funding of sponsored care**
  - **Cost-shifting is caused by:**
    - Uninsured
    - Payment below costs

Impact of Chronic Underpayment



Oregon's Uncompensated Care



Where We Think You Can Help:

- Address workforce shortage
- Improve incentives for primary care
- Improve funding for public health
  - Role of public health vs. insurance

What We Think Won't Help

- CON and Regional Health Regulation
- Rate Setting
- Revenue Confiscation

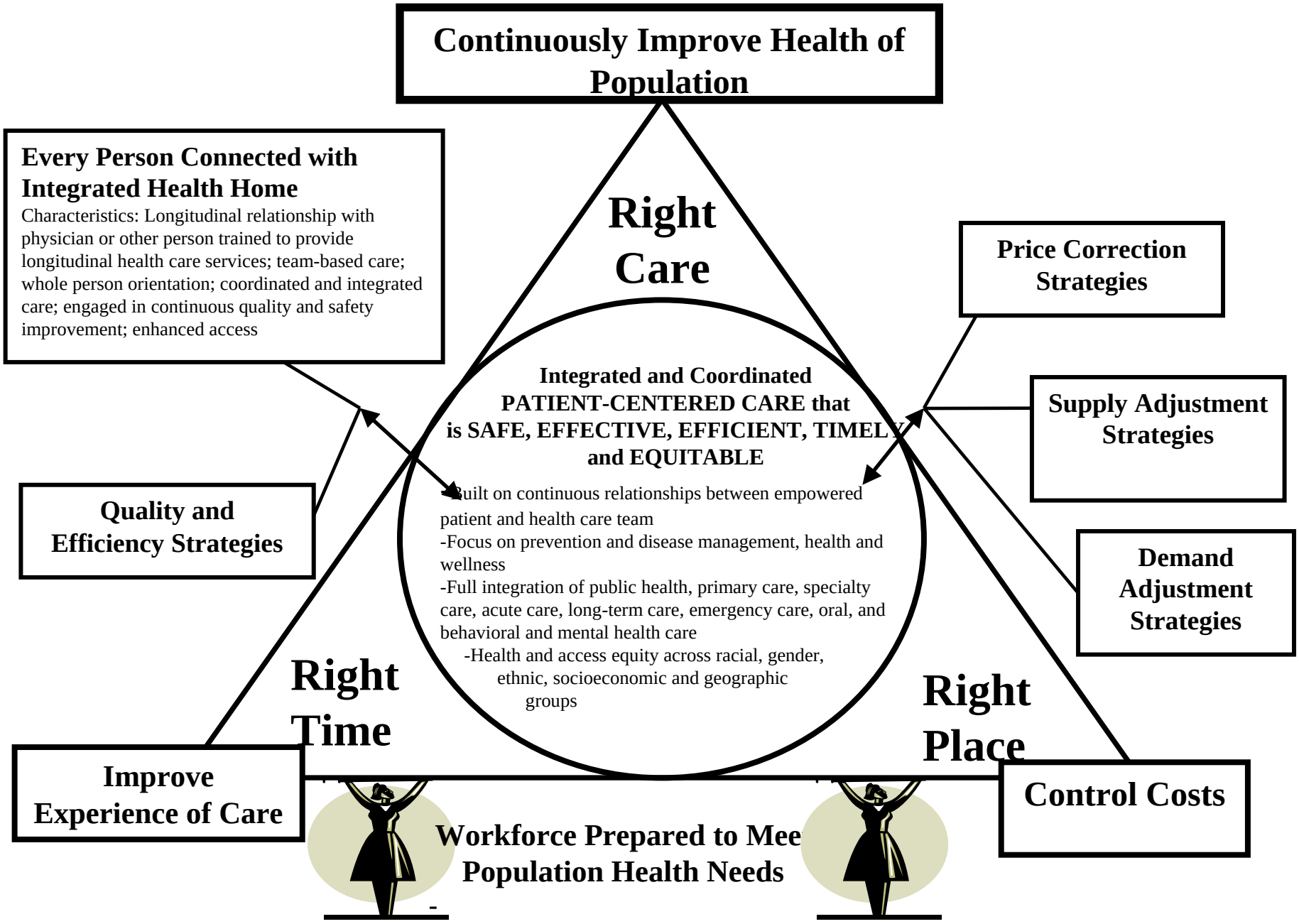
Next Up:

- Cost drivers
- Hospital margins
- Competition in the marketplace

Oregon Health Fund Board Delivery Systems Committee

Cost Containment Strategies

Committee Discussion – 2/21/08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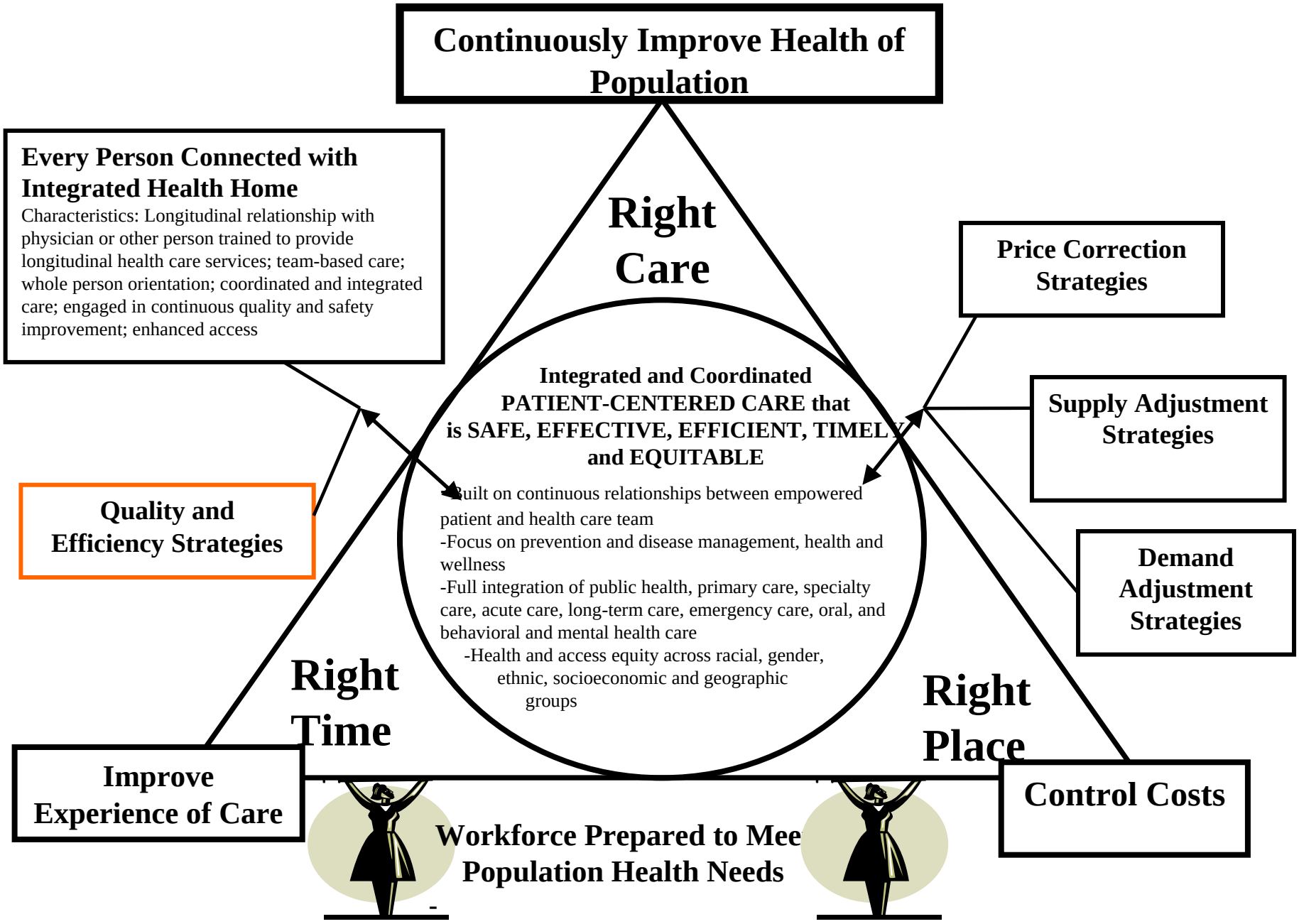
Goals of Cost Containment

- Improve Quality and Efficiency of Care Provided Across Oregon
- Correct Health Care Price Signals
- Adjust Demand for Care By Encouraging Healthy Behaviors and Informed Decision-Making
- Adjust Supply of Care Through Incentives to Encourage Provision of Effective and Efficient Care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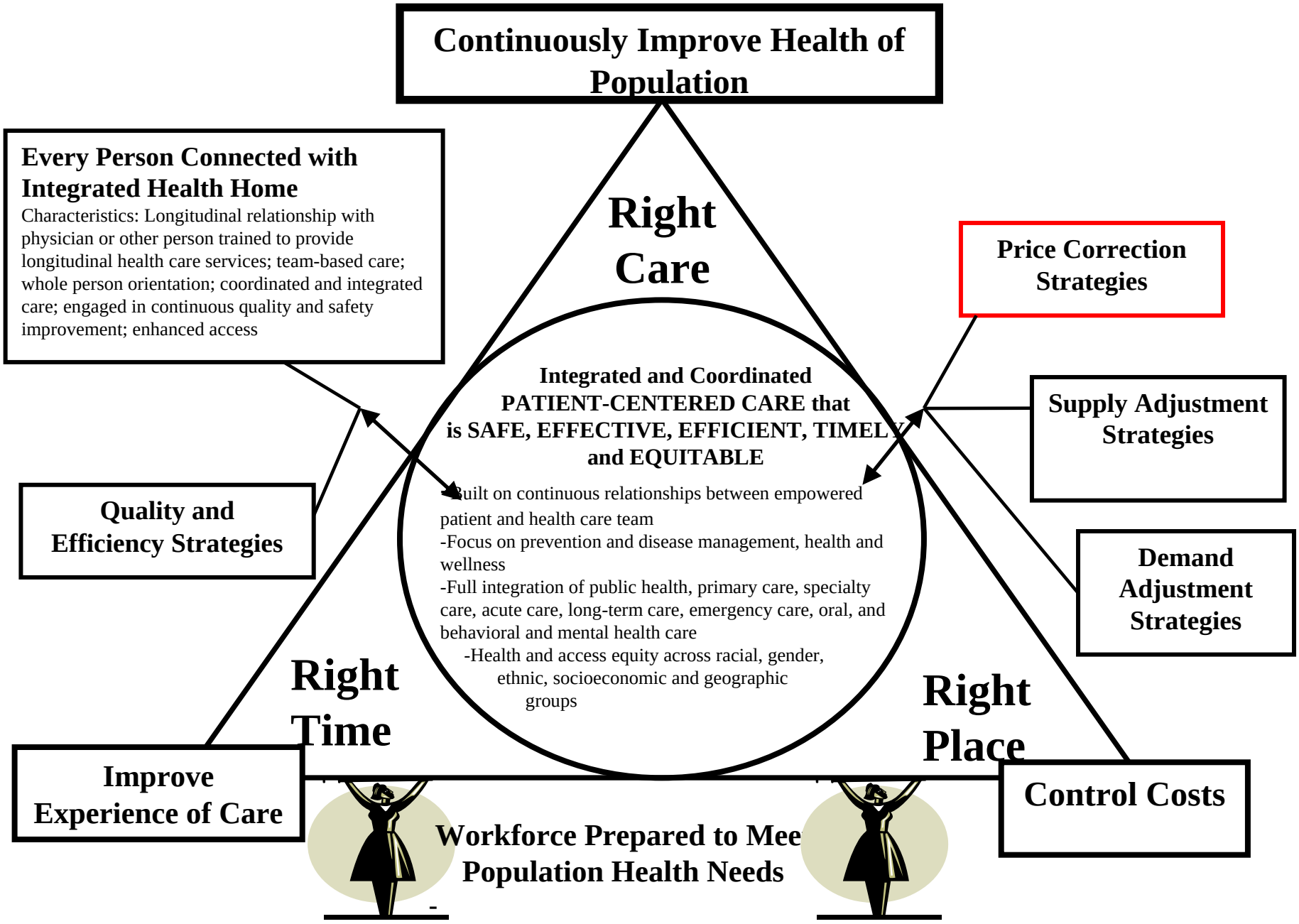
Improve Quality and Efficiency of Care Provided Across Oregon

- Pay for Quality
  - Competitive contracting/value-based purchasing for all publicly purchased health care
  - No billing for National Quality Forum “never events”

Improve Quality and Efficiency of Care Provided Across Oregon

- Improved Quality and Transparency
  - Recommendations from QI to be received 3/08
- Health Information Technology
  - Recommendations to come from HIIAC


Continuously Improve Health of Population
Every Person Connected with Integrated Health Home
Characteristics: Longitudinal relationship with physician or other person trained to provide longitudinal health care services; team-based care; whole person orientation; coordinated and integrated care; engaged in continuous quality and safety improvement; enhanced access
Right Care
Price Correction Strategies
Integrated and Coordinated PATIENT-CENTERED CARE that is SAFE, EFFECTIVE, EFFICIENT, TIMELY and EQUITABLE
-Built on continuous relationships between empowered patient and health care team
-Focus on prevention and disease management, health and wellness
-Full integration of public health, primary care, specialty care, acute care, long-term care, emergency care, oral, and behavioral and mental health care
-Health and access equity across racial, gender, ethnic, socioeconomic and geographic groups
Supply Adjustment Strategies
Quality and Efficiency Strategies
Demand Adjustment Strategies
Right Time
Right Place
Improve Experience of Care
Control Costs
Workforce Prepared to Mee
Population Health Needs

Correct Health Care Price Signals

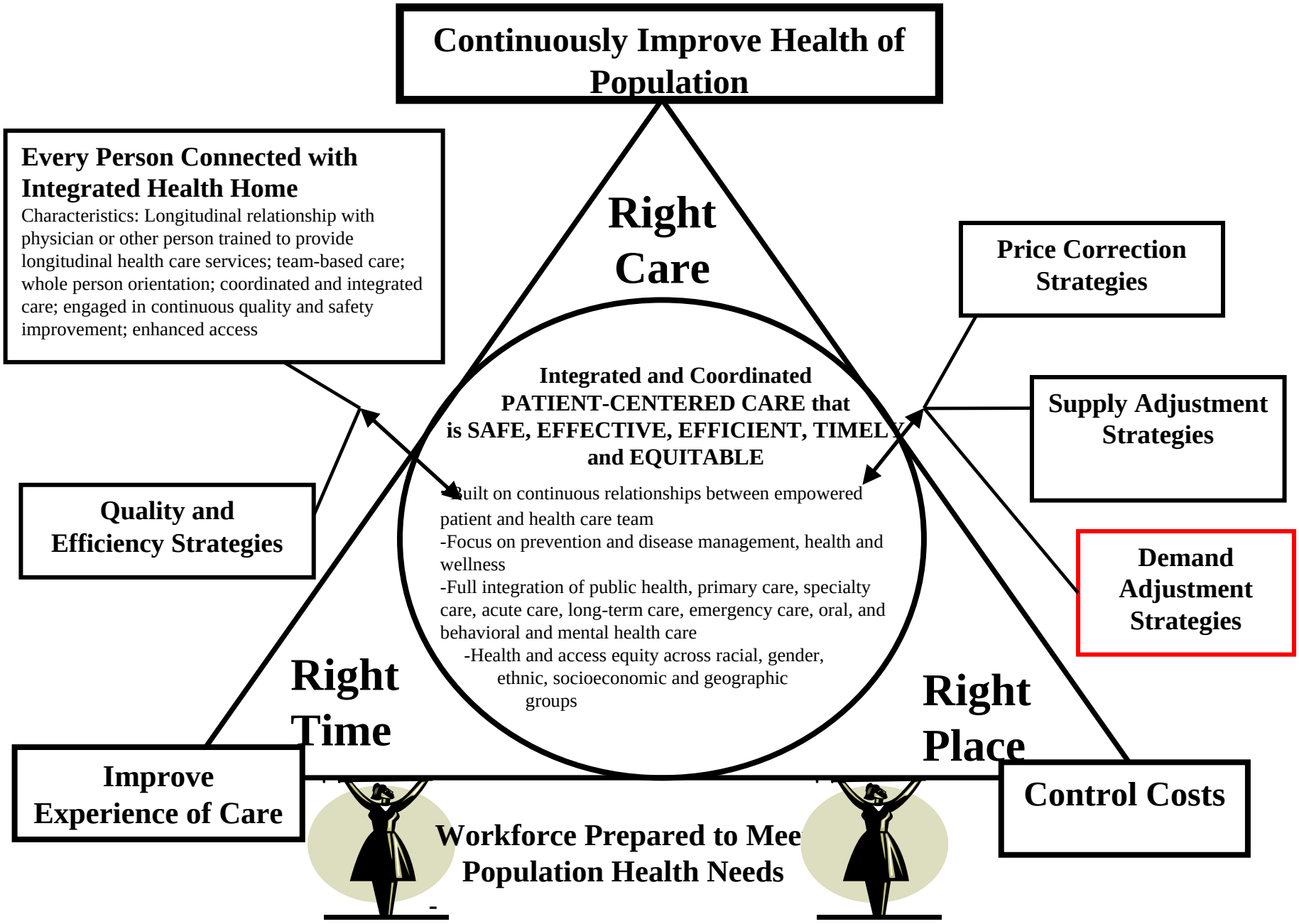
- Uniform Payer Rates
  - Uniform payer rates for hospitals and/or all providers based on % Medicare rates
- Reduce Administrative Spending
  - Encourage all payers to adopt common forms and procedures for enrollment and billing, matching Medicare requirements as close as possible

Correct Health Care Price Signals

- Health Plan Regulation
  - Set minimum loss rations
  - Cap administrative costs and profits/net income of insurance providers
  - Add investment income and insurer profits as key factors to be reported and considered in rate approval process
  - Increase transparency by defining insurance rate filings as public records open to public scrutiny
  - Expand scope of insurance rate review to larger groups

Correct Health Care Price Signals

- Hospital Regulation
  - Limit profits/net income of hospitals
- Reduce Pharmaceutical Spending
  - Negotiated drug prices for all OHFP participants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Population Health Needs

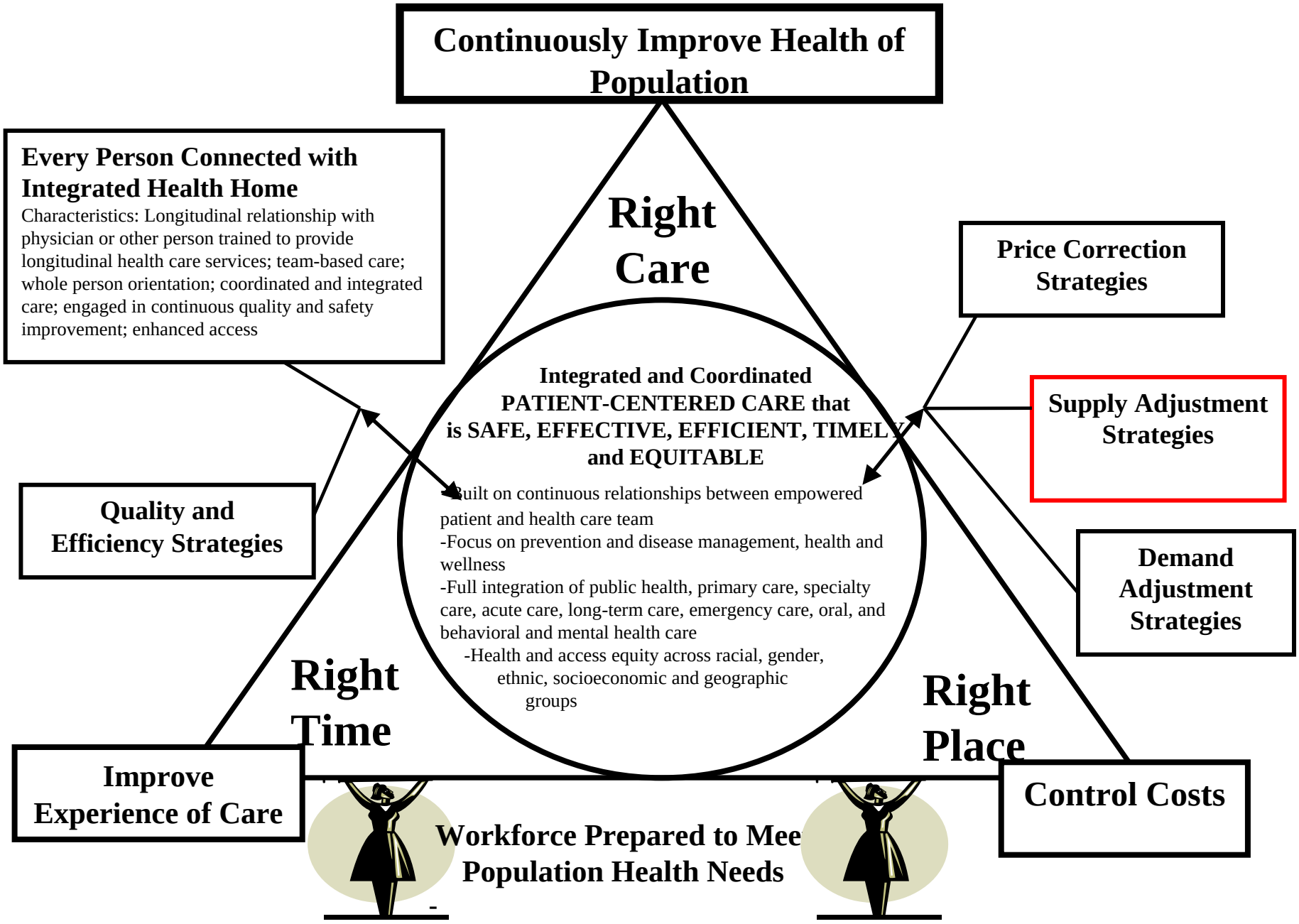
Adjust Demand for Care

- Public Health Strategies
  - Fund public health activities with evidence of positive outcomes
- Health Plan Design
  - Support plan design that encourages healthy behaviors, prevention and disease management
  - Explore no/reduced copays for preventative services
  - Increased cost-sharing for treatment options found to be inconsistent with clinical guidelines

Adjust Demand for Care

- Creating Culture of Health
  - Encourage employers, schools and community organizations to build a culture of health and encourage activities that reduce absenteeism, decrease disability rates and increase productivity
  - Build culture of health for state employees

- Shared Decision Making
  - Encourage use of patient decision aids before having certain preference sensitive procedures where have shown to increase use of cost-effective interventions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Population Health Needs

Adjust Supply of Care

- Targeted Capital Investment
  - Redesign certificate of need or establish alternative program to effectively control costs, reduce duplicative services and encourage investments in primary care
  - Creation of centers of excellence programs
  - Pilot regional health planning organizations

Adjust Supply of Care

- Comparative Effectiveness/Medical Technology Assessment
  - Create collaboration around evaluation of new devises, drugs, procedures and other treatments for comparative effectiveness
  - Develop and/or endorse clinical guidelines for OHFP providers and widespread statewide adoption
  - Require OHFP plans to design benefits from evidence of added value of treatments and procedures and consistently update using new information
  - Pilot projects that require private and public purchasers and health plans to collaborate around joint policies regarding coverage of new technologies and procedures

Adjust Supply of Care

- Provider Payment Strategies Focused on Integrated Health Homes
  - Bundled per member per month prospective payments for providing integrated health home services (risk adjusted)
  - Capitated payment to integrated health homes to provide all primary care and disease management services (tied to clinical guidelines, risk-adjusted)
  - Pay for Process – reward providers for providing integrated health home services
  - Pay for Performance – reward providers for better health outcomes, higher quality and more efficient use of resources

Adjust Supply of Care

- Provider Payment Strategies Focused on Integrated Health Homes
  - Bundled payments based on episodes of care or portion of episodes of care
  - Condition specific capitation
  - Performance payments for practices able to meet quality goals
- Hospital Payments
  - Hospital pay for performance with bonus payments based on top performance, absolute performance and/or performance improvement

How the Oregon Health Fund Board can improve the quality of care and slow the rate of cost growth

John McConnell, PhD
Oregon Health & Science University

Familiar problems…

- A complex, fragmented, & confusing system
- Very little coordination
- Very little or no incentive to limit care
- Inadequate data to do cost-effectiveness analyses
- Current innovations too incremental to really “bend the cost curve”
  - Pay for performance
  - Certificate of Need
  - Minimum loss ratios
  - Encouraging patient decision aids
  - Etc etc

A “bigger picture” approach

- Define Accountable Care Organizations
  - See Fisher et al., Health Affairs 2006
- Use the ACO to report outcomes, utilization rates, and spending
- Two rationales:
  - Performance measurement
  - Local accountability

Defining the Accountable Care Organization: Empirical Observations

1. Almost all physicians work within or around a single hospital and can be directly affiliated with that hospital using claims data
2. Patients cared for by these empirically defined medical groups can be identified through claims
3. Most of the care for these patients is provided by the empirically defined medical group or a referral hospital and its staff that are readily identified

- Thus: these empirically defined hospital / medical staff groups (Accountable Care Organizations) provide care to relatively large and stable populations (providing statistical precision in both outcome and cost measures)

Defining the Accountable Care Organization: How to

- Step 1: Assign physicians to hospitals
- Step 2: Assign patients to hospitals

- The resulting “network” of physicians and patients assigned to a particular hospital may be treated as an ACO and provides a region for providing quality measurements (and perhaps rewards)
  - No formal contracting agreement binds the physicians or patients assigned to an ACO.

Now you've defined your ACO(s)

- What does that get you?
- First, let's look at performance measurements
- It could get you this…

	ACO #1	ACO #13
Number of beneficiaries	50,000	60,000
Quality of ambulatory care		
Colorectal cancer screening	12.0%	15.0%
Diabetic eye exams	41.0%	44.2%
Hospital utilization and outcomes (per 1000 beneficiaries)		
Emergency department visits	800	700
Short-stay hospital discharges	400	307
Acute care institutional days	5	4
In-hospital mortality, CABG	0.02	0.01
Technical quality of care (using post-discharge surveys)	87	94
Measures of coordination		
Concentration of medical staff at primary hospital	60.7%	84.3%
Concentration of medical staff at primary and secondary hospital	81.3%	94.2%
Different physicians seen (average)	5.1	4.3
Spending per beneficiary		
Physician services	$3000	$2200
Acute care hospital	$2600	$2200
Total	$5600	$4400

ACO Rationale #1: performance measurement

- Opportunities for comparing outcomes among high intensity sites vs. low intensity sites
  - Not just outcomes among individuals undergoing a selected procedure
- Measures spending per beneficiary
  - not just hospital prices
- Measures and promotes coordination between physicians, clinics, and hospitals
  - Not just silos
- New set of aggregated data to improve the ability to do technological assessments *and* outcomes assessments

ACO Rationale #2: local accountability

- We know that cost growth is a major challenge to health reform
- Local decisions that influence capacity (capital investments, recruitment, and physicians' choices about practice location), are a first step in the chain to more-intensive practice patterns and the overuse of supply-sensitive services
- Comprehensive measures of longitudinal quality and costs at the ACO level would bring the impact of such decisions to light
- Hospitals that recruited additional specialists or expanded their acute care facilities could expect to see those decisions reflected in their longitudinal performance measures
- Local accountability could be tied to cost growth rates – e.g., reward ACO providers who achieve quality targets while reducing the growth of *overall* costs.

How do we get there?

- Step 1: Define ACOs using Medicare, Commercial, and/or OHP claims data
  - Dartmouth group has already done this!
- Step 2: Use what we have started…
  - OHPR: Hospital Quality/Outcomes
    - Uses hospital discharge data
  - OHPR: Hospital Pricing
    - Uses commercial insurance claims
  - QualityCorporation: Ambulatory Quality/Outcomes
    - Uses commercial & Medicaid insurance claims
- …but provide public performance at the ACO level
- Step 3: Incentivize to control long-term cost growth

Exploring this model

- Builds on (and coordinates!) ongoing attempts to provide more public reporting
  - A defined role for the Quality Institute
- Is compatible with Medicare's Physician Group Practice Demonstration
- Does not mean abandoning or changing any reform options for covering the uninsured
- Does not require new contractual agreements with physicians or hospitals
- Does not need to be conducted on a statewide basis
  - E.g., could be piloted in selected regions in Oregon
- Can be structured as "tax-saving" or cost-saving
  - E.g. Finance Quality Institute with an initial endowment of $XX million with a charter:
  - if they can generate more than $XX million in cost-savings within 10 years, then they will get a more permanent charter

Thank you…

…and questions?

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Investing in Oregon's Health Care Safety Net

Opportunities and Challenges

Safety Net Advisory Council (SNAC)

Staff support – Office of Health Systems Planning (HSP) Office of Health Policy and Research (OHPR)

Members of the Safety Net Advisory Council

Priscilla Lewis, Co-chair – Providence Health Systems
Craig Hostetler, Co-chair – Oregon Primary Care Association
Bill Thorndike – Medford Fabrication
Jackie Rose – Oregon School-based Health Care Network
Tom Fronk – Benton County Health Department
Vanetta Abdellatif – Multnomah County Health Department
Scott Ekblad – Office of Rural Health
Abby Sears – Our Community Health Information Network (OCHIN)
Ron Maurer – State Representative
Beryl Fletcher – Oregon Dental Association
Jim Thompson – Oregon Pharmacy Association
Tracy Gratto – Coalition of Community Health Clinics
Steve Kliewer – Wallowa Valley Center for Health and Wellness
Matt Carlson – Portland State University

SNAC's CHARGE

- *The Safety Net Advisory Council (SNAC) provides the Governor, the Director of DHS, the OHPR Administrator, the Oregon Health Fund Board, the Oregon Health Policy Commission (OHPC) and the Medicaid Advisory Committee (MAC) with specific policy recommendations for the provision of safety net services for vulnerable populations who experience barriers to accessing care.*

What is the Health Care Safety Net?

"The health care safety net is a key delivery system element for the protection of the health of Oregonians and the delivery of community-based care."

Enrolled Senate Bill 329 – 74th Oregon Legislative Assembly – 2007 Regular Session

Patients the Safety Net Serves

- Populations Experiencing Significant Barriers to Accessing Care

(financial barriers only one of many)

- Cultural
- Language
- Transportation
- Geographic
- Homeless
- Higher prevalence of mental illness
- Substance abuse, including meth addicts
- Cognitive impairment/ memory problems
- Decreased functional status
- Health literacy barriers
- Socially isolated
- Financial

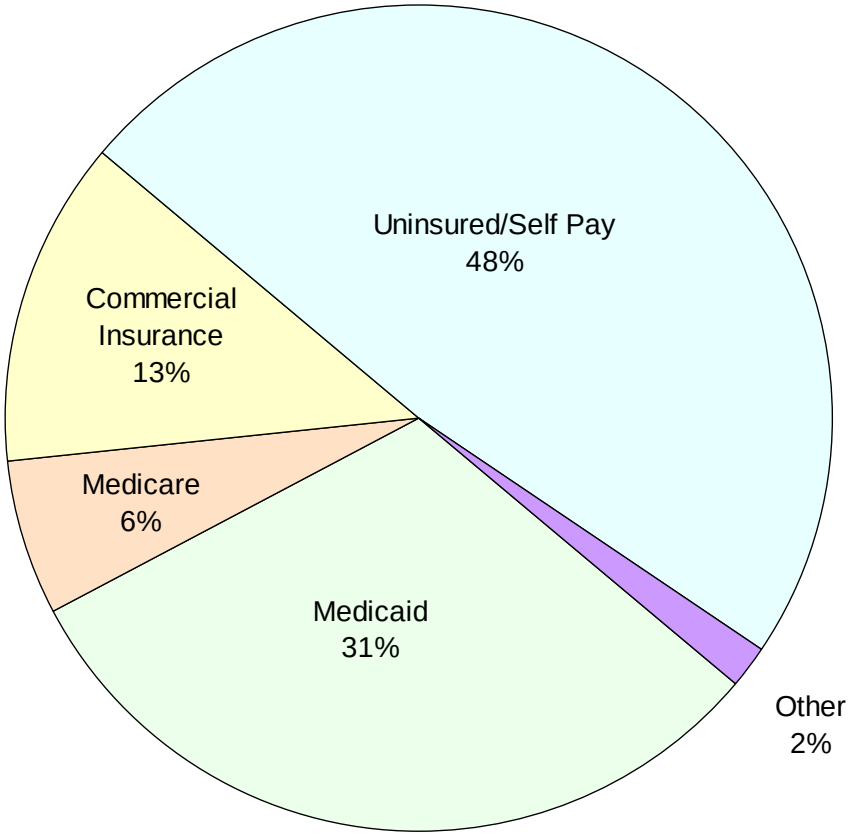
A community's response

- Federally Qualified Health Centers – or Community Health Centers
- School-based Health Centers
- Isolated Rural Health Facilities
- Community Sponsored Clinics
- Hospital Emergency Departments
- Local Health Departments
- Tribal Health Clinics

Safety Net Clinics

- **School-based Health Centers** - currently 45 centers in 19 counties
- **Isolated Rural Health Facilities** – currently 17 facilities in 14 counties
- **Federally Qualified Health Centers** - 26 centers with over 150 sites located in 27 counties
- **Community Sponsored Clinics** - (approximate) 14 clinics in 6 counties
- **Tribal Health Clinics** – 10 Clinics in 9 counties

Percent of Patients by Insurance status – (All safety net clinics – SNAC core data)



Numbers of Patients by Insurance Status (All Safety Net Clinics, SNAC core data)

- Medicaid – 83,957
- Medicare – 16,772
- Commercial Insurance – 34,890
- Uninsured/Self Pay – 130,988
- Other – 4,301

- **Total – 270,908**

Types of Services Offered

Type of Services and Intensity Varies Across Safety Net

- Primary and acute care
- Urgent and emergent care
- Mental and behavioral health
- Dental health
- Chronic Care Management
- Interpretation services
- Care Coordination/delivery system navigation
- Referrals to other supportive services
- Transportation

What we don't (but NEED) to know

- Data gaps across the safety net
- We know more about some sectors of the safety net than others*.
- Areas of Need:
  - Hospital ED patient visits for safety net patients statewide
  - Better data on where workforce gaps are, particularly for midlevel providers and ancillary staff
  - Uniform measures, where appropriate, across the system
- A more detailed data set forthcoming and SNAC will continue to work on data gaps

*OCHIN has a sub-set of FQHC's with robust data. A demonstrable benefit of Health Information Technology

Safety Net Advisory Council's Recommendations

- STABLE FUNDING
- CRITICAL INFRASTRUCTURE/ TOOLS
- WORKFORCE

Essential Building Blocks

- There is currently no public fund or financing mechanism to support the safety net. An Investment Fund would support community investment, expand safety net impact and help to assure its strength and viability
- Oregon and the nation are moving toward greater readiness to implement Health Information Technology to improve access, quality, safety and efficiency. The safety net has a role to play but needs assistance with broad-based adoption
- Safety net providers and rural providers in particular, struggle with recruitment, retention and distribution of the health care workforce. Creative and flexible strategies are necessary to fill these gaps.

Recommendations

STABLE FUNDING…

Establish the Safety Net Integrity Fund

- Assist clinics in financial trouble
- Assist with strategic investments to maintain infrastructure
- Invest in new site development or expansion
- Link funds to technical assistance to address specific organizational issues/challenges
- Fund expansions of RX assistance programs
- Fund dental and behavioral service expansion

Critical Investment

"Grow" an investment fund over a 3-year period sustained at $ 3 million per year.

Options for Funding:

- Legislative appropriation
- Public Bond
- Public-Private partnerships
- "Clinic Adoption" model

Recommendations

INFRASTRUCTURE/TOOLS

Support Electronic Health Record Adoption across the Safety Net

- Provide systematic approach to EHR adoption across the safety net
- Assist with capital-intensive start up and ongoing maintenance and technical assistance costs.
- Provide better patient and treatment information. Improve the safety, quality and efficiency of care

Critical Investment

Options for Funding:

- Safety Net EHR Investment Fund – legislative appropriation
- State and Federal Partnership – leveraging Medicaid and Medicare $
- Oregon Style "Utility"- modeled after utility services framework

Recommendations

WORKFORCE

Implement innovative approaches to meet safety net workforce needs

- Rural Locum Tenens Program
- Flexible community health workforce options
- Oregon Health Service Corps (Loan Repayment)
- Updated Tax Credits
- Provide an increased pipeline of midlevel providers to rural communities

Critical Investment

- **Rural Locum Tenens –** fees, grant funding, legislative appropriation
- **Oregon Health Service Corps –** legislative appropriation
- **Updated Tax credits –** Legislative appropriation
- **Increase Pipeline for Midlevel practitioners –** legislative appropriation, public-private cost-sharing
- **Flexible Workforce Approaches –** Legislative appropriation to fund grant program

An essential piece of the delivery system

- Access for Oregon's most vulnerable patients - providing primary care for a disproportionate number of low-income, chronically ill, racially and culturally diverse Oregonians; many of whom experience homelessness, language barriers, mental illness, geographic isolation and lack of health insurance.
- Laboratories for innovation – especially adept at meeting the needs of complex patients and developing creative and culturally attuned approaches to providing comprehensive and integrated care.
- Essential to primary care capacity – The rest of the health care system could not absorb these patients if the safety net disappeared

Public Health & Health Care Reform

Presentation to the Oregon Health Fund Board's Committee on Delivery Systems

February 21, 2008

Grant Higginson, MD, MPH
Interim State Public Health Officer
Oregon Public Health Division
Department of Human Services

Integration of PH into Reform

- Opportunities:
  - Ensuring balance between clinical care and non-clinical services that promote health
    - Supporting sustainable population-based services
  - Improving effectiveness of clinical care by incorporating evidence-based PH concepts

- Why is it important?
  - Health status improvement = Goal of reform
  - Cost savings

Cost-effective population-based services

- Physical activity
  - Fitness program (Browne); B/C = 2.45
  - Promotion centers (Golaszewski); B/C = 3.23
- Sexually transmitted disease prevention
  - Screening and contact follow-up (Chesson); $5.0 billion in US savings 1990-2003
- School-based health centers
  - Comprehensive services (Guo); Hospitalization costs decreased 85% (~ $1000 per child)

(Select examples only – More data to come)

Health status improvements from population-based services

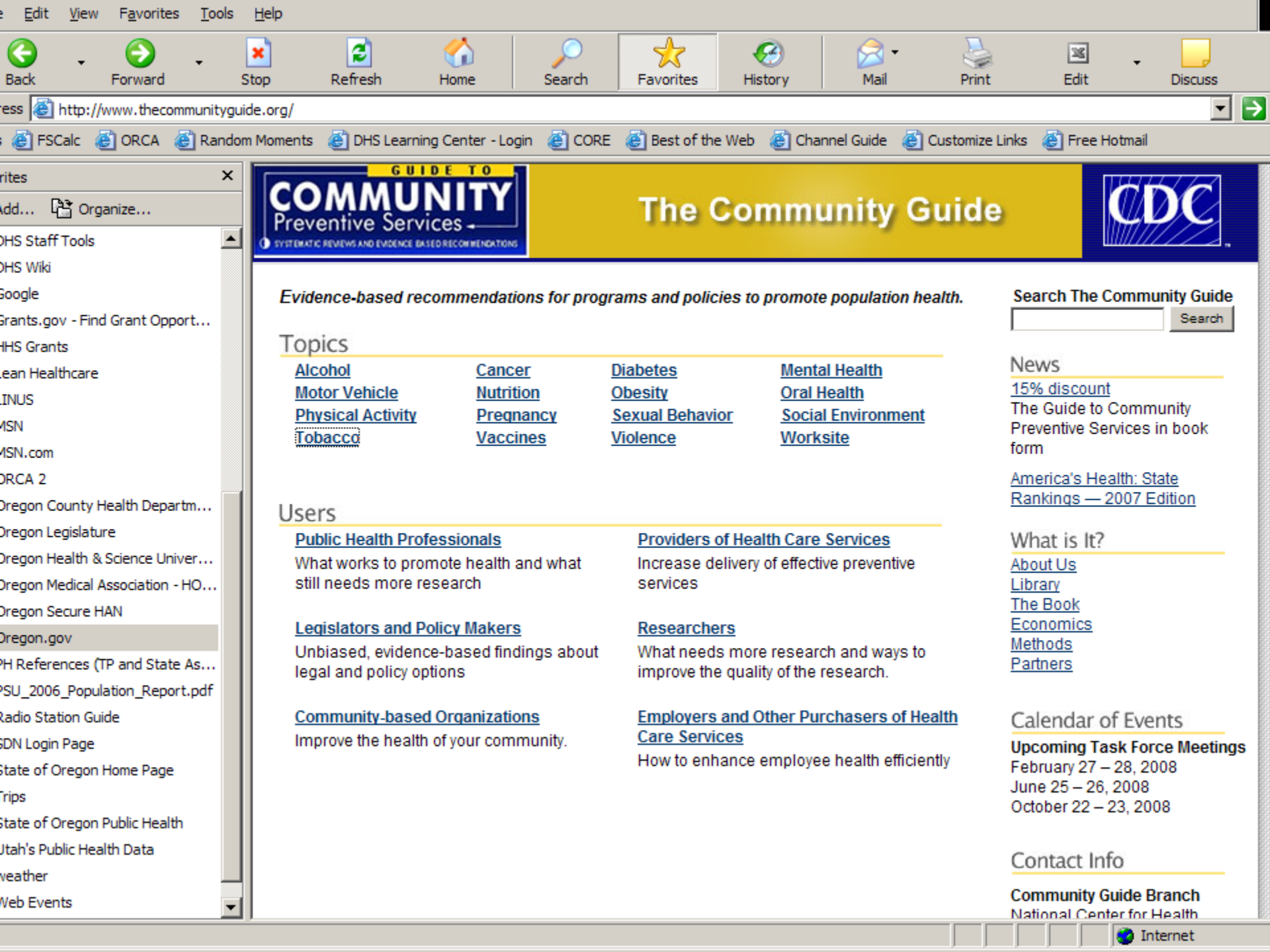
- Immunization
  - 33,000 lives saved and 14,000,000 cases of disease prevented per year (CDC)
- Public Health Nurse Home Visiting
  - 56% fewer health care visits for injuries and 48% less incidence of child abuse (Olds)
- Tobacco Prevention
  - Ed programs reduce teen smoking 20-40% (US SG)
  - 1750 fewer infants exposed to smoke/year (OR TPEP)

(Select examples only – More data to come)

Effectiveness of public health

- Cost-effective research
- Improved outcomes research
- Intuitively: Healthy people cost less

  Healthy people/communities the goal
- Difficult “sell”
- Standard should be Evidence-Based practice
  - Good research available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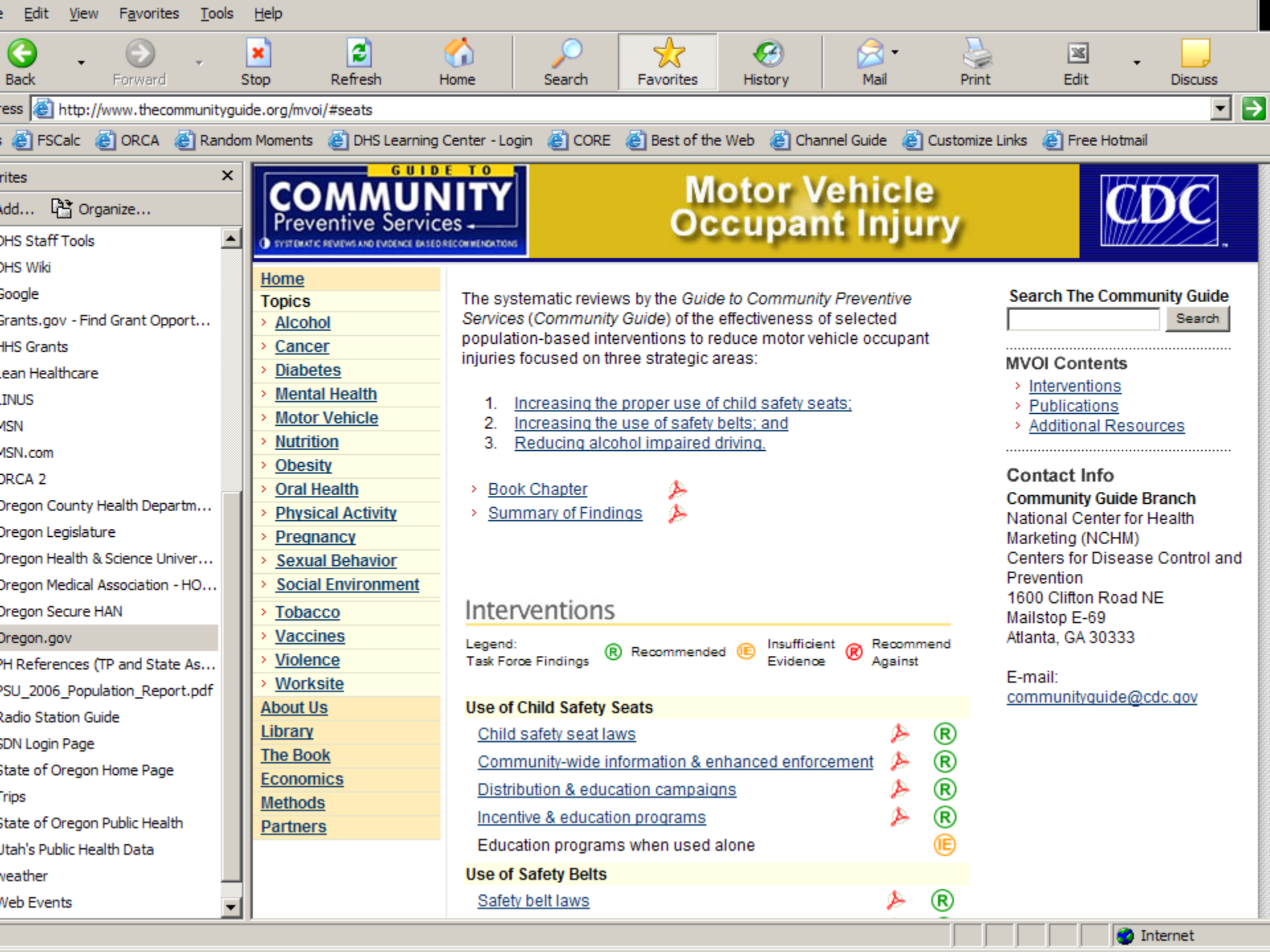
GUIDE TO COMMUNITY Preventive Services
SYSTEMATIC REVIEWS AND EVIDENCE BASED RECOMMENDATIONS
The Community Guide
CDC
Evidence-based recommendations for programs and policies to promote population health.
Search The Community Guide
Search
Topics
Alcohol Cancer Diabetes Mental Health
Motor Vehicle Nutrition Obesity Oral Health
Physical Activity Pregnancy Sexual Behavior Social Environment
Tobacco Vaccines Violence Worksite
Users
Public Health Professionals
What works to promote health and what still needs more research
Providers of Health Care Services
Increase delivery of effective preventive services
Legislators and Policy Makers
Unbiased, evidence-based findings about legal and policy options
Researchers
What needs more research and ways to improve the quality of the research.
Community-based Organizations
Improve the health of your community.
Employers and Other Purchasers of Health Care Services
How to enhance employee health efficiently
News
15% discount
The Guide to Community Preventive Services in book form
America's Health: State Rankings — 2007 Edition
What is It?
About Us
Library
The Book
Economics
Methods
Partners
Calendar of Events
Upcoming Task Force Meetings
February 27 – 28, 2008
June 25 – 26, 2008
October 22 – 23, 2008
Contact Info
Community Guide Branch
National Center for Health
Internet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Motor Vehicle
Nutrition
Obesity
Oral Health
Physical Activity
Pregnancy
Sexual Behavior
Social Environment
Tobacco
Vaccines
Violence
Worksite
About Us
Library
The Book
Economics
Methods
Partners
The systematic reviews by the Guide to Community Preventive Services (Community Guide) of the effectiveness of selected population-based interventions to reduce motor vehicle occupant injuries focused on three strategic areas:
1. Increasing the proper use of child safety seats;
2. Increasing the use of safety belts; and
3. Reducing alcohol impaired driving.
Book Chapter
Summary of Findings
Interventions
Legend: Task Force Findings
Recommended
Insufficient Evidence
Recommend Against
Use of Child Safety Seats
Child safety seat laws
Community-wide information & enhanced enforcement
Distribution & education campaigns
Incentive & education programs
Education programs when used alone
Use of Safety Belts
Safety belt laws
Search The Community Guide
Search
MVOI Contents
Interventions
Publications
Additional Resources
Contact Info
Community Guide Branch
National Center for Health Marketing (NCHM)
Centers for Disease Control and Prevention
1600 Clifton Road NE
Mailstop E-69
Atlanta, GA 30333
E-mail:
communityguide@cdc.gov
Internet

What does integration mean?

- **Expanded population-based, community services outside of the delivery system**
  - More balanced investment in prevention
  - Prioritize services (most bang for buck) but allow flexibility at community level
  - Core support for governmental public health
    - Potential “trap” for marginalizing

What does integration mean?

- Expanded population-based, community services outside of the delivery system
- **Engagement of delivery system in population-based service activities**
  - Delivery system “hook”
    - Community services delivery vs PH vs contracting
  - Involvement in community coalitions
    - Specific diseases / issues
    - Delivery system access / quality

What does integration mean?

- Expanded population-based, community services outside of the delivery system
- Engagement of delivery system in population-based service activities
- **Incorporation of PH concepts into the provision of clinical care**
  - Implement preventive care services recs
  - Adopt Chronic (comprehensive) Care Model
  - Conduct self-evaluation re prevention services

What does integration mean?

- Expanded population-based, community services outside of the delivery system
- Engagement of delivery system in population-based service activities
- Incorporation of PH concepts into the provision of clinical care
- **Systems support to ensure integration is occurring and that it's making a difference**

Supporting integration of public health

- Technical assistance
  - Prioritizing & Identifying evidence-based services
  - Implementing Chronic Care Model, etc
  - Identifying prevention service providers
- Coordination and standards setting
- System-wide data analysis and evaluation

(Role of governmental public health)

- Incentives and/or mandates – Accountability for specific activities and services defined

How do we get to integration?

- Policy and Will
  - Importance of SB 329 process
- Incentives and/or Mandates for specific services and activities
- Systems Support – Public Health function
- Resources
  - For Services and for System Support
- Evaluation
  - Process & Outcomes

Oregon is on the Cutting Edge

Questions ?

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An Oregon Quality Institute

Recommendations from the Quality Institute Work Group to the OHFB Delivery Systems Committee

Work Group Membership

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  Oregon Health Policy Commission
  Lake Oswego
- **Maribeth Healey, Vice-Chair**
  Director
  Oregonians for Health Security
  Clackamas
- **Nancy Clarke**
  Executive Director
  Oregon Health Care Quality Corporation
  Portland
- **Richard Cohen, MD**
  Physician
  Grants Pass
- **Jim Dameron**
  Administrator
  Oregon Patient Safety Commission
  Portland
- **Gwen Dayton**
  Executive Vice President and Chief Counsel
  Oregon Assn. of Hospitals & Health Systems
  Lake Oswego
- **Robert Johnson**
  Chair
  Department of Community Dentistry
  OHSU School of Dentistry
  Portland
- **Gil Muñoz**
  Chief Executive Officer
  Virginia García Memorial Health Center
  Hillsboro

Work Group Membership

- **Ralph Prows, MD**
  Chief Medical Officer
  Regence of Oregon
  Portland
- **Glenn Rodríguez, MD**
  Chief Medical Officer, Oregon Region
  Providence Health System
  Portland
- **Kathy Savicki**
  Clinical Director
  Mid-Valley Behavioral Care Network
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- **Brett C. Sheppard, MD**
  Professor and Vice-Chairman of Surgery
  Oregon Health & Science University
  The Digestive Health Center
  Pancreatic/Hepato Biliary and Foregut Units
  Department of General Surgery
  Portland
- **Maureen Wright, MD**
  Assistant Regional Medical Director of Quality
  Kaiser Permanente Northwest Region
  Portland
- **Mike Williams**
  Attorney
  Williams Love O'Leary & Powers, P.C.
  Portland

Work Group Process

- Eight meetings (one by conference call)
- Joined at first substantive meeting by Dennis Scanlon, Assistant Professor in Health Policy and Administration at Penn State University
- Carol Turner, a facilitator from Decisions Decisions in Portland, facilitated five of the work group's meetings

Initial Tasks

- Environmental scan of quality and transparency efforts in Oregon and other states
- Defined "Quality" and "Transparency"
- Drafted problem statement
- Clarified starting assumptions
- Prioritized roles

Preamble to Recommendations

- **Ongoing quality assessment and a process for quality improvement is the keystone of any viable health care system. An Oregon Quality Institute will serve as a leader to unify existing quality efforts and lead Oregon toward a higher performing health care delivery system. Long term, stable state investment in and dedication to quality improvement and increased transparency will lead to a health care system that is safer, more effective, patient-centered, timely, efficient, and equitable.**

Governance and Structure

- Established as a publicly chartered public-private organization to:
  - Give Institute legitimacy and a well-defined mission
  - Allow for flexibility in operations and funding
  - Allow Institute to accept direct state appropriations
  - Give Institute rulemaking abilities and statutory authority and protections
- The Quality Institute must provide strong confidentiality protections for the data it collects and reports and must provide the same protections to information submitted by other organizations
- Board of Directors of the Quality Institute
  - Appointed by the Governor and confirmed by the Senate
  - Include no more than 7 members who are knowledgeable about and committed to quality improvement and represent a diverse constituency
  - Supported by advisory committees that represent a full range of stakeholders
- Staff
  - Executive Director appointed by and serves at the pleasure of the Board
  - Small professional staff - partner or contract with another organization to provide administrative support

Funding

- In order for the Quality Institute to be stable, state government must make a substantial long-term financial investment in the Quality Institute. $2.3 million annually for a period of at least 10 years (adjusted for inflation) is recommended .
- The Quality Institute will partner and collaborate with other stakeholders to maximize output and minimize duplication of efforts.
- The Quality Institute may seek additional voluntary funding from private stakeholders and grant-making organizations to supplement state appropriations.

Funding

- Assumptions
  - Addresses all priority roles.
  - Strategic investments will fund projects, in partnership with other quality improvement organizations, that align with the mission of the Quality Institute and accelerate improvement.
  - Strategic alliances with other organizations and transparent decisions about use of dollars to maximize quality improvement across the health care system.
- Annual Budget
- *Operations*
- Personnel Costs (lead staff, data analyst, policy analyst, support staff) $575,000
- Software and Infrastructure $30,000
- *Roles: Coordination and Collaboration and Policy Advising*
- Meeting Costs $50,000
- *Roles: Systematic Measurement of Quality*
- Vendor Costs (data collection and reporting) $900,000
- *Roles: Provider Improvement , Technical Assistance*
- *and Consumer Engagement*
- Strategic Investments* $750,000
- Total
  $2,305,000

Quality Institute Roles (1)

- **The Quality Institute's overarching role will be to lead Oregon toward a higher performing health care delivery system by initiating, championing and aligning efforts to improve the quality and transparency of health care delivered to Oregonians**

Quality Institute Roles (2)

- **Priority Roles**:
  1. Set and prioritize ambitious goals for Oregon in the areas of quality improvement and transparency.
  2. Convene public and private stakeholders to align all groups around common quality metrics for a range of health care services.
  3. Ensure providers have the ability to produce and access comparable and actionable information about quality, utilization of health care resources and patient outcomes that allows for comparison of performance and creation of data-driven provider and delivery system quality improvement initiatives.

Quality Institute Roles (3)

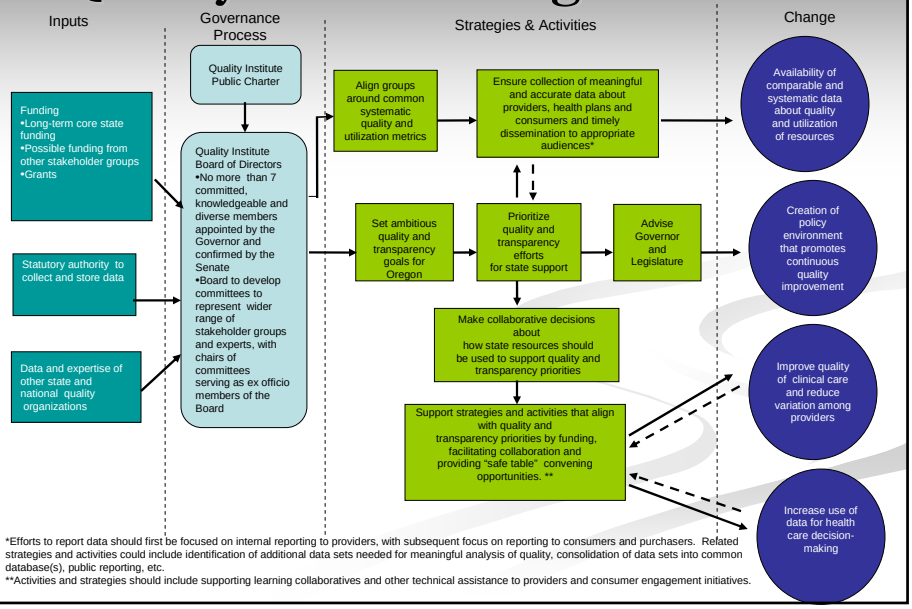
- **Priority Roles**:
  4. Ensure the collection (by coordinating and consolidating collection efforts and directly collecting data when not available) and timely dissemination of meaningful and accurate data about providers, health plans and patient experience.
  5. Advise the Governor and the Legislature on an ongoing basis on policy changes/regulations to improve quality and transparency.

Quality Institute Roles (4)

As the budget allows, the Board should use data and evidence to identify opportunities to improve quality and transparency through the following activities (either directly carried out by the Quality Institute or in partnership with other stakeholder groups):

- Develop and assess new quality improvement strategies through demonstration and pilot projects.
- Develop a collaborative process for endorsing and disseminating guidelines of care and assessing the comparative effectiveness of technologies and procedures.
- Lessen the burden of reporting that currently complicates the provision of health care.
- Support learning collaboratives and other technical assistance for providers to develop and share best practices
- Align with Health Information Infrastructure Advisory Committee (HIIAC) recommendations and support efforts to develop and facilitate the adoption of health information technology.
- Support efforts, in partnership with providers, to engage consumers in the use of quality and utilization data and evidence-based guidelines to make health decisions and take responsibility for their own health.

Quality Institute Logic Model



*Efforts to report data should first be focused on internal reporting to providers, with subsequent focus on reporting to consumers and purchasers. Related strategies and activities could include identification of additional data sets needed for meaningful analysis of quality, consolidation of data sets into common database(s), public reporting, etc.

**Activities and strategies should include supporting learning collaboratives and other technical assistance to providers and consumer engagement initiatives.

Architecting World Quality Care for Oregonians

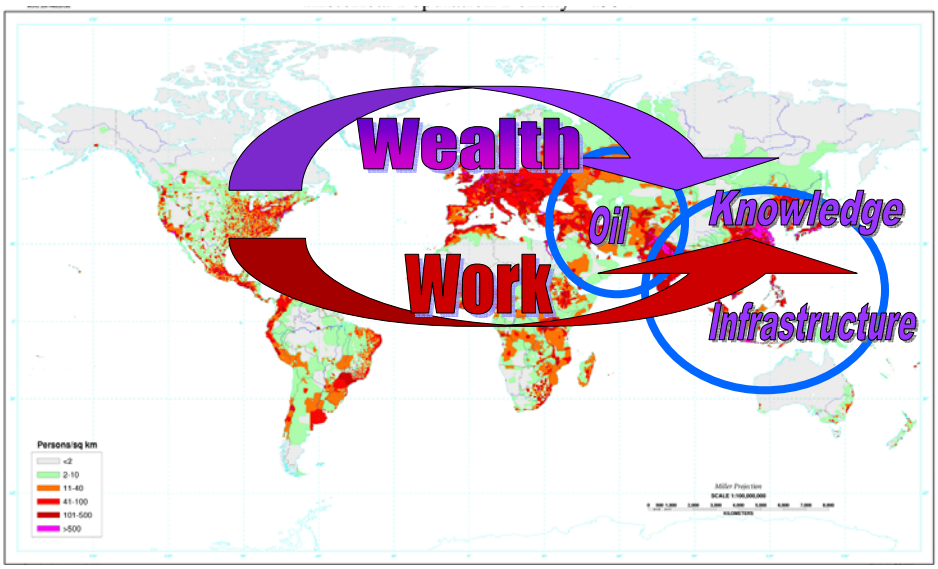
April 2008

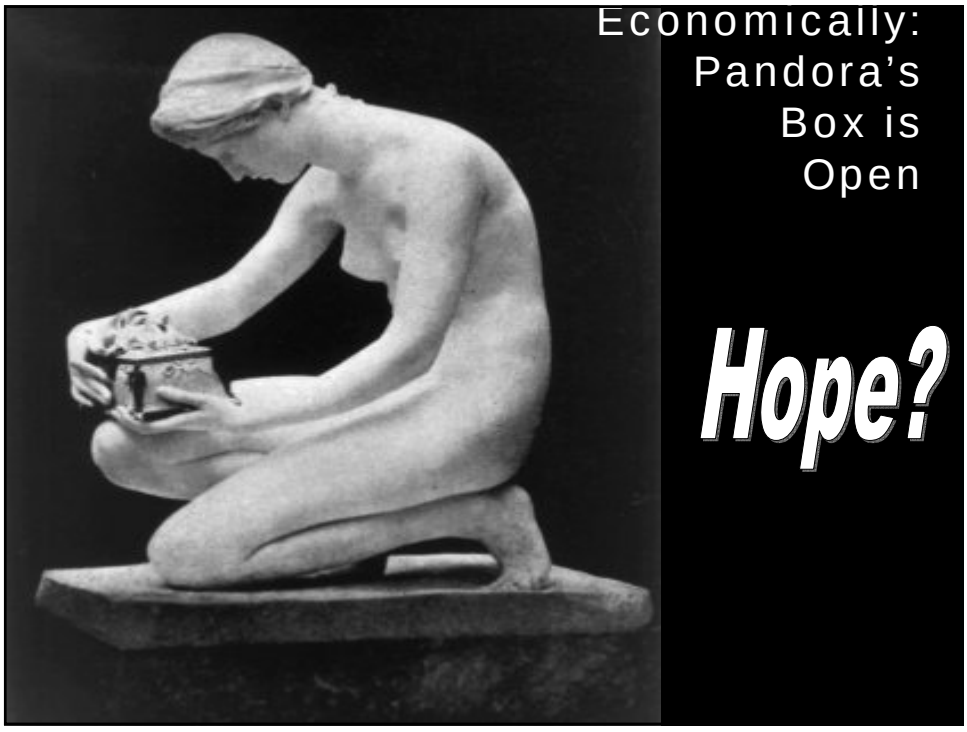
Discussion Brief

What is the Context for the Fund Board?

Boeing Losses $35B Contract To Airbus

Advanced Cultures
Technologically Accelerating

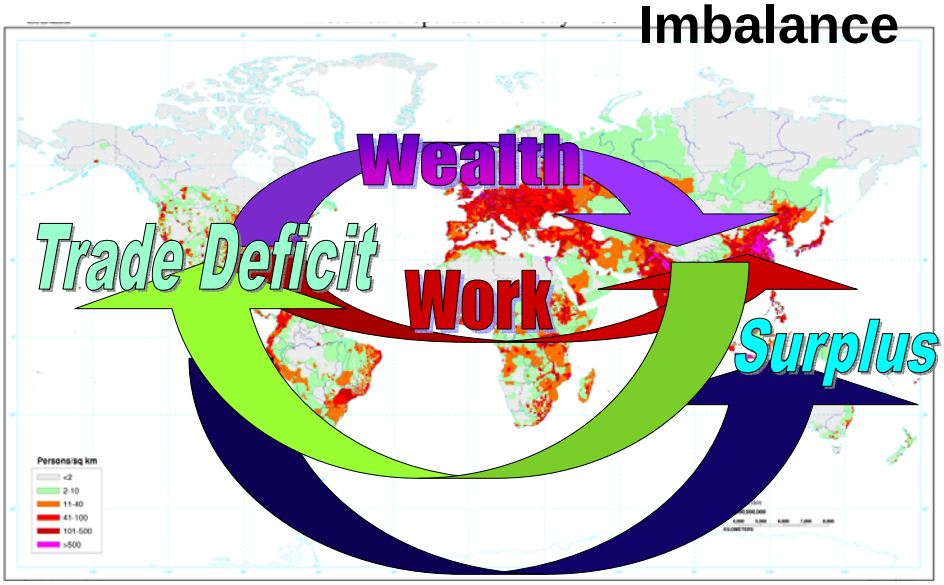




Economically:
Pandora's Box is Open

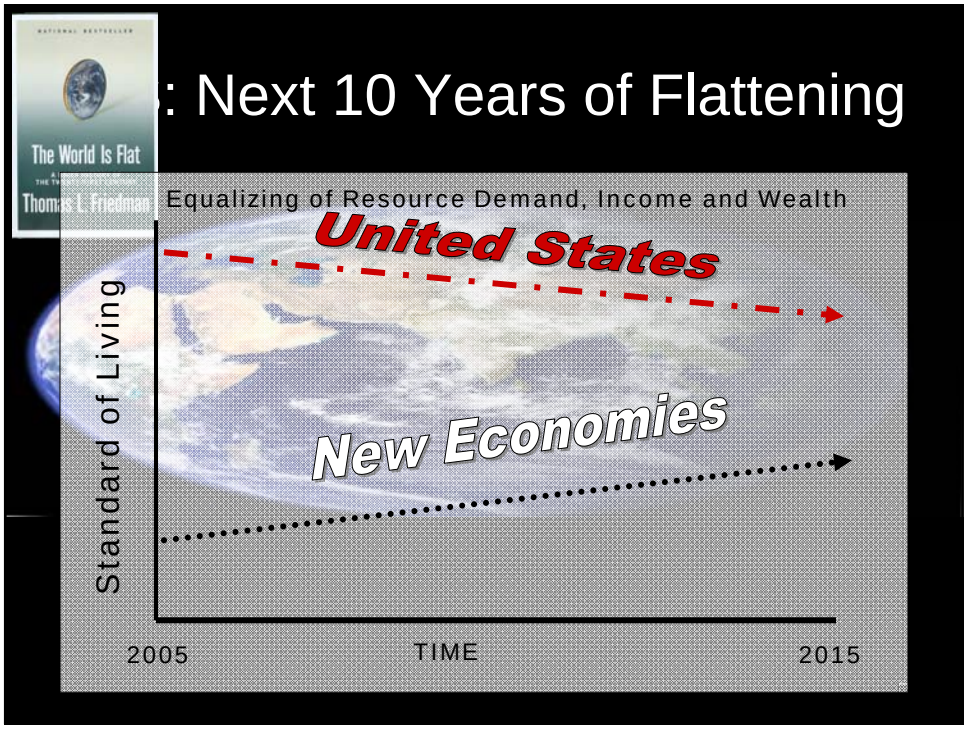
Hope?

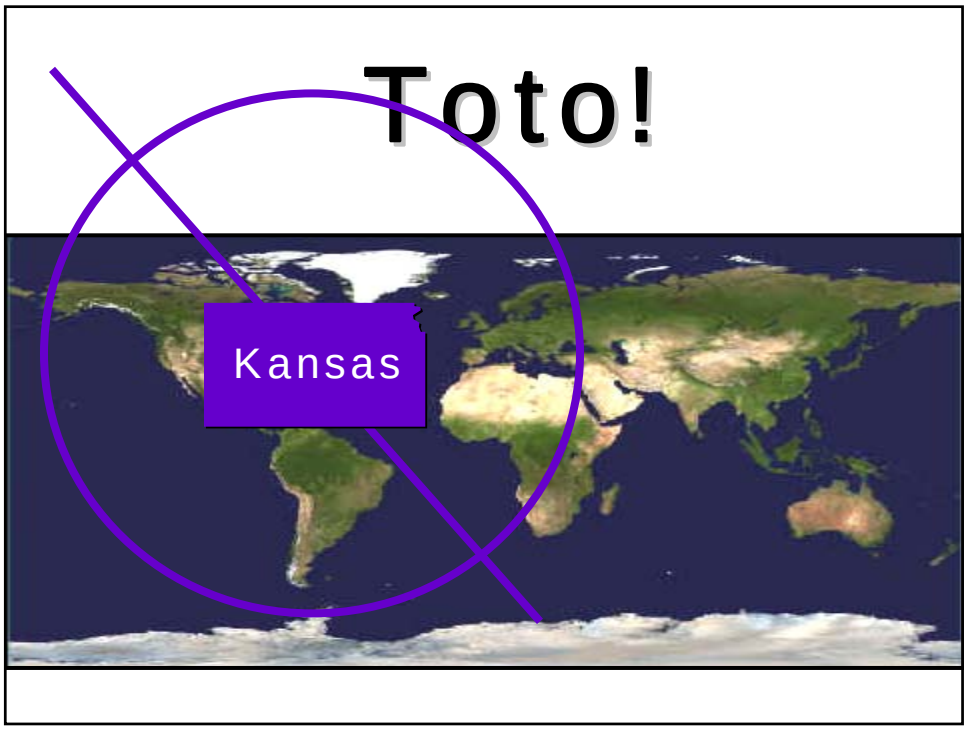
Trade and Currency Imbalance



US Economy in World Rebalance

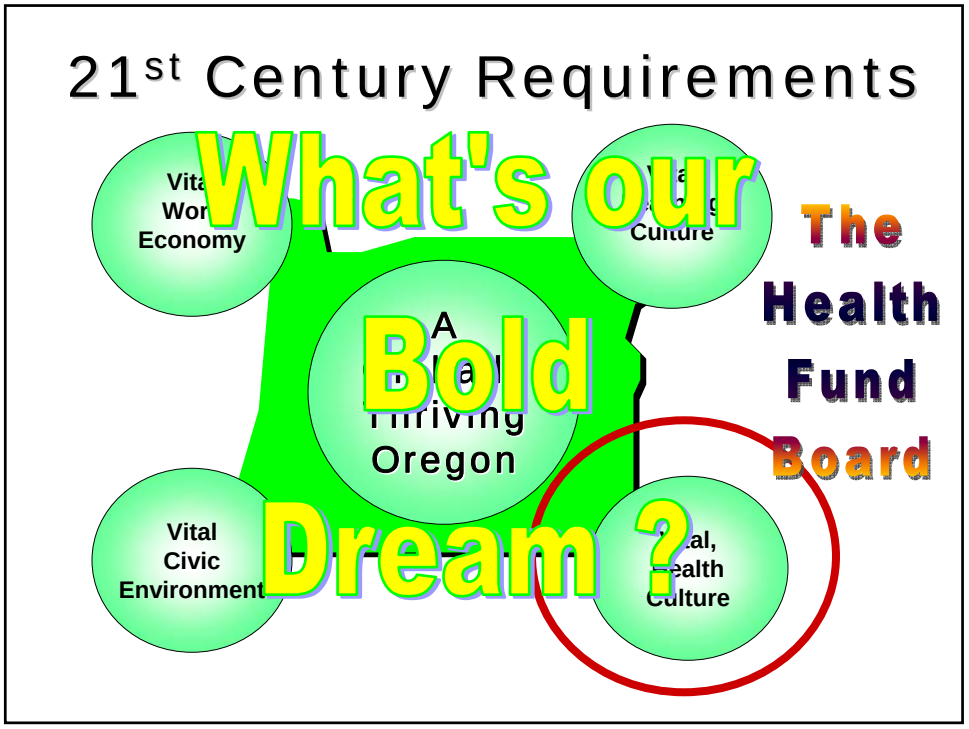
- **Fundamental Changes:**
  - **Production:**
    - Technological, Division of work, Work Flow, Geography for Manufacturing and Service
  - **Personal Income Shifts**
  - **Public Revenue:** Federal, State, Local
- **Reversible?**
- ***Probably Accelerating***


: Next 10 Years of Flattening
The World Is Flat
Thomas L. Friedman
Equalizing of Resource Demand, Income and Wealth
United States
New Economies
Standard of Living
2005
TIME
2015


Toto!
Kansas

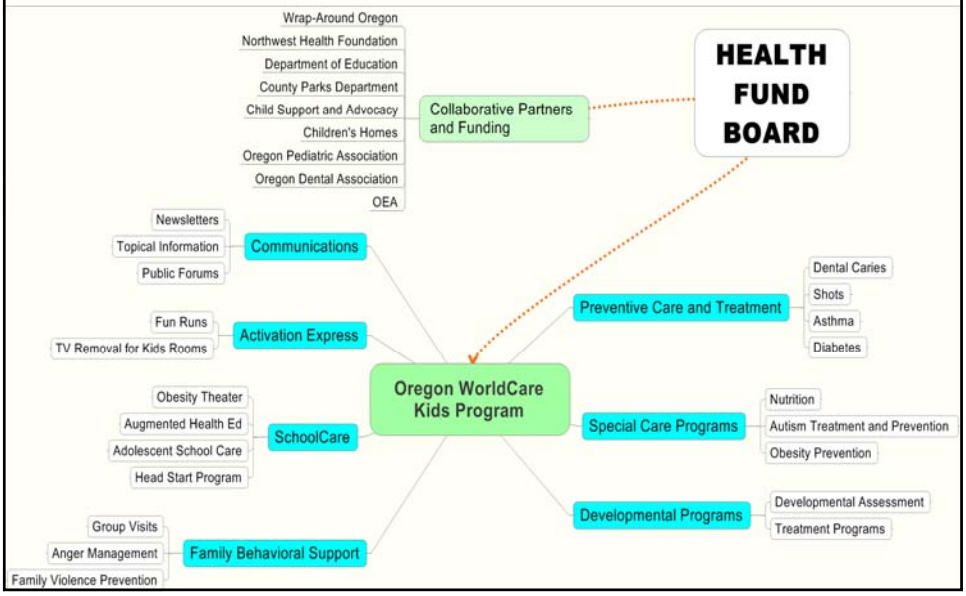
Dubai 1990: Before Craziness

Dubai: Same Street: 2003


21st Century Requirements
What's our
Bold
Dream ?
The
Health
Fund
Board
Vital
Economy
Culture
A
Thriving
Oregon
Vital
Civic
Environment
Culture


WorldCare
OREGON
WorldCare
Babies
WorldCare
Seniors
WorldCare
Children
World Class
Care:
OREGON
WorldCare
Adolescence
WorldCare Adults

Sample:
Oregon WorldCare Kids



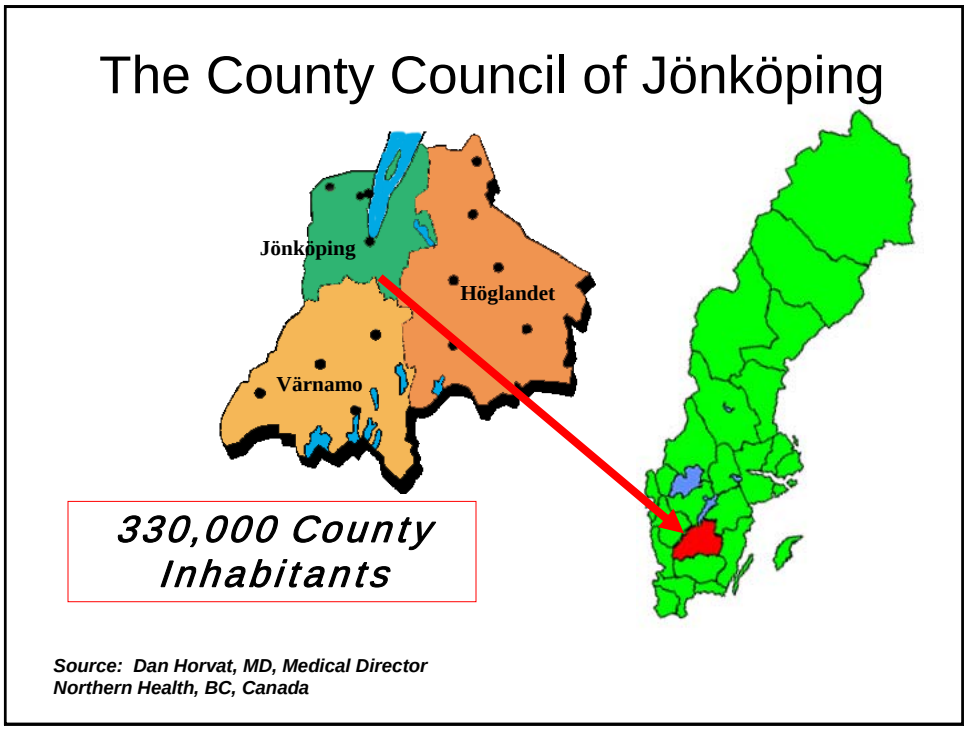
SCF: What Happened?

15 years later:

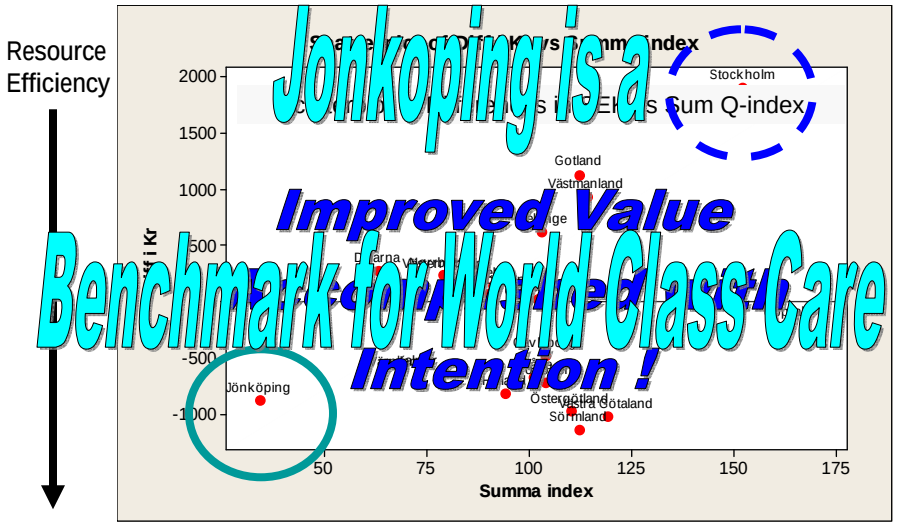
They have World Class HealthCare!

- 15 [illegible]
  - Apartheid-like health care
- Bureau of Indian Affairs creat[illegible]ocal option
  - Kath[illegible]ders ruthlessly asked:
- "Why can't Native Americans have [illegible]?


Where to find World Class Care
Ranking of countries by type of health index.
Highest Health-expenditure 2001
Sweden 11
France 6
Austria 6 3 7 9
Luxembourg 17 4 2 3
Germany 2
Belgium 10
Canada 4
Denmark 14 5
Ireland 17 13
New Zealand 18 20
Slovak Republic 22
Portugal 16 17
Source: Social and Cultural Planning Office of the Netherlands (SCP)
World Cost and Health Status rankings
What's Our
Why shouldn't
Bold Dream for
Have
World Class Care?
The Future?
Less Expensive
Source: Dan Horvat, MD: Northern Health, BC


The County Council of Jönköping
Jönköping
Höglandet
Värnamo
330,000 County Inhabitants
Source: Dan Horvat, MD, Medical Director
Northern Health, BC, Canada

And Jönköping Within Sweden

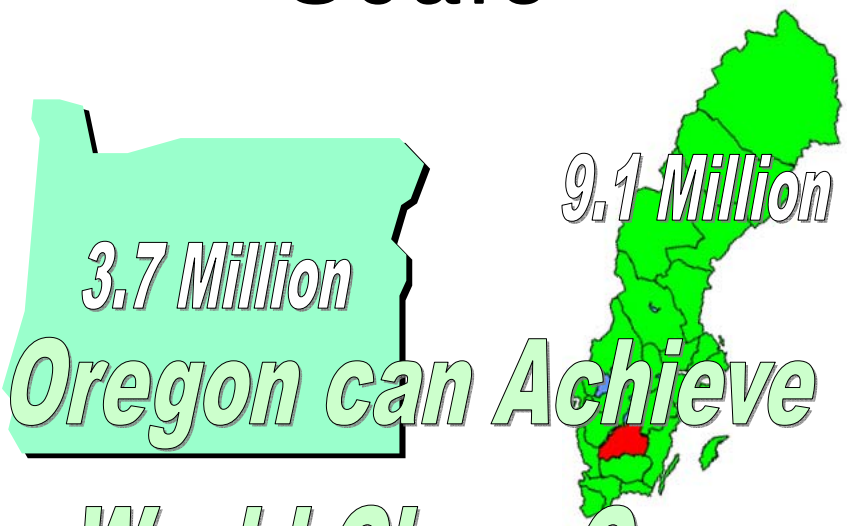


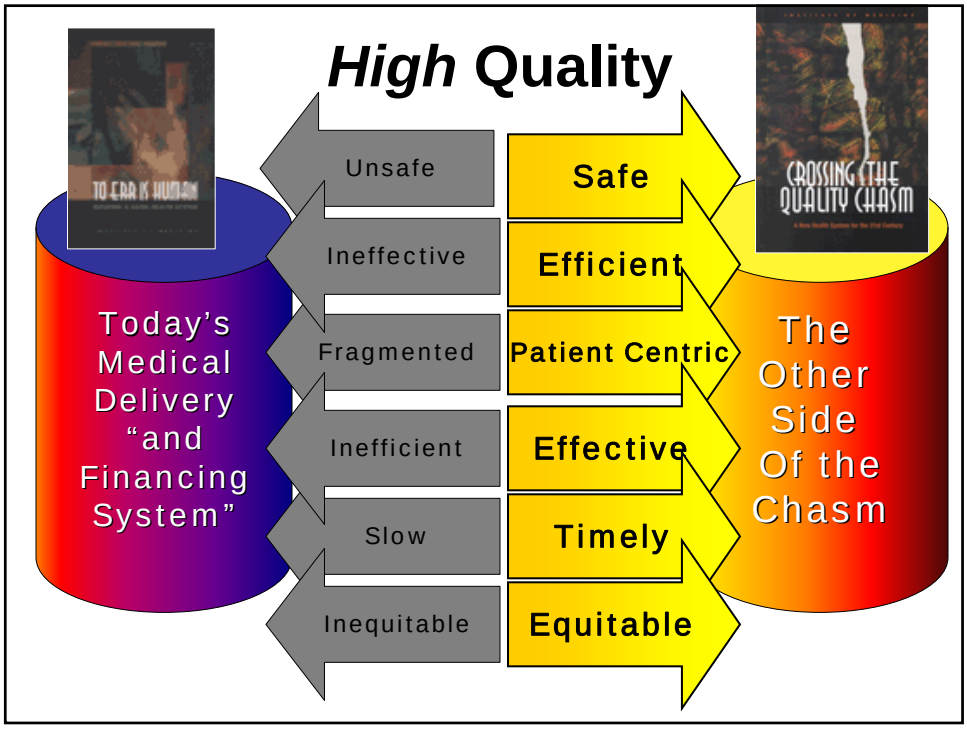
Source: Dan Horvat, MD: Northern Health, BC

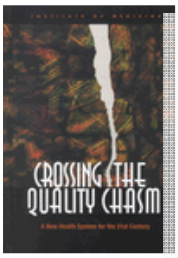
TRANSFORMATION IS NOT A DREAM

WAITING IS NOT AN OPTION

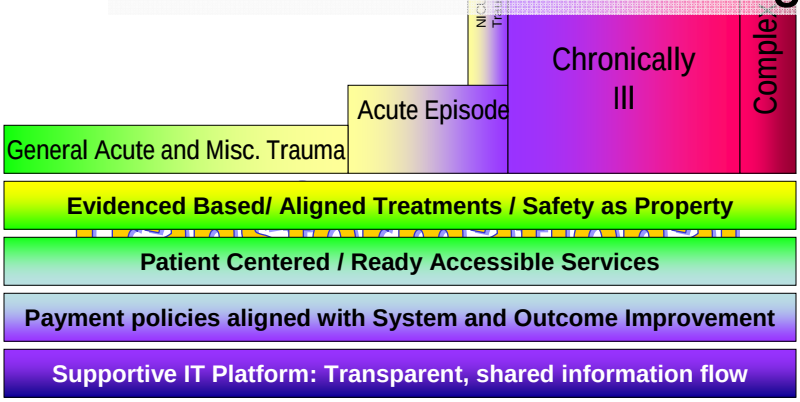
Scale


3.7 Million
9.1 Million
Oregon can Achieve
World Class Care


High Quality
Today's Medical Delivery "and Financing System"
The Other Side Of the Chasm
Unsafe
Ineffective
Fragmented
Inefficient
Slow
Inequitable
Safe
Efficient
Patient Centric
Effective
Timely
Equitable

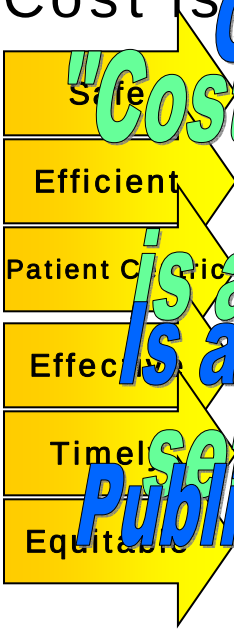


IOM's Crossing the Quality Chasm *is* a Whole System Transformation Strategy



Source: Institute of Medicine, Crossing the Quality Chasm

Cost is inherent in Quality



- No waiver requirements
- Done with no waste
- Meeting Patient
- Right thing, First time
- No Gaps
- Fair to each person

"Cost Containment" is an antiquated set of concepts

Quality in this sense is a FUNDAMENTAL Public Policy Strategy


"Quality at a"
World Class
Standard


Who is the
Responsible
AGENT for
Quality?
Berwick's Take
QUALITY CHASM
In Patient's Eyes
• Don't do things that cannot
• Don't make me feel
•Don't make me Wait
•Don't waste
•Money
• No Needless
•No Needless
•Pain
•No Unwanted
•No Waste
• Effective
• Timely
• Efficient
• Equitable
Source: Don Berwick, CEO Institute for Healthcare Improvement

Example: "*How to Kill Don…*"

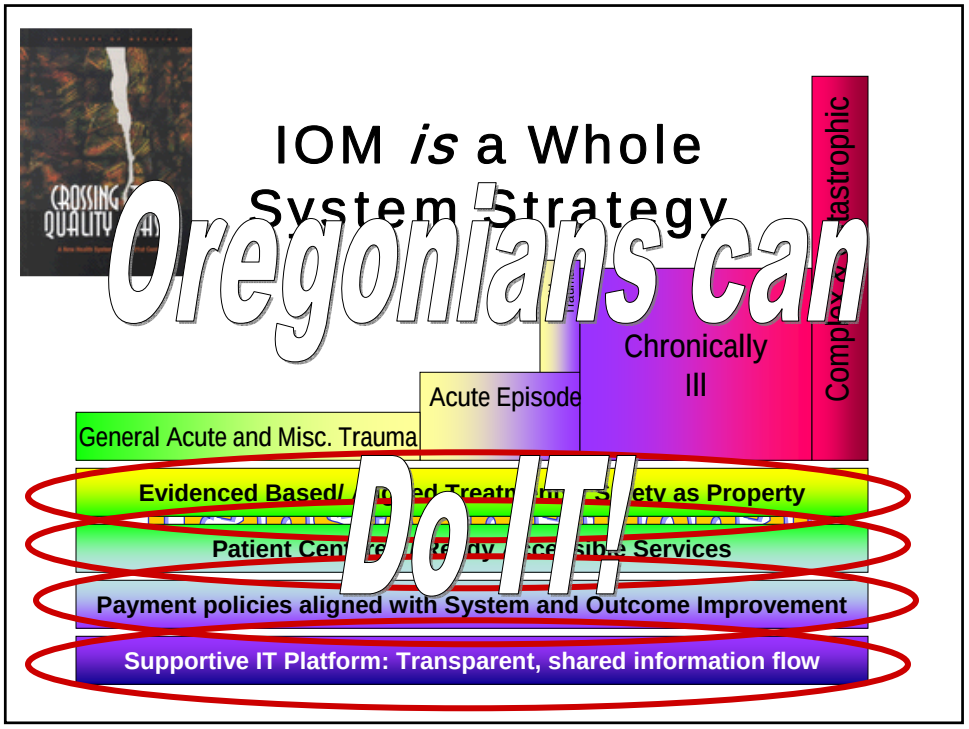
- Infect him
- Make him bleed
- Forget to prevent pulmonary embolism
- Give him pneumonia
- Forget his allergies
- [illegible]
- [illegible]
- [illegible]

Safety of Oregonians:
WHOSE RESPONSIBILITY?

Don's RFP for Care

Can we buy
and arrange
Real Quality
For Each Oregonian?

- S1: Don't kill me
  - 1A: Meets evidence standards
- S2: Don't [illegible]
  - 2A: Don't do things that cannot help
  - 2B: Reliably do what can help me
  - 2C: Relieve my pain
    - Physical [illegible]
- S3: Don't [illegible]
  - 3A: Share Information
  - 3B: Give me choices
  - [illegible]
  - [illegible]
  - 3E: Be sensitive to Cultural Differences
- S4: Don't make me wait
  - 4A: Manage Access
  - [illegible] Flow
  - [illegible] ck of things
- S5: Don't waste money


IOM *is* a Whole System Strategy
Oregonians Can
Do IT!
Chronically Ill
Acute Episode
General Acute and Misc. Trauma
Evidenced Based/
Patient Cen
Payment policies aligned with System and Outcome Improvement
Supportive IT Platform: Transparent, shared information flow


World Class Care
OREGON
Are we after
WorldCare Babies
WorldCare Children
WorldCare Adolescence
World Class Care: OREGON
LESS?
WorldCare Adults

What's World Class Quality

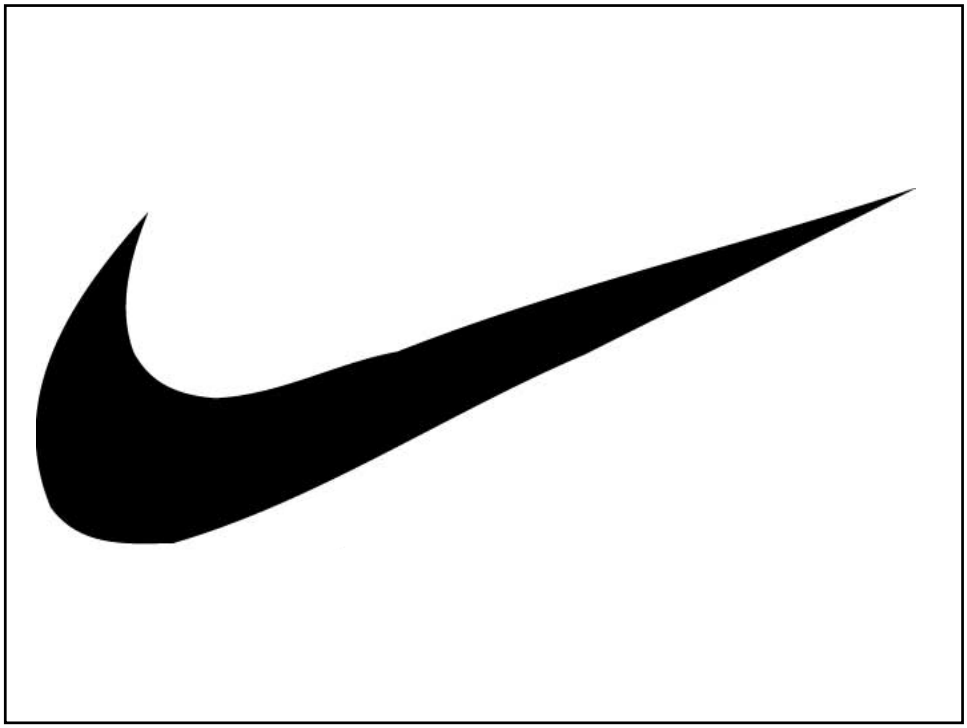
- **Within Top 5 in World Measures for:**
  - **Health status and outcomes**
  - **User Satisfaction with the system**
  - **Cost**
- **Universal**
- **Institute of Medicine's "Blueprint Fulfilled"**
  - **Safe, Efficient, et.al.**
  - **Transparent, IT and Payment alignments**
- **Globally competitive again**

What does a *Targeting Vision* Do?

- **Organizes the very broad technical details**
  - **Is an organizing paradigm**
- **Is a filter for prioritization**
  - **"Does it drive world class care for each Oregonian?"**
- **Is a sustainable goal**
- **Is a goal that all citizen can get behind**
- **Inspires higher aspiration and creativity**
- **Is really what we want to achieve**

TRANSFORMATION IS NOT A DREAM

WAITING IS NOT AN OPTION



Oregon Health Fund Board

Kaiser Permanente Vision

Providing Members With a Medical Home

Total Panel Ownership

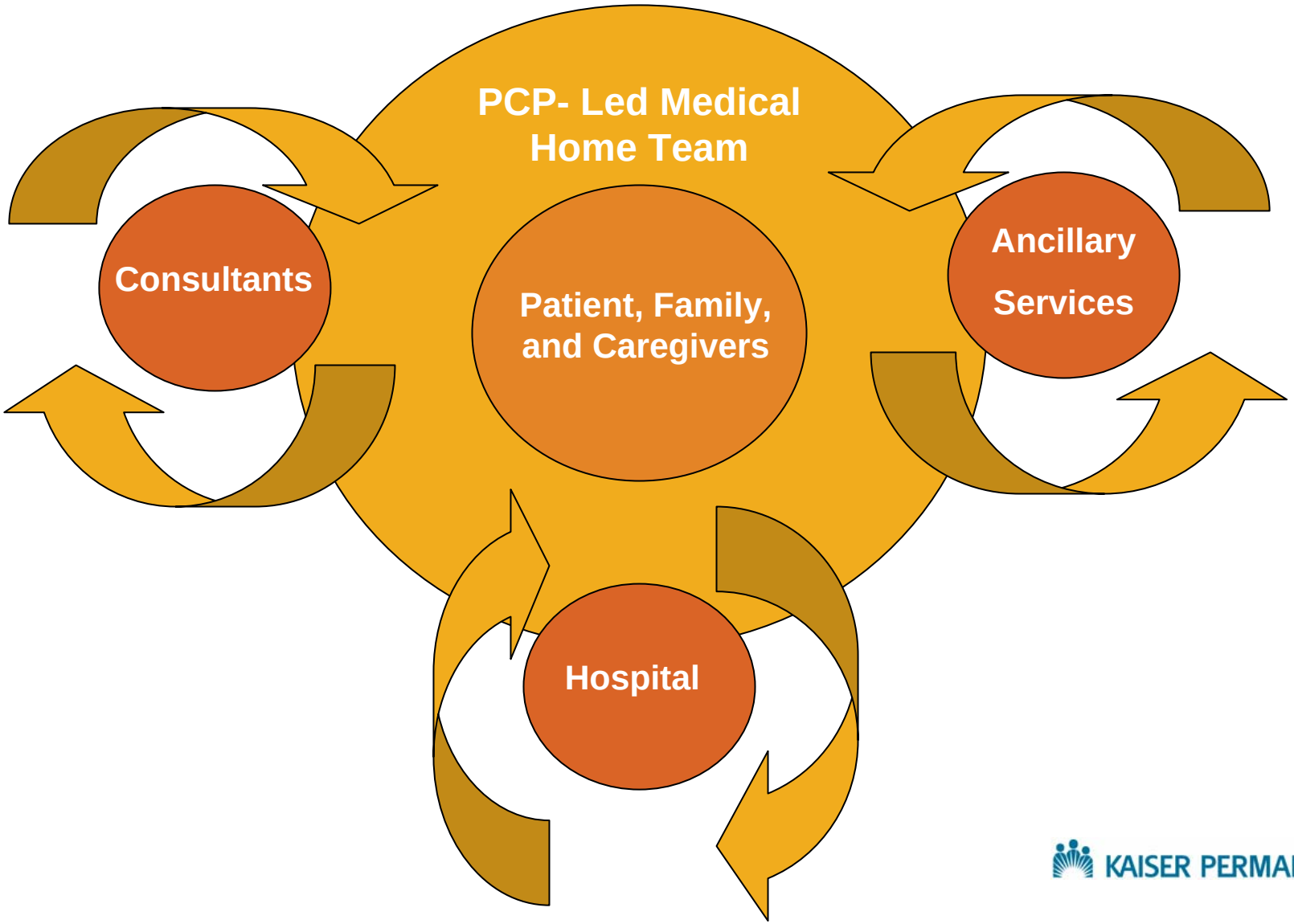
KAISER PERMANENTE®

Why Should Patients Have a Medical Home? Why Should You Advocate for Such a Healthcare Delivery System?

- Service Improves - Members have a home that coordinates all their care
- Quality Improves - Members with a primary care clinician/home have consistently better quality outcomes
- Resource Stewardship Improves - States with more PCPs, and patients who have a PCP, experience more cost effective care

KAISER PERMANENTE®

Primary Care Vision



KAISER PERMANENTE®

Primary Care Vision

All members are attached to a primary care physician

Members have several choices to access their physician

- Office visits
- Scheduled phone encounters
- Email encounters

KAISER PERMANENTE®

The Medical Home
Challenges for Kaiser

Service Excellence is the Key

- Goals
  - Service Culture Improvement
  - Improved Phone Service for Members
  - Access Improvement Primary Care
    - Enhancing the ability of members to develop a relationship with a primary care clinician
    - Increasing appointment availability to better meet members needs
  - Access Improvement Specialty Care
    - Reduce time from referral to appointment
    - Direct access for selected specialties

KAISER PERMANENTE®

Total Panel Ownership and Our Electronic Medical Record (EMR)

- Our Electronic Medical Record facilitates the Medical Home Model. All care is documented in one EMR, accessible by all members of the care team.
- The Panel Support Tool facilitates comprehensive Inreach
- The Panel Support Tool facilitates focused Outreach from the team and centrally

KAISER PERMANENTE®

Our EMR is the Member's EMR

The member can access much of their EMR via kp.org

- Medical conditions, labs, vaccine records, appointments

Health Risk Assessment coming in 2008

- Available on kp.org to all members
- Integrated into our EMR
- Members receive suggestions regarding prevention issues and lifestyle changes to address

KAISER PERMANENTE®

Member Perspective & KPNW Departments
KPNW Primary Care Model of Care for Quality & Service

Hospital Care
If hospitalized, I am confident that I will receive excellent care and be contacted after discharge to see if I have any further needs.

Regional Call Center
When I need an appointment or advice, my needs are met quickly.

Coordination of Care
When multiple specialists manage my care, I am confident that my care will be coordinated.

Specialty Care
I am called as promised and receive excellent care. My PCP knows what is going on.

My Clinician & Team

Member & Family Self Care Support
I am supported to take care of my condition within my community to the extent that I am able.

After Hours
When seen in after hours care, I am confident that my PCP and team are well informed and will follow up with me if needed.

Regional Clinical Support Services
I can get medications & tests I need.

My Medical Home
My Clinician and Team know me. They provide outstanding Care and Service and coordinate my care as needed.

Transition Care Coordination
My care is coordinated for me if I need to go from facility to facility or back to my home.

Regional Telephonic Medical Center
When I am seen outside of our system, a team helps me transition back to KP.

Multidisciplinary Case/Care Management
I receive 1:1 professional care and support for my condition when I need it.

KP.ORG
I can go to kp.org to easily access my record and get health care information.

Population- Based Care
I am contacted to help prevent or slow progression of my condition.

KAISER PERMANENTE®

Sources

States with more general practitioners use more effective care and have lower spending, while those with more specialists have higher costs and lower quality. *Baicker K, Chandra A. Medicare spending, The Physician workforce and Beneficiaries' Quality of Care. Health affairs, 2004*

International comparisons of health care systems have shown a relationship at the macro level between a well-structured primary health care plan and lower total health care costs…Provider continuity in family medicine remains one of the most important explaining variables of total health care costs (including costs for specialist visits and hospitalizations). *De Maeseneer JM, et al. Provider continuity in family medicine: Does it make a difference for total health care costs? Ann Fam Med 2003;1:144-148*

94% of patients value having a primary care physician who knows about all their medical problems. *Grumback K, et. al.. Resolving the gatekeeper conundrum. JAMA 1999;282261-266*

When more primary care physicians, per person, are practicing in a community, hospitalization rates are lower*. Parchman ML, Culler S. Primary care physicians and avoidable hospitalization. J Fam Pract 1994;39:123-128.*

Mortality rates are lower where there are more primary care physicians, but this is not the case for specialist supply. Increasing the supply of specialists will not improve the US position in population health relative to other industrialized countries, and is likely to lead to greater disparities in health status and outcomes. *Starfield B, Shi L, et. Al. The effects of specialist supply on populations' health: assessing the evidence. Health Aff (Millwood). 2005 Jan-Jun; Suppl Web Exclusives:W5-97-W5-1-7*

Physician services: 25% of national health services spending. Primary Care: 6-8% of total spending for personal health services. *GorollA, et. al. Fundamental reform of payment for adult primary care: comprehensive payment for comprehensive care. JGIM 2007;22:410-415*

KAISER PERMANENTE®

Funded by the
John A. Hartford foundation

Initial development at
Intermountain Healthcare

Medical homes in primary care: policy implications from Care Management Plus

Presented by: David A. Dorr, MD MS
Assistant Professor, Medical Informatics General Internal Medicine, OHSU; for the Care Management Plus team

Date: Dec 12th, 2007

Case study

Ms. Viera

a 75-year-old woman
with diabetes,
high blood pressure,
mild congestive heart failure,
joint pain and
recently diagnosed dementia.

She sees 13 outpatient providers per year, fills 50 prescriptions per year, and patients like her represent ~50% of Medicare expenditures.

If her care is not coordinated across providers and transitions, she has an increased risk of hospitalizations and ED visits, increased risk of advancing disease, and high risk of functional decline.

How can Ms. Viera receive high quality, efficient care?

OREGON HEALTH & SCIENCE UNIVERSITY

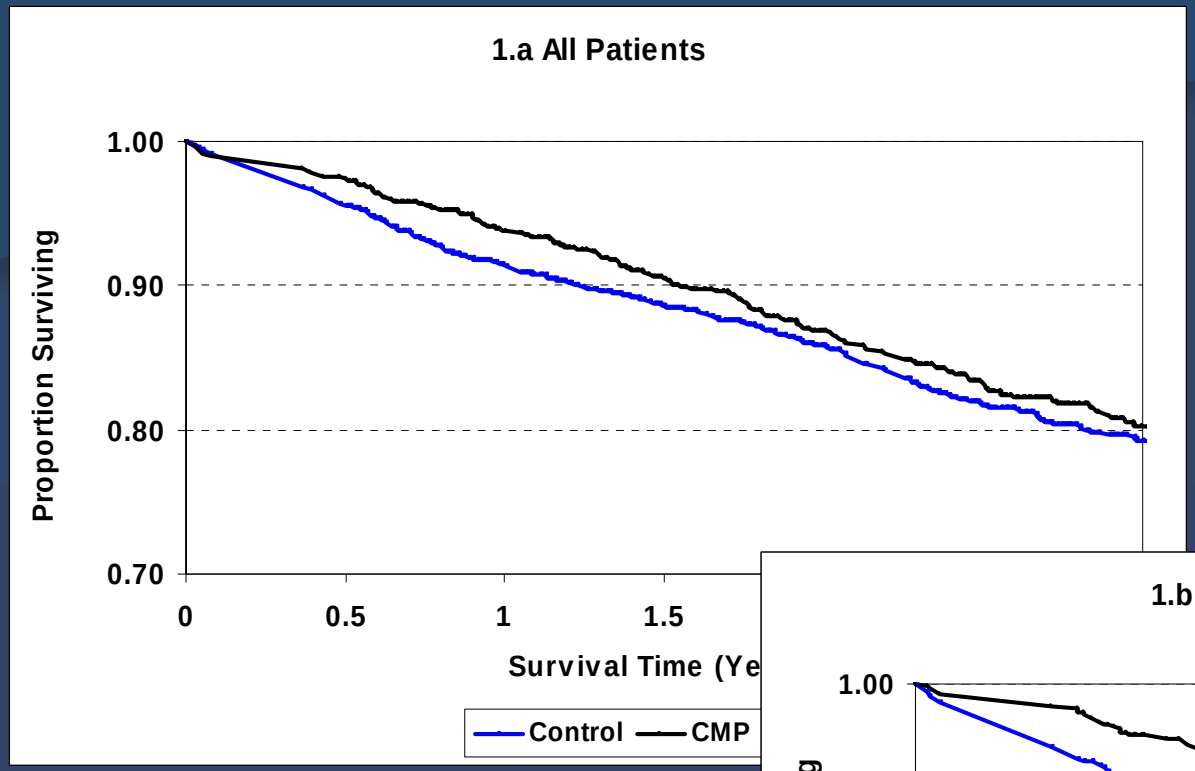
To help meet Ms. Viera's (and her family's) needs, we developed and tested a program called Care Management Plus.

In more than 40 primary care clinics in 4 states; started at Intermountain Healthcare in Utah and spread to OHSU, PeaceHealth, others …

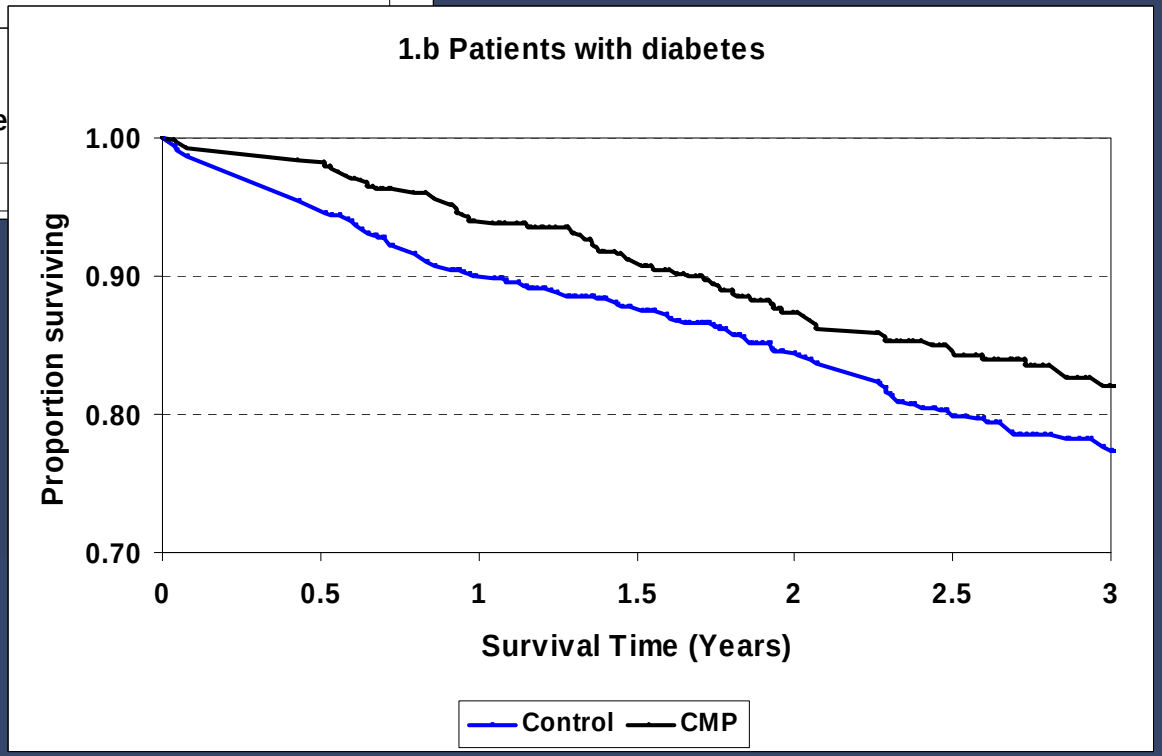
This helps primary care clinics develop components common to a medical home.

OREGON HEALTH & SCIENCE UNIVERSITY

Benefits from better primary care through our study …



Diseases under better control
Patients / primary care team more satisfied
Teamwork brought efficiency gains of 8-12%
Cost savings for insurers up to $250,000 per clinic
Cost savings for clinic - limited



Dorr, AcademyHealth, 2006
Dorr et al, HSR, 2005
Dorr et al, DM, 2006
Wilcox, The CMJ, 2007
Dorr, AJMC, 2007

Primary Care Medical Home

Whole person care
Assessment, patient preferences, education, team-based care; self-management, motivation, coaching

Collaborative care planning / Coordination
Time working with patient/family to create plan
Effort to gather information and update team

Performance Measurement
Focus on measurement; voice of the patients; responsiveness

Health Information technology
Longitudinal (tracks)
Integrative (summarizes)
Best practices (reminds)

Access
Build capacity through flexible contacts (60% in person / 40% telephone / etc) and better teamwork

Quality and safety
Quality improvement
Team-based protocols

(Dorr, JGIM, 2007)

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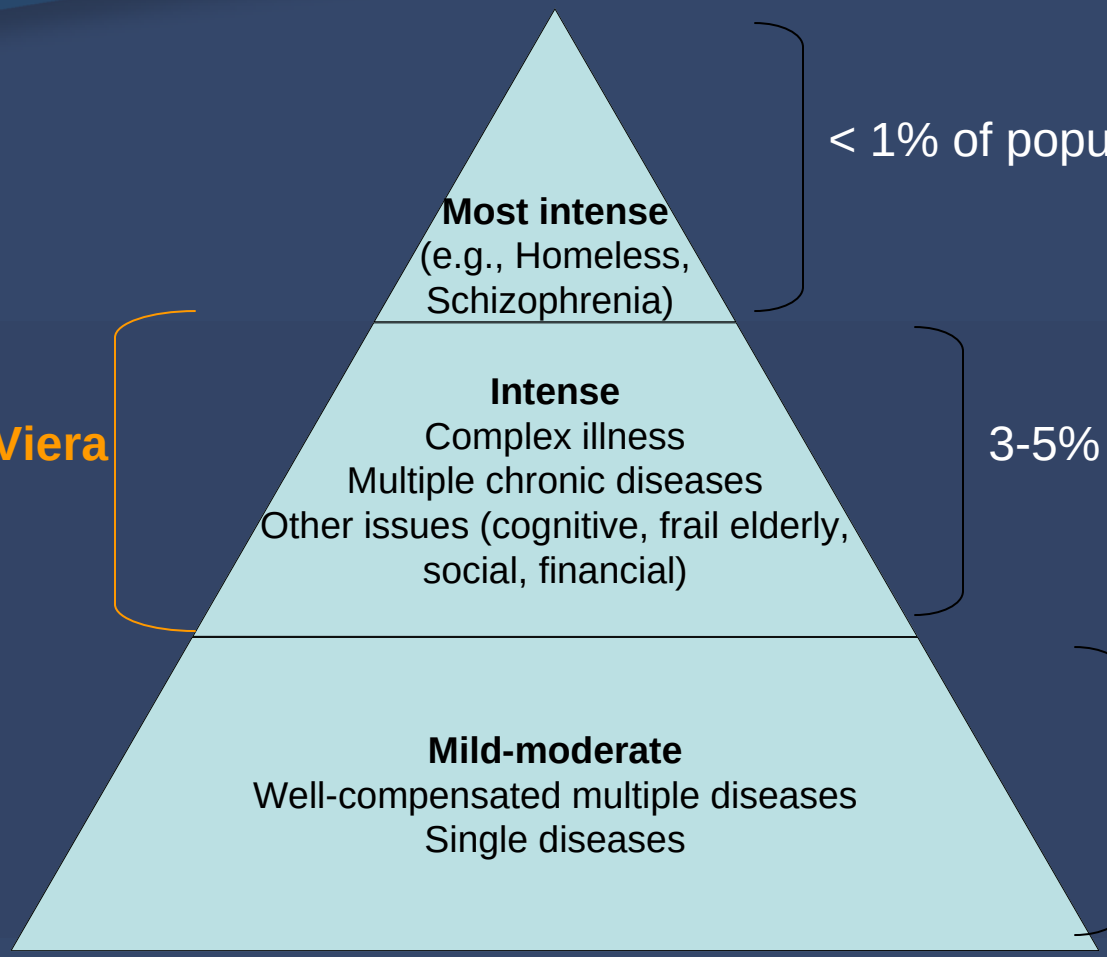
Care coordination varies by intensity and function for different populations and needs.



< 1% of population

3-5% of population

50% of pop.

Patients like Ms. Viera

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Challenges in creating Medical Homes from our work

Area	Our experience	Next Steps
1. Reimbursement	Misaligned incentives	Thoughtful reform
2. Capacity	Negatively perceived environment; change attractive	(re)Train; redesign; but mostly incent
3. Reliability	Variation in clinics and implementation	Metrics (e.g., revised NCQA PPC); demonstrations
4. Costs	Not a one year, zero sum game.	Demonstration with high need patients

The Care Management Plus Team

- OHSU
  - David Dorr, MD, MS
  - K. John McConnell, PhD
  - Kelli Radican
- Intermountain Healthcare
  - Cherie Brunker, MD
- Columbia University
  - Adam Wilcox, PhD

Advisory board

- Tom Bodenheimer
- Larry Casalino
- Eric Coleman
- Cheryl Schraeder
- Heather Young

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(additional slides)

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Redesigning metrics – National Committee on Quality Assurance Physician Practice Connection

- Access and Communication
- Tracking (registry use)
- Care Management
- Patient self-management support
- Performance reporting and improvement

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PP3: Care Management (e.g.)

- Element D.1-11. For the three clinically important conditions, the physician and nonphysician staff use the following components of care management support:
  - Conducting pre-visit planning with clinician reminders
  - **Setting individualized care plans**
  - **Setting individualized treatment goals**
  - **Assessing patient progress toward goals**
  - Reviewing medication lists with patients
  - **Reviewing self-monitoring results and incorporating them into the medical record at each visit**
  - **Assessing barriers when patients have not met treatment goals**
  - **Assessing barriers when patients have not filled, refilled or taken prescribed medications**
  - **Following up when patients have not kept important appointments**
  - **Reviewing longitudinal representation of patient's historical or targeted clinical measurements**
  - **Completing after-visit follow-up**

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Health Fund Board
Primary Care Renewal

David Labby, MD, PhD
CareOregon Medical Director

12/12/07

CareOregon

What I’m going to talk about...

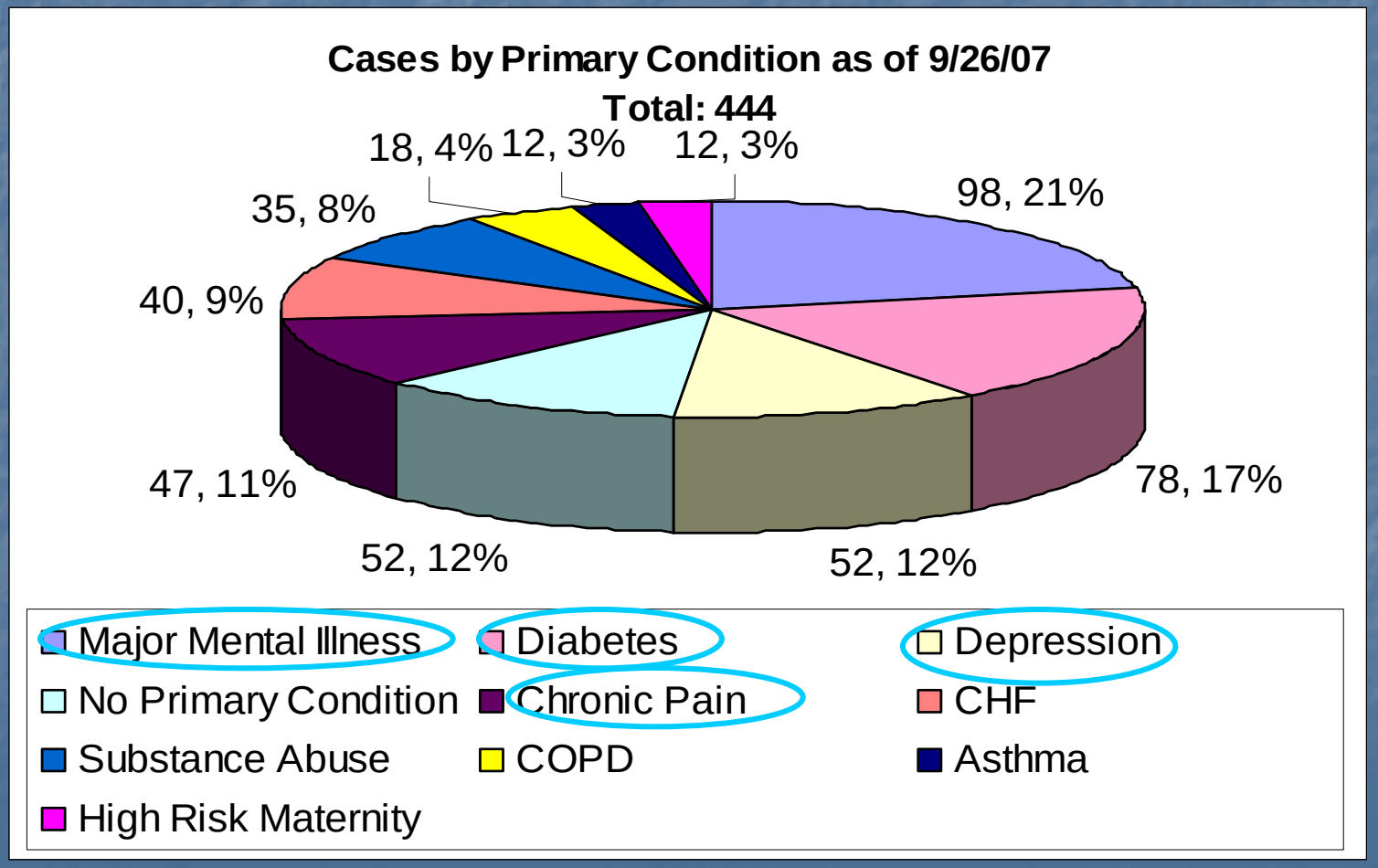
- Who we are...
  - Largest Medicaid managed care plan
  - Quality As A Business Strategy
- CareOregon’s experience in helping to build Primary Care Homes...
  - Model integration
  - Model implementation

Medical management changes:

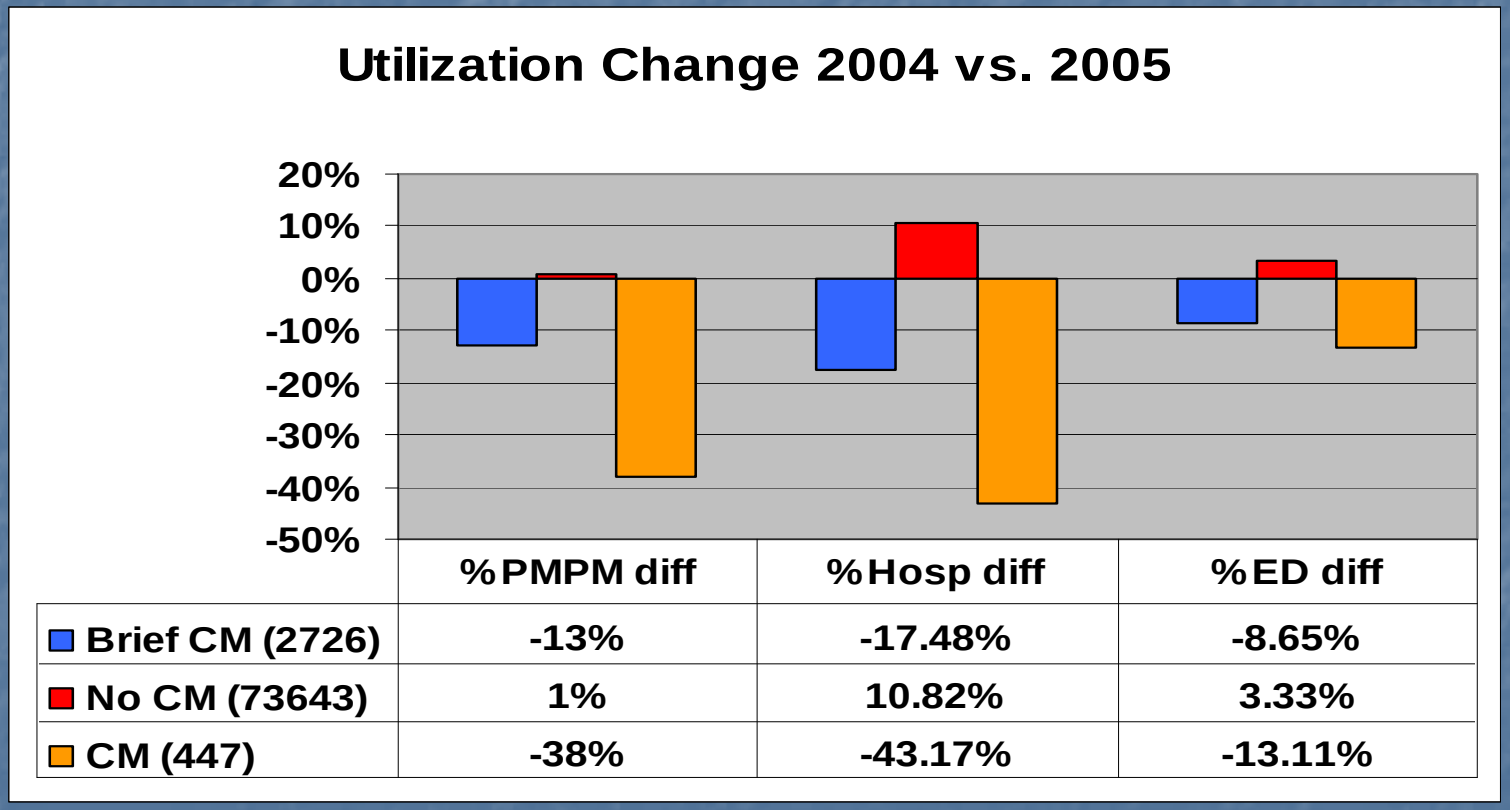
In 2003 we ramped up our internal complex care case management program...

- Johns Hopkins predictive software, ACGs
- Effective in decreasing cost and improving functional outcomes.
- Multi-disciplinary team based approach to care coordination and management.
- Improving health is about more than medical care...

Snapshot of our CareSupport population



Where have we reduced costs?



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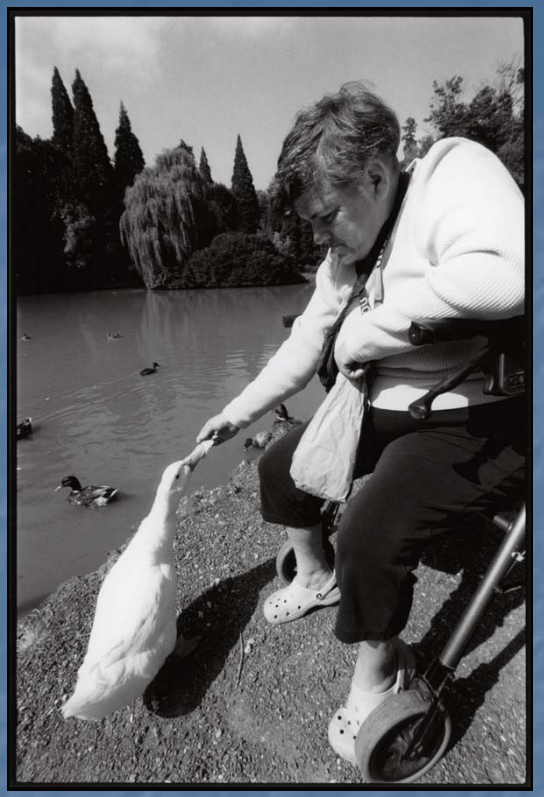
CareSupport: Cost Savings

Risk	Yr 1 pmpm	Yr 2 pmpm	Hospital	ED	Paid Change
High Risk Member	$3712	$2016	-41%	-7%	$1.86 Million
Lower Risk Member	$1085	$559	-33%	-13%	$1.66 Million

What we've learned...

CareSupport works well for a limited population...



But how do reach more people?

Critical Partnerships...

Care Support and System Innovation Program (CSSI)

- Board supported.
- Quality Improvement Funding Initiative.
- Opportunity to partner with our provider community to enhance care and learning.
- Provide dollars and now more technical assistance.

Key Transformation Components from SCF:

"Your work is not your schedule, but the health of the population you serve."

- Team based care
  - High functioning clinician, Case Manager, CMA, BH team
- Panel Management
  - Knowing panel member needs, proactive care
- "Customer" Driven Care
  - Rich stakeholder feedback on values, performance
- Direct Access
  - Removing barriers to communication, visits
- Integrated Behavioral Health
  - Co located solution based interventions

- Plus: Commitment to process improvement and excellence
  - Dedicated Process Improvement leadership and staff, Development Center

CSSI 2006: Waiting is not an option

Goal

The goal of the CSSI Program is to foster a culture of evidence-based practice and continuous improvement in CareOregon provider organizations, helping to empower providers over time with the skills, knowledge and resources to be able to create the substantial change necessary to meet IOM goals.

Project proposals will be evaluated based on each team's experience and demonstrated ability to create change in their organization, with each new project demonstrating improved design, outcomes reporting, institutional commitment and capability.

Funding Categories and Eligibility Criteria

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CSSI “PCR” Track Pilot Sites

- Virginia Garcia – Cornelius
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Use Established Change Methods

- Basic Tools for creating change: "Model for Improvement"
  - Know what you are trying to improve
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Model for Improvement

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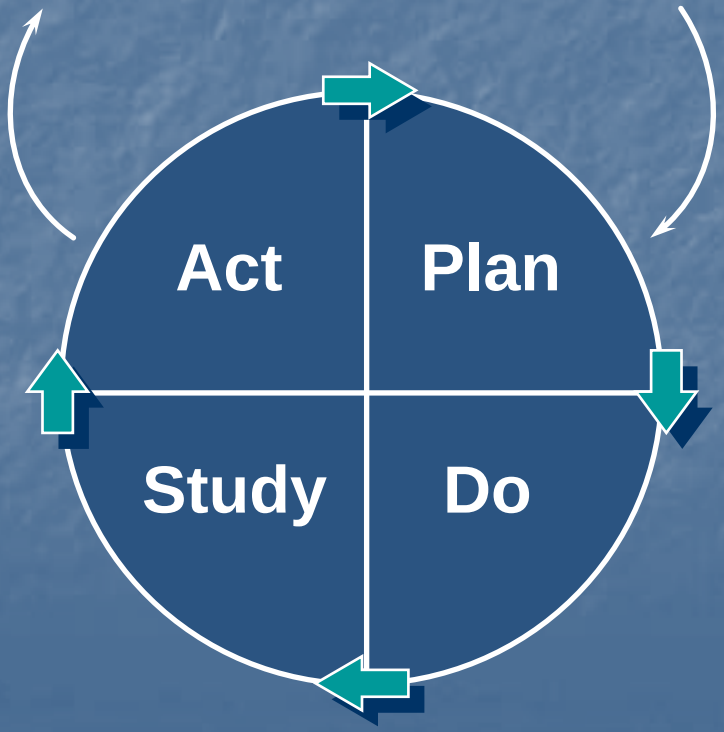

Team Based Care: Change Ideas

SCF Specific Changes	Change Ideas
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What we know...

- Primary Care Homes are being developed and renewed in Oregon.
- There is general agreement that these models provide better, cost effective care.
- The Health Fund Board can be a catalyst for the spread of primary care homes.
- Oregonians would benefit from access to a care home in their community.

Additional Information

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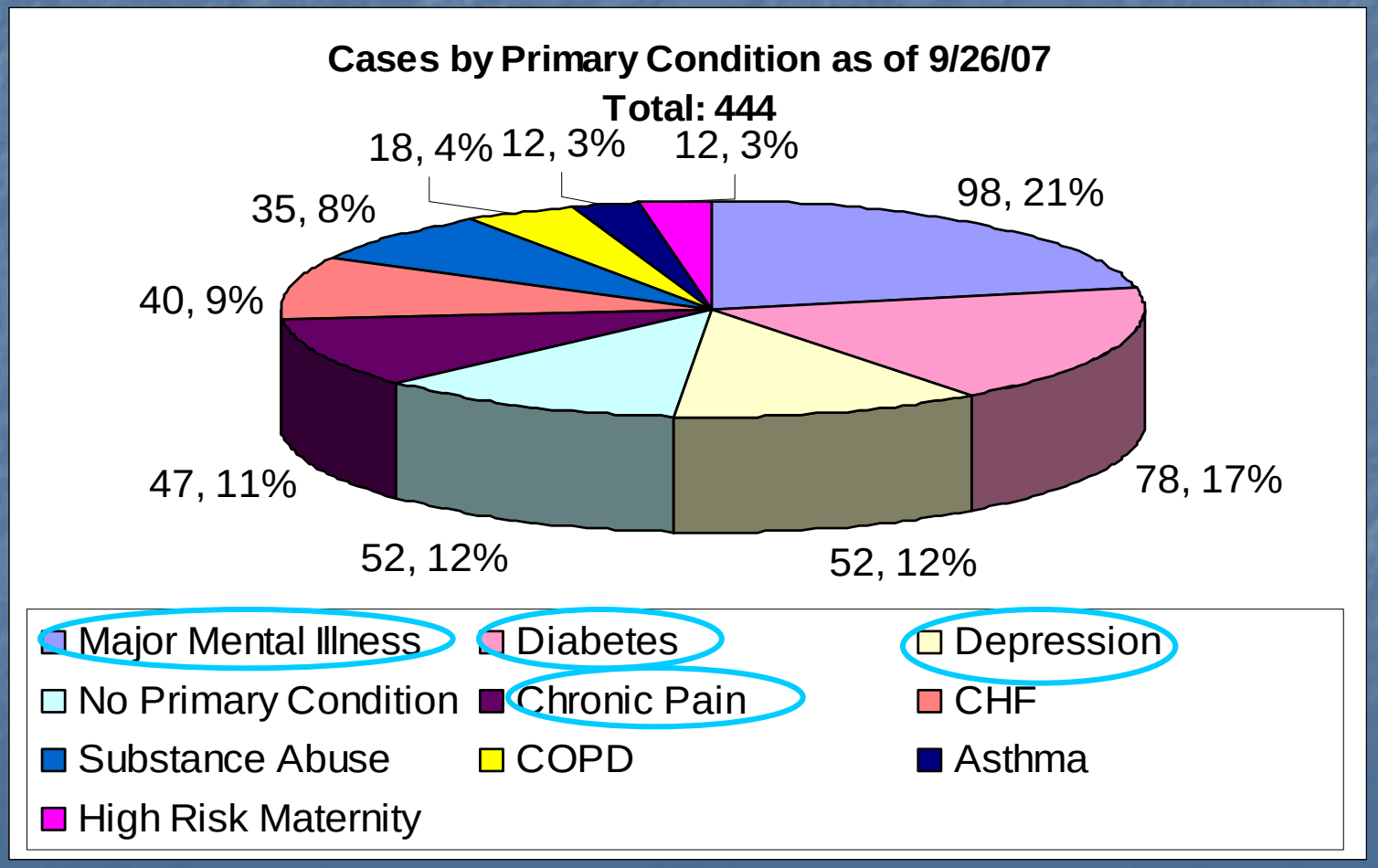

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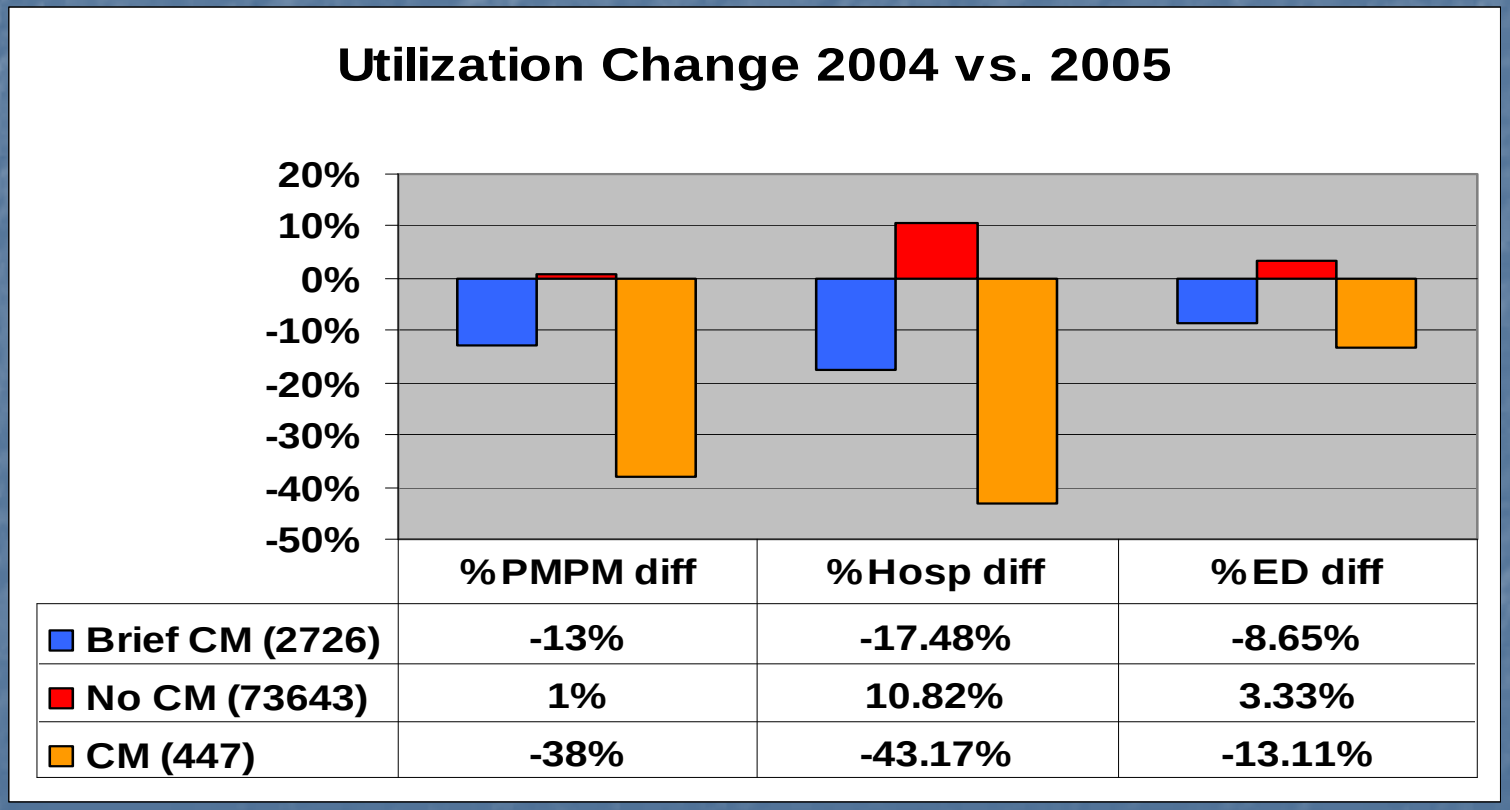

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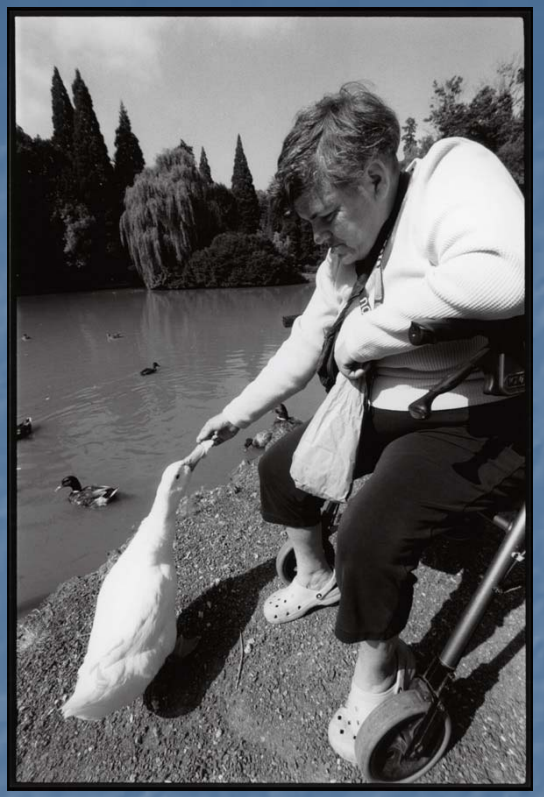

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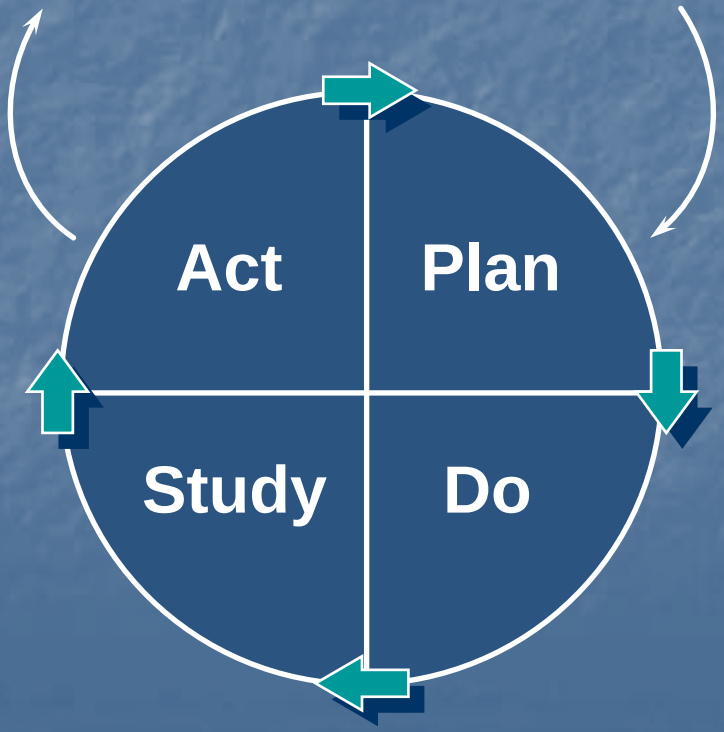

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CareOregon

The Medical Home Model of Primary Care

Presentation to the Oregon Health Fund Board and Delivery System Committee

Jeanene Smith MD,MPH

December 12, 2007

SB 329: The Healthy Oregon Act

- Calls for greater emphasis on primary and preventative care, chronic disease management, health promotion and wellness
- Calls for payment reform that rewards more efficient and effective care
- Specifically states that all participants in the Oregon Health Fund Program should have a “primary care medical home”

Challenges Facing Primary Care System in Oregon

- Workforce shortage
- Decreasing access to providers
- Overwhelming workload for primary care providers
- Patients not receiving recommended primary care
- Inadequate and inequitable reimbursement

So what is a “Medical Home”?

- “Right care at the right place at the right time”
  (Institute for Medicine)
- “The cornerstone of our entire system is the support of long-term, trusting, continual ***relationships*** with our customers”
  (D. Eby- Southcentral Foundation – Alaska)

And also includes: Integration of medical care with the community’s behavioral, dental and public health resources as well as social services to maximize <u>health</u>

Patient-Centered Medical Home – One definition

- Whole Person Orientation
- Coordinated and/or Integrated Care
- Quality and Safety
- Enhanced Access
- Personal Physician
- Physician Directed Medical Practice
- Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home

Joint Principles released by American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and American Osteopathic Association in February 2007

Evidence to Support Primary Care and Medical Home Model

- Countries with stronger primary care systems have better health outcomes and lower per-capita costs
- Having a regular source of preventive and primary care is associated with:
  - Lower per person costs
  - Fewer emergency room visits and hospitalizations
  - Better health outcomes
  - Higher patient satisfaction
- Medical homes have the potential to eliminate disparities in terms of access to quality care among racial and ethnic minorities

Medical Home Initiatives and Demonstration Projects

- PEBB requires vendors providing benefits to state employees to work towards providing medical home services to enrollees
  - Kaiser, Regence, Samaritan, Providence
- North Carolina Community Care created networks of providers to link Medicaid population with primary care homes
  - Resulted in better health outcomes and lower costs
- Many others listed in background paper – presenters will describe other efforts in OR

What are the necessary supports to make and sustain a change?

- “Fully integrated care means that every part of the system is intentionally planned to avoid duplication and maximize unique capabilities…this takes planning, learning and supporting the workforce through continual change”

  (M. Tierney – Southcentral Foundation – Alaska)

Key Considerations

- The relationship at the center of this paradigm change is that of the patient and his/her primary care team
- Transforming Oregon's primary care practices into medical homes must be seen as one part of wider effort to revitalize primary care and overall delivery of healthcare
- Providers (including physicians, nurses, etc.) must be part of any successful transformation process
- The workforce will need ongoing support through the redesign process, including learning collaborations and quality improvement trainings

Key Considerations - continued

- No one “right” way – communities and practices must have flexibility to innovate and develop models that work in particular settings
- Special consideration must be given to how medical home concept can be implemented in rural communities and for vulnerable populations
- Payment reform needed to reward provision of patient-centered, high-quality, efficient care

Today's Presentations

- Health Plan Initiatives
  - Dr. David Labby - CareOregon
  - Dr. Ralph Prows - Regence Blue Cross Blue Shield
  - Dr. Thomas Hickey - Kaiser Permanente
- Clinic/Provider Initiatives
  - Dr. Chuck Kilo– GreenField Health, Better Health Initiative
  - Dr. David Dorr – OHSU Care Management Plus

Primary Care Home: Overview of Collaboratives

Joint Meeting of the Oregon Health Fund Board, Delivery System Committee and Oregon Health Policy Commission

December 12, 2007

Ralph M. Prows, MD
Senior Medical Director
Regence BlueCross BlueShield of Oregon

Regence

Agenda

- **The National Landscape** – What's going on at the BCBS Association Level?
- **The Regional Landscape** – What's going on at Regence?
- **The Future Directions** - research and development of the primary care home

Regence

The National Landscape – What's going on at the BCBS Association Level?

- Patient-Centered Medical Home Collaborative
  - 22 BCBS Plan demonstrations
  - AAFP, ACP, AOA, and AAP

- Patient-Centered Primary Care Collaborative –
  - BCBSA = 1st payer on Executive Committee
  - NBGH, NBCH, GM, many others
  - AARP
  - Bridges to Excellence, NCQA, DMAA
  - AAFP, ACP, AOA, and AAP

Regence

The Regional Landscape – What's going on at Regence?

- Why is Regence engaged in this?

- Pilots
  - Clinical Performance Improvement
  - Pay 4 Condition
  - Patient Satisfaction
  - HIT Community Connectivity
  - Expanded Primary Care Home Collaboratives

Regence

Clinical Performance Improvement Pilots

- Criteria for selection: develop infrastructure for Patient Centered Medical Home
  - EHR in place or staged for implementation
  - Intention to implement patient-centered chronic care model
  - Generally focused on diabetes, expand to other conditions
  - Build-out registries and redesign of delivery
  - Track outcomes over time

Clinical Performance Improvement Pilots

- 2006-2007: Legacy, Family Physicians Group, PeaceHealth, North Bend Medical Center, Corvallis Clinic

- 2007-2008: Portland Family Practice, Pacific Medical Group, High Lakes, Greenfield, PeaceHealth

Pay 4 Condition

- OHSU
- Goal: model a risk-stratified reimbursement system tied to improving the care of patients with diabetes
- Team approach
- Population based

Patient Satisfaction

- **5 Medical groups**
  - Portland Clinic, Salem Clinic, Womens Healthcare Associates, Orthopedic and Fracture Care, Northwest Primary Care
- **MGMA survey,** standard methodology
- **Scientifically comparable reports**
  - physician-specific + group level reports compared to peers, region and nation
- **Data-directed improvement plans, expert redesign assistance**
- **Goal:** achieve 90th percentile of MGMA nationally

Regence

The Future Directions - research and development of the medical home

- Expanded Primary Care Home Collaboratives
  - 3 year pilots
  - 2 large scale collaboratives in Oregon, 1 in Washington
  - Demonstrated leadership and record of accomplishment in prior CPI pilots
  - Rigorous research design and evaluation strategy
- Process redesign, clinical quality, utilization and cost outcomes

Conclusions

- Primary care medical home: a compelling concept with promising early trends

- More research needed
  - Quality impact
  - Global cost impact
  - Reimbursement methodology

Oregon Health Fund Board

Kaiser Permanente Vision

Providing Members With a Medical Home

Total Panel Ownership

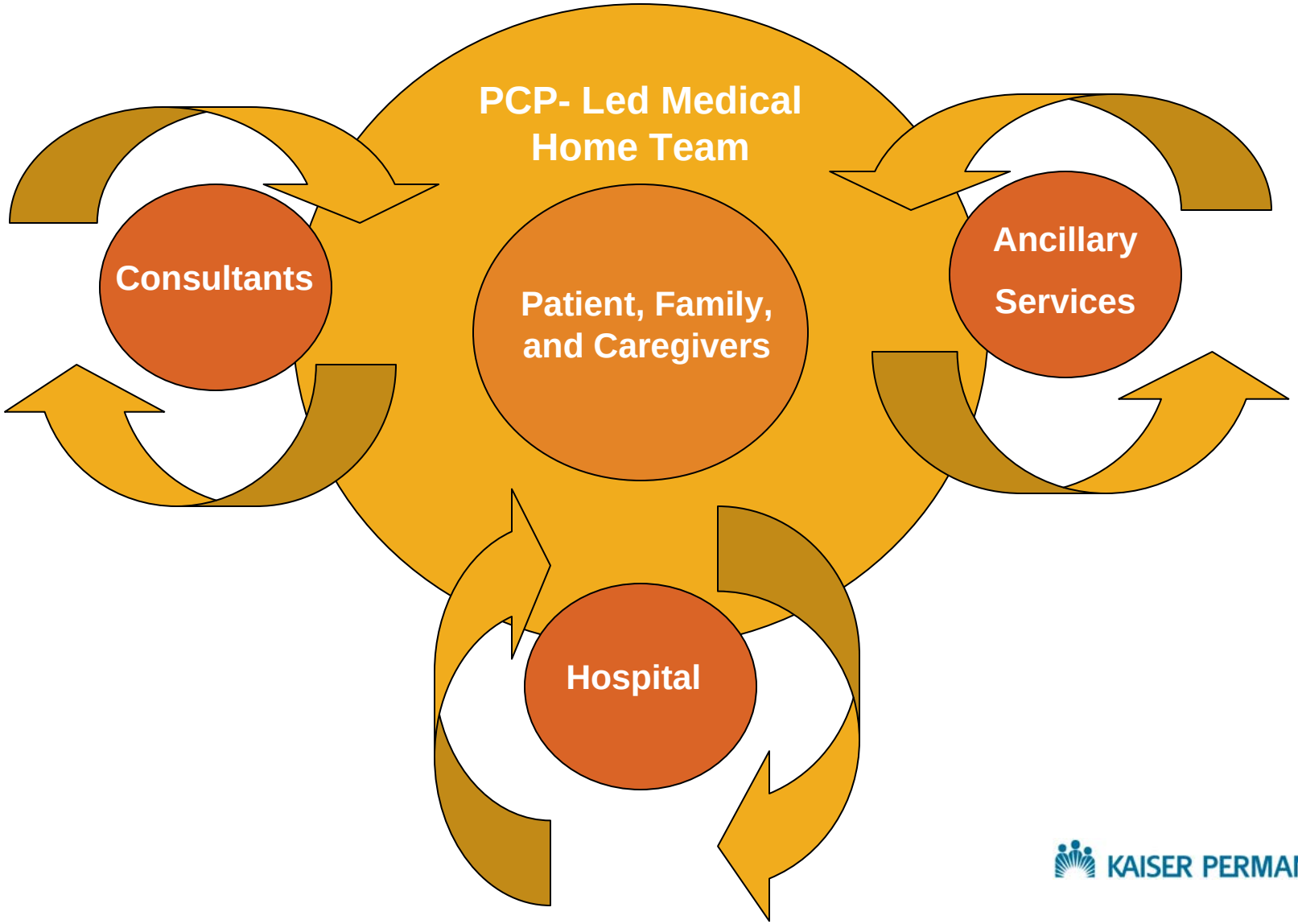
KAISER PERMANENTE®

Why Should Patients Have a Medical Home? Why Should You Advocate for Such a Healthcare Delivery System?

- Service Improves - Members have a home that coordinates all their care
- Quality Improves - Members with a primary care clinician/home have consistently better quality outcomes
- Resource Stewardship Improves - States with more PCPs, and patients who have a PCP, experience more cost effective care

KAISER PERMANENTE®

Primary Care Vision



KAISER PERMANENTE®

Primary Care Vision

- All members are attached to a primary care physician
- Members have several choices to access their physician
  - Office visits
  - Scheduled phone encounters
  - Email encounters

KAISER PERMANENTE®

The Medical Home Challenges for Kaiser

Service Excellence is the Key

- Goals
  - Service Culture Improvement
  - Improved Phone Service for Members
  - Access Improvement Primary Care
    - Enhancing the ability of members to develop a relationship with a primary care clinician
    - Increasing appointment availability to better meet members needs
  - Access Improvement Specialty Care
    - Reduce time from referral to appointment
    - Direct access for selected specialties

KAISER PERMANENTE®

Total Panel Ownership and Our Electronic Medical Record (EMR)

- Our Electronic Medical Record facilitates the Medical Home Model. All care is documented in one EMR, accessible by all members of the care team.
- The Panel Support Tool facilitates comprehensive Inreach
- The Panel Support Tool facilitates focused Outreach from the team and centrally

KAISER PERMANENTE®

Our EMR is the Member's EMR

The member can access much of their EMR via kp.org

- Medical conditions, labs, vaccine records, appointments

Health Risk Assessment coming in 2008

- Available on kp.org to all members
- Integrated into our EMR
- Members receive suggestions regarding prevention issues and lifestyle changes to address

KAISER PERMANENTE®

Member Perspective & KPNW Departments
KPNW Primary Care Model of Care for Quality & Service

Hospital Care
If hospitalized, I am confident that I will receive excellent care and be contacted after discharge to see if I have any further needs.

Regional Call Center
When I need an appointment or advice, my needs are met quickly.

Coordination of Care
When multiple specialists manage my care, I am confident that my care will be coordinated.

Specialty Care
I am called as promised and receive excellent care. My PCP knows what is going on.

My Clinician & Team

Member & Family Self Care Support
I am supported to take care of my condition within my community to the extent that I am able.

After Hours
When seen in after hours care, I am confident that my PCP and team are well informed and will follow up with me if needed.

Regional Clinical Support Services
I can get medications & tests I need.

My Medical Home
My Clinician and Team know me. They provide outstanding Care and Service and coordinate my care as needed.

Transition Care Coordination
My care is coordinated for me if I need to go from facility to facility or back to my home.

Regional Telephonic Medical Center
When I am seen outside of our system, a team helps me transition back to KP.

Multidisciplinary Case/Care Management
I receive 1:1 professional care and support for my condition when I need it.

KP.ORG
I can go to kp.org to easily access my record and get health care information.

Population- Based Care
I am contacted to help prevent or slow progression of my condition.

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Sources

States with more general practitioners use more effective care and have lower spending, while those with more specialists have higher costs and lower quality. *Baicker K, Chandra A. Medicare spending, The Physician workforce and Beneficiaries' Quality of Care. Health affairs, 2004*

International comparisons of health care systems have shown a relationship at the macro level between a well-structured primary health care plan and lower total health care costs…Provider continuity in family medicine remains one of the most important explaining variables of total health care costs (including costs for specialist visits and hospitalizations). *De Maeseneer JM, et al. Provider continuity in family medicine: Does it make a difference for total health care costs? Ann Fam Med 2003;1:144-148*

94% of patients value having a primary care physician who knows about all their medical problems. *Grumback K, et. al.. Resolving the gatekeeper conundrum. JAMA 1999;282261-266*

When more primary care physicians, per person, are practicing in a community, hospitalization rates are lower. *Parchman ML, Culler S. Primary care physicians and avoidable hospitalization. J Fam Pract 1994;39:123-128.*

Mortality rates are lower where there are more primary care physicians, but this is not the case for specialist supply. Increasing the supply of specialists will not improve the US position in population health relative to other industrialized countries, and is likely to lead to greater disparities in health status and outcomes. *Starfield B, Shi L, et. Al. The effects of specialist supply on populations' health: assessing the evidence. Health Aff (Millwood). 2005 Jan-Jun; Suppl Web Exclusives:W5-97-W5-1-7*

Physician services: 25% of national health services spending. Primary Care: 6-8% of total spending for personal health services. *GorollA, et. al. Fundamental reform of payment for adult primary care: comprehensive payment for comprehensive care. JGIM 2007;22:410-415*

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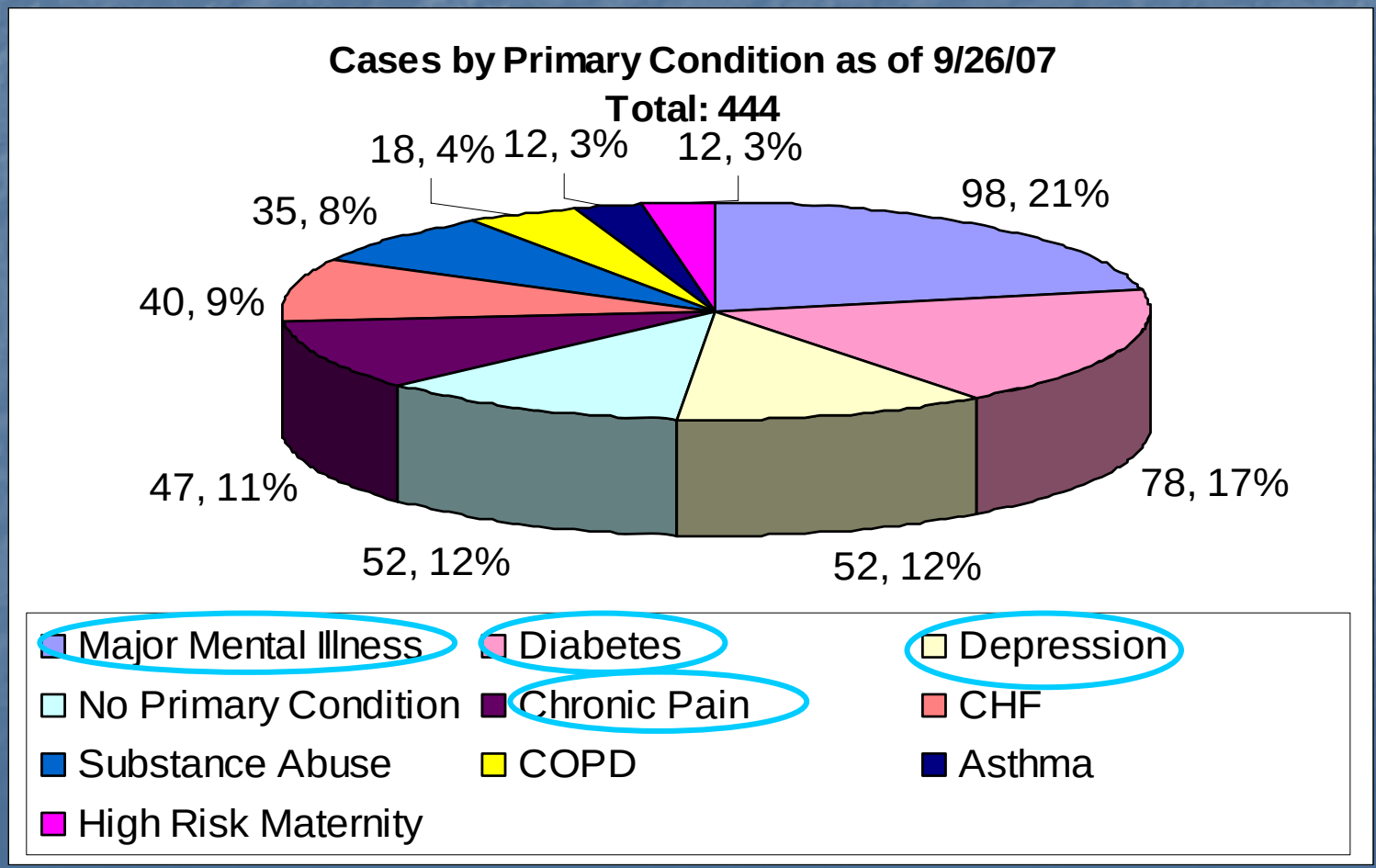
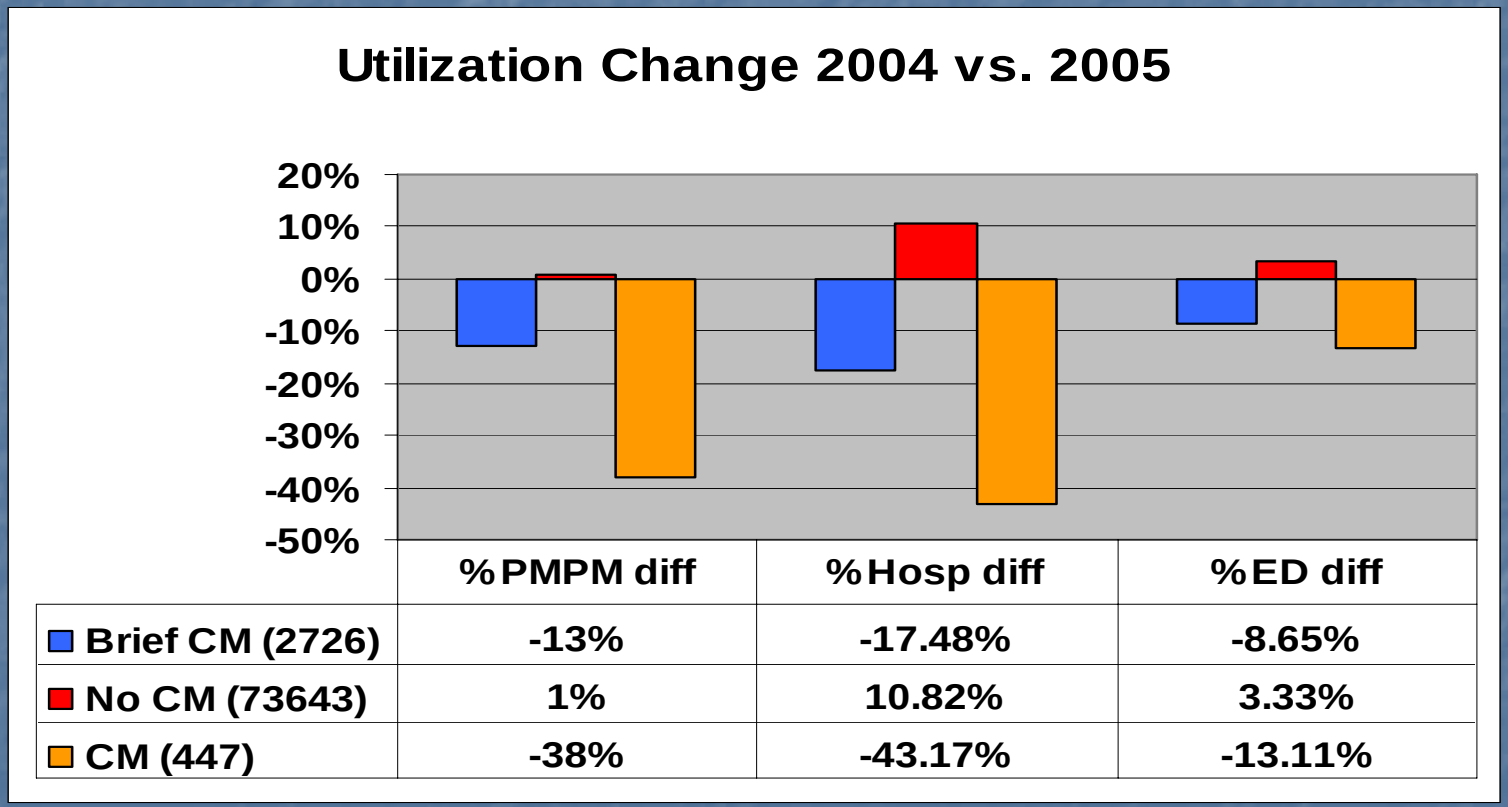
- Effective in decreasing cost and improving functional outcomes.
- Multi-disciplinary team based approach to care coordination and management.
- Improving health is about more than medical care...

Snapshot of our CareSupport population



Where have we reduced costs?



	%PMPM diff	%Hosp diff	%ED diff
Brief CM (2726)	-13%	-17.48%	-8.65%
No CM (73643)	1%	10.82%	3.33%
CM (447)	-38%	-43.17%	-13.11%

CareSupport: Cost Savings

Risk	Yr 1 pmpm	Yr 2 pmpm	Hospital	ED	Paid Change
High Risk Member	$3712	$2016	-41%	-7%	$1.86 Million
Lower Risk Member	$1085	$559	-33%	-13%	$1.66 Million

What we've learned...

CareSupport works well for a limited population...

But how do reach more people?

Critical Partnerships...

Care Support and System Innovation Program (CSSI)

- Board supported.
- Quality Improvement Funding Initiative.
- Opportunity to partner with our provider community to enhance care and learning.
- Provide dollars and now more technical assistance.

Key Transformation Components from SCF:

"Your work is not your schedule, but the health of the population you serve."

- Team based care
  - High functioning clinician, Case Manager, CMA, BH team
- Panel Management
  - Knowing panel member needs, proactive care
- "Customer" Driven Care
  - Rich stakeholder feedback on values, performance
- Direct Access
  - Removing barriers to communication, visits
- Integrated Behavioral Health
  - Co located solution based interventions

- Plus: Commitment to process improvement and excellence
  - Dedicated Process Improvement leadership and staff, Development Center

CSSI 2006: Waiting is not an option

Goal

The goal of the CSSI Program is to foster a culture of evidence-based practice and continuous improvement in CareOregon provider organizations, helping to empower providers over time with the skills, knowledge and resources to be able to create the substantial change necessary to meet IOM goals.

Project proposals will be evaluated based on each team's experience and demonstrated ability to create change in their organization, with each new project demonstrating improved design, outcomes reporting, institutional commitment and capability.

Funding Categories and Eligibility Criteria

There are four categories of CSSI funding: ambulatory care-based projects, hospital-based projects, innovation projects, and projects solicited by CareOregon.

1) Ambulatory Care: Population Based Projects-- Improving Care for One Hundred to One Thousand Lives

The CSSI 2007 focus for Ambulatory care-based projects is improving the lives of significant populations of CareOregon members and other patients. Projects will be expected to impact defined groups of patients based on evidence-based care and/or established best practices at one of the following levels:

a) Whole system primary care delivery redesign including **ALL** of the following:

- Patient/ customer driven care
- Same day access
- Proactive panel management
- Team care delivery (clinician, case manager, etc)
- Integrated behavioral health

CSSI “PCR” Track Pilot Sites

- Virginia Garcia – Cornelius
- Central City Concern
- OHSU Richmond
- Legacy Internal Medicine
- Multnomah County Health Dept

Use Established Change Methods

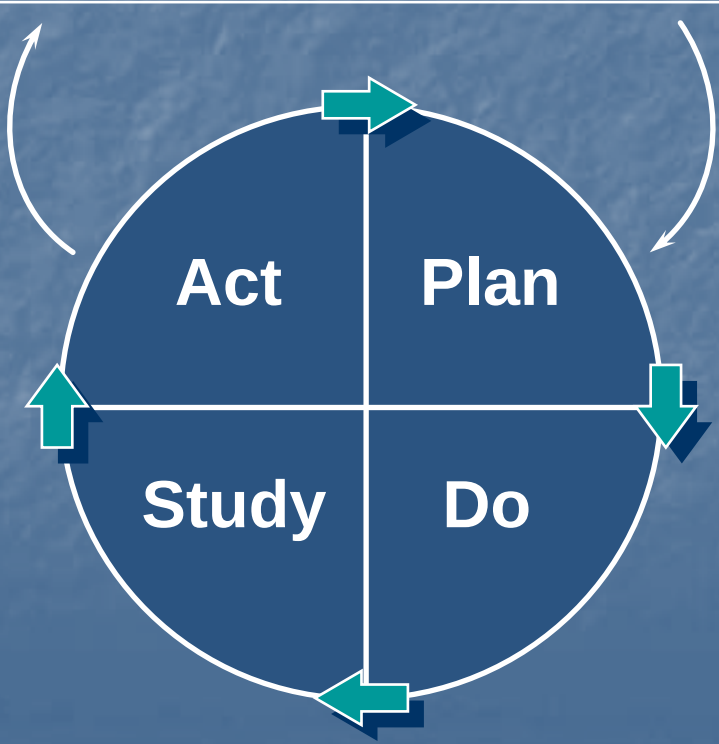
- Basic Tools for creating change: "Model for Improvement"
  - Know what you are trying to improve
  - Test small changes that can be done quickly, with simple measures
  - Keep building on small changes: be ambitious, but be patient

Model for Improvement

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?



Team Based Care: Change Ideas

SCF Specific Changes	Change Ideas
Allow team time to consult, review care	Block out time at beginning of sessions for team huddles, clinician calls to patients, chart review
Look at daily schedules to find visits that could be calls by RN or MD	AM team huddle to review next 3 day schedule and triage work
Create Care Plans on team basis	AM team huddle to review new care plans for proactive or follow up care
Establish target conditions, interventions	Initially focus on one or two target areas to refine processes, adding others incrementally
Allow clinic visits to all team members	Schedule RN, MA or BH visits depending on need

What we know...

- Primary Care Homes are being developed and renewed in Oregon.
- There is general agreement that these models provide better, cost effective care.
- The Health Fund Board can be a catalyst for the spread of primary care homes.
- Oregonians would benefit from access to a care home in their community.

Additional Information

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CareOregon

Funded by the
John A. Hartford foundation

Initial development at
Intermountain Healthcare

Medical homes in primary care: policy implications from Care Management Plus

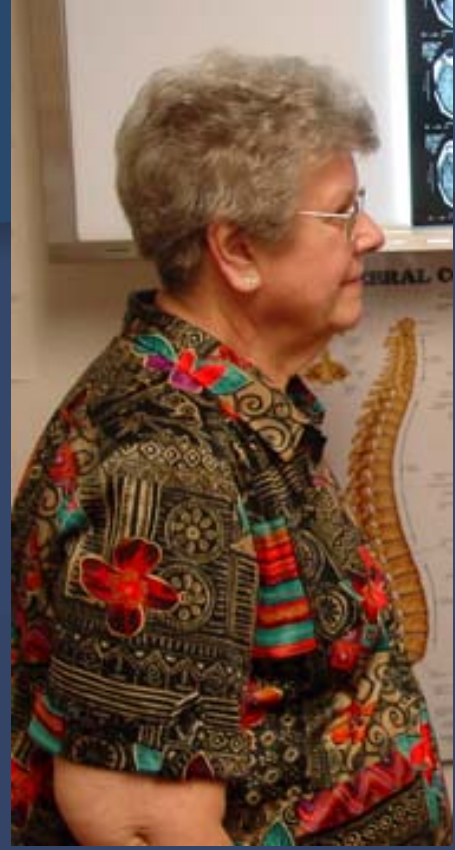
Presented by: David A. Dorr, MD MS
Assistant Professor, Medical Informatics General Internal Medicine, OHSU; for the Care Management Plus team

Date: Dec 12th, 2007

Case study

Ms. Viera

a 75-year-old woman
with diabetes,
high blood pressure,
mild congestive heart failure,
joint pain and
recently diagnosed dementia.



She sees 13 outpatient providers per year, fills 50 prescriptions per year, and patients like her represent ~50% of Medicare expenditures.

If her care is not coordinated across providers and transitions, she has an increased risk of hospitalizations and ED visits, increased risk of advancing disease, and high risk of functional decline.

How can Ms. Viera receive high quality, efficient care?

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To help meet Ms. Viera's (and her family's) needs, we developed and tested a program called Care Management Plus.

In more than 40 primary care clinics in 4 states; started at Intermountain Healthcare in Utah and spread to OHSU, PeaceHealth, others …

This helps primary care clinics develop components common to a medical home.

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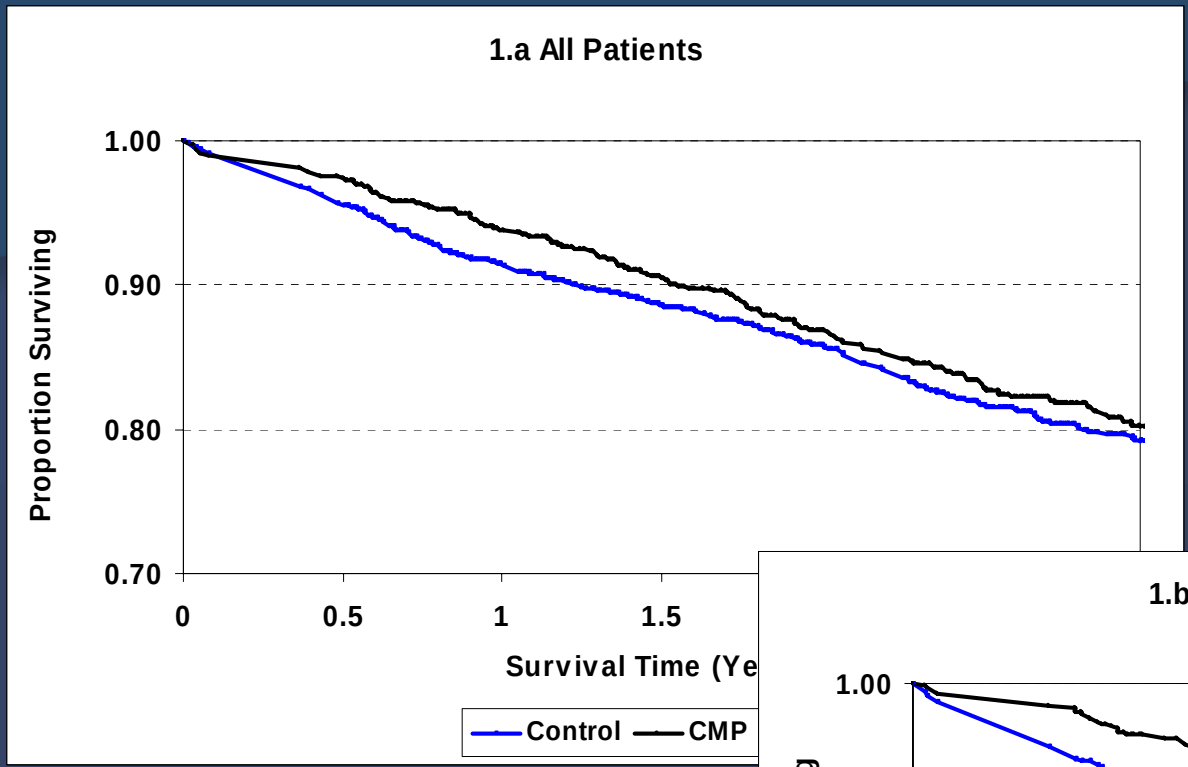
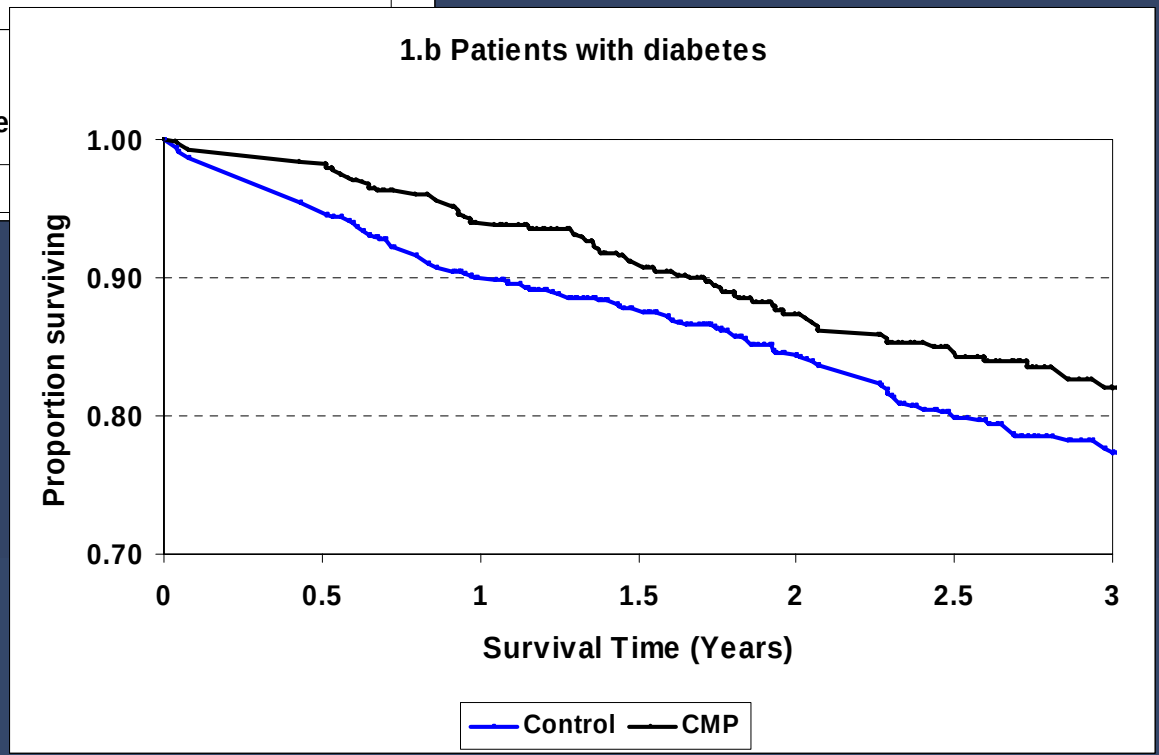
Benefits from better primary care through our study …



Diseases under better control
Patients / primary care team more satisfied
Teamwork brought efficiency gains of 8-12%
Cost savings for insurers up to $250,000 per clinic
Cost savings for clinic - limited



Dorr, AcademyHealth, 2006
Dorr et al, HSR, 2005
Dorr et al, DM, 2006
Wilcox, The CMJ, 2007
Dorr, AJMC, 2007

Primary Care Medical Home

Whole person care
Assessment, patient preferences, education, team-based care; self-management, motivation, coaching

Collaborative care planning / Coordination
Time working with patient/family to create plan
Effort to gather information and update team

Performance Measurement
Focus on measurement; voice of the patients; responsiveness

Health Information technology
Longitudinal (tracks)
Integrative (summarizes)
Best practices (reminds)

Access
Build capacity through flexible contacts (60% in person / 40% telephone / etc) and better teamwork

Quality and safety
Quality improvement
Team-based protocols

(Dorr, JGIM, 2007)

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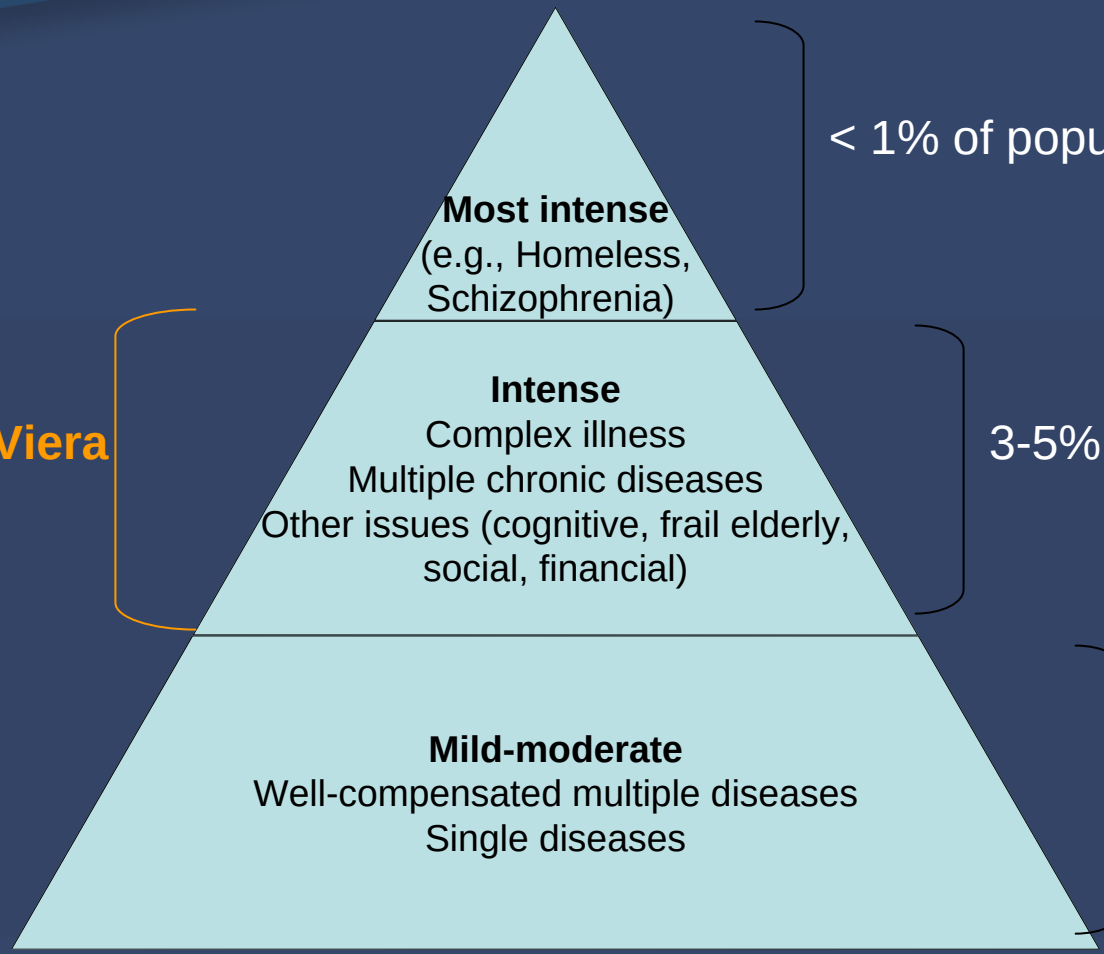
Care coordination varies by intensity and function for different populations and needs.



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Challenges in creating Medical Homes from our work

Area	Our experience	Next Steps
1. Reimbursement	Misaligned incentives	Thoughtful reform
2. Capacity	Negatively perceived environment; change attractive	(re)Train; redesign; but mostly incent
3. Reliability	Variation in clinics and implementation	Metrics (e.g., revised NCQA PPC); demonstrations
4. Costs	Not a one year, zero sum game.	Demonstration with high need patients

The Care Management Plus Team

- OHSU
  - David Dorr, MD, MS
  - K. John McConnell, PhD
  - Kelli Radican
- Intermountain Healthcare
  - Cherie Brunker, MD
- Columbia University
  - Adam Wilcox, PhD

Advisory board

- Tom Bodenheimer
- Larry Casalino
- Eric Coleman
- Cheryl Schraeder
- Heather Young

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(additional slides)

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Redesigning metrics – National Committee on Quality Assurance Physician Practice Connection

- Access and Communication
- Tracking (registry use)
- Care Management
- Patient self-management support
- Performance reporting and improvement

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PP3: Care Management (e.g.)

- Element D.1-11. For the three clinically important conditions, the physician and nonphysician staff use the following components of care management support:
  - Conducting pre-visit planning with clinician reminders
  - **Setting individualized care plans**
  - **Setting individualized treatment goals**
  - **Assessing patient progress toward goals**
  - Reviewing medication lists with patients
  - **Reviewing self-monitoring results and incorporating them into the medical record at each visit**
  - **Assessing barriers when patients have not met treatment goals**
  - **Assessing barriers when patients have not filled, refilled or taken prescribed medications**
  - **Following up when patients have not kept important appointments**
  - **Reviewing longitudinal representation of patient's historical or targeted clinical measurements**
  - **Completing after-visit follow-up**

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Primary Care Home: Overview of Collaboratives

Joint Meeting of the Oregon Health Fund Board, Delivery System Committee and Oregon Health Policy Commission

December 12, 2007

Ralph M. Prows, MD
Senior Medical Director
Regence BlueCross BlueShield of Oregon

Regence

Agenda

- **The National Landscape** – What's going on at the BCBS Association Level?
- **The Regional Landscape** – What's going on at Regence?
- **The Future Directions** - research and development of the primary care home

Regence

The National Landscape – What's going on at the BCBS Association Level?

- Patient-Centered Medical Home Collaborative
  - 22 BCBS Plan demonstrations
  - AAFP, ACP, AOA, and AAP

- Patient-Centered Primary Care Collaborative –
  - BCBSA = 1st payer on Executive Committee
  - NBGH, NBCH, GM, many others
  - AARP
  - Bridges to Excellence, NCQA, DMAA
  - AAFP, ACP, AOA, and AAP

Regence

The Regional Landscape – What's going on at Regence?

- Why is Regence engaged in this?

- Pilots
  - Clinical Performance Improvement
  - Pay 4 Condition
  - Patient Satisfaction
  - HIT Community Connectivity
  - Expanded Primary Care Home Collaboratives

Regence

Clinical Performance Improvement Pilots

- Criteria for selection: develop infrastructure for Patient Centered Medical Home
  - EHR in place or staged for implementation
  - Intention to implement patient-centered chronic care model
  - Generally focused on diabetes, expand to other conditions
  - Build-out registries and redesign of delivery
  - Track outcomes over time

Clinical Performance Improvement Pilots

- 2006-2007: Legacy, Family Physicians Group, PeaceHealth, North Bend Medical Center, Corvallis Clinic

- 2007-2008: Portland Family Practice, Pacific Medical Group, High Lakes, Greenfield, PeaceHealth

Pay 4 Condition

- OHSU
- Goal: model a risk-stratified reimbursement system tied to improving the care of patients with diabetes
- Team approach
- Population based

Patient Satisfaction

- **5 Medical groups**
  - Portland Clinic, Salem Clinic, Womens Healthcare Associates, Orthopedic and Fracture Care, Northwest Primary Care
- **MGMA survey,** standard methodology
- **Scientifically comparable reports**
  - physician-specific + group level reports compared to peers, region and nation
- **Data-directed improvement plans, expert redesign assistance**
- **Goal:** achieve 90th percentile of MGMA nationally

The Future Directions - research and development of the medical home

- Expanded Primary Care Home Collaboratives
  - 3 year pilots
  - 2 large scale collaboratives in Oregon, 1 in Washington
  - Demonstrated leadership and record of accomplishment in prior CPI pilots
  - Rigorous research design and evaluation strategy
- Process redesign, clinical quality, utilization and cost outcomes

Conclusions

- Primary care medical home: a compelling concept with promising early trends

- More research needed
  - Quality impact
  - Global cost impact
  - Reimbursement methodology

The Medical Home Model of Primary Care

Presentation to the Oregon Health Fund Board and Delivery System Committee

Jeanene Smith MD,MPH

December 12, 2007

SB 329: The Healthy Oregon Act

- Calls for greater emphasis on primary and preventative care, chronic disease management, health promotion and wellness
- Calls for payment reform that rewards more efficient and effective care
- Specifically states that all participants in the Oregon Health Fund Program should have a “primary care medical home”

Challenges Facing Primary Care System in Oregon

- Workforce shortage
- Decreasing access to providers
- Overwhelming workload for primary care providers
- Patients not receiving recommended primary care
- Inadequate and inequitable reimbursement

So what is a “Medical Home”?

- “Right care at the right place at the right time”
  (Institute for Medicine)
- “The cornerstone of our entire system is the support of long-term, trusting, continual ***relationships*** with our customers”
  (D. Eby- Southcentral Foundation – Alaska)

And also includes: Integration of medical care with the community’s behavioral, dental and public health resources as well as social services to maximize health

Patient-Centered Medical Home – One definition

- Whole Person Orientation
- Coordinated and/or Integrated Care
- Quality and Safety
- Enhanced Access
- Personal Physician
- Physician Directed Medical Practice
- Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home

Joint Principles released by American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and American Osteopathic Association in February 2007

Evidence to Support Primary Care and Medical Home Model

- Countries with stronger primary care systems have better health outcomes and lower per-capita costs
- Having a regular source of preventive and primary care is associated with:
  - Lower per person costs
  - Fewer emergency room visits and hospitalizations
  - Better health outcomes
  - Higher patient satisfaction
- Medical homes have the potential to eliminate disparities in terms of access to quality care among racial and ethnic minorities

Medical Home Initiatives and Demonstration Projects

- PEBB requires vendors providing benefits to state employees to work towards providing medical home services to enrollees
  - Kaiser, Regence, Samaritan, Providence
- North Carolina Community Care created networks of providers to link Medicaid population with primary care homes
  - Resulted in better health outcomes and lower costs
- Many others listed in background paper – presenters will describe other efforts in OR

What are the necessary supports to make and sustain a change?

- “Fully integrated care means that every part of the system is intentionally planned to avoid duplication and maximize unique capabilities…this takes planning, learning and supporting the workforce through continual change”

  (M. Tierney – Southcentral Foundation – Alaska)

Key Considerations

- The relationship at the center of this paradigm change is that of the patient and his/her primary care team
- Transforming Oregon's primary care practices into medical homes must be seen as one part of wider effort to revitalize primary care and overall delivery of healthcare
- Providers (including physicians, nurses, etc.) must be part of any successful transformation process
- The workforce will need ongoing support through the redesign process, including learning collaborations and quality improvement trainings

Key Considerations - continued

- No one “right” way – communities and practices must have flexibility to innovate and develop models that work in particular settings
- Special consideration must be given to how medical home concept can be implemented in rural communities and for vulnerable populations
- Payment reform needed to reward provision of patient-centered, high-quality, efficient care

Today's Presentations

- Health Plan Initiatives
  - Dr. David Labby - CareOregon
  - Dr. Ralph Prows - Regence Blue Cross Blue Shield
  - Dr. Thomas Hickey - Kaiser Permanente
- Clinic/Provider Initiatives
  - Dr. Chuck Kilo– GreenField Health, Better Health Initiative
  - Dr. David Dorr – OHSU Care Management Plus

VALUE-BASED HEALTH CARE PURCHASING
Providence Forums
October 2007

Jean Thorne, Administrator
Public Employees' Benefit Board (PEBB) and
Oregon Educators Benefit Board (OEBB)

Overview

- What is PEBB?
- Why PEBB chose to change its focus
- PEBB's Vision for changes in health care delivery
- PEBB's RFP and results
- Challenges for PEBB
- eValue8™ as a tool for value-based purchasing
- How purchasers can support value

PEBB Background

- Designs and purchases health care and other benefits on behalf of state employees
- Governed by 8-member Governor-appointed board (management and labor reps)
- Largest employer-based purchaser in Oregon
- PEBB Program
  - 45,000 employees
  - 120,000 covered lives
  - 2 medical care vendors (Kaiser, Regence) prior to 2006

Why PEBB Changed Its Focus

In 2002, the PEBB Board questioned whether PEBB was getting value for its health care investment.

Value = Quality/Cost

Is PEBB Getting Value: *Quality?*

- Estimated 2,000 *preventable* hospital deaths in Oregon
- Performance for chronic disease at about 55% of recommended care

Is PEBB Getting Value: *Cost?*

- Annual expenses: *(estimated)* 2005: $435M
- Average *annual* increase 1999-2005: 10.5%
  - vs. average annual raises: 1.7%
  - vs. average annual inflation 2.0%
- Proportion of total employee compensation now going to health benefits: 12.3%
- Proportion of general fund: 2.5%
- Estimated general fund proportion, 2009-2011: 3.6% to 4.5%

PEBB Vision – Why Now?

- Current contracting arrangements not clearly containing costs or improving health - *and trends are going in the wrong direction*.
- Merely increasing member cost-sharing does not address underlying issues of health care costs

What's The Appropriate Role For PEBB?

- Be crystal clear about what we want
- Use purchasing tools to encourage positive private sector response
- Educate all stakeholders about need for change and opportunity for improvement
- Hold plans and providers accountable for performance
- Offer ways to help members achieve best possible state of health

PEBB's Strategic Vision

PEBB envisions a ***new state of health*** for its members statewide.

Key components of the PEBB program include:

PEBB Vision Components

- Systems of care that provide evidence-based medicine to maximize health and utilize dollars wisely.
- A focus on improving quality and outcomes, not just providing healthcare.
- The promotion of consumer education, healthy behaviors, and informed choices.

PEBB Vision Components

- Appropriate market and consumer incentives that encourage the right care at the right time.
- System-wide transparency through explicit, available and understandable reports about costs, outcomes and other useful data.
- Benefits affordable to the state and employees.

Some Guiding Principles

- Seek “systems” of care – coordination, integration, accountability across all traditional boundaries
- Each member should have a medical home
- Set expectations for improved clinical and population-based outcomes
- Establish benchmarks against which to measure improved health status
- Recognize role of technology in supporting better clinical decision-making and patient information

RFP Domains

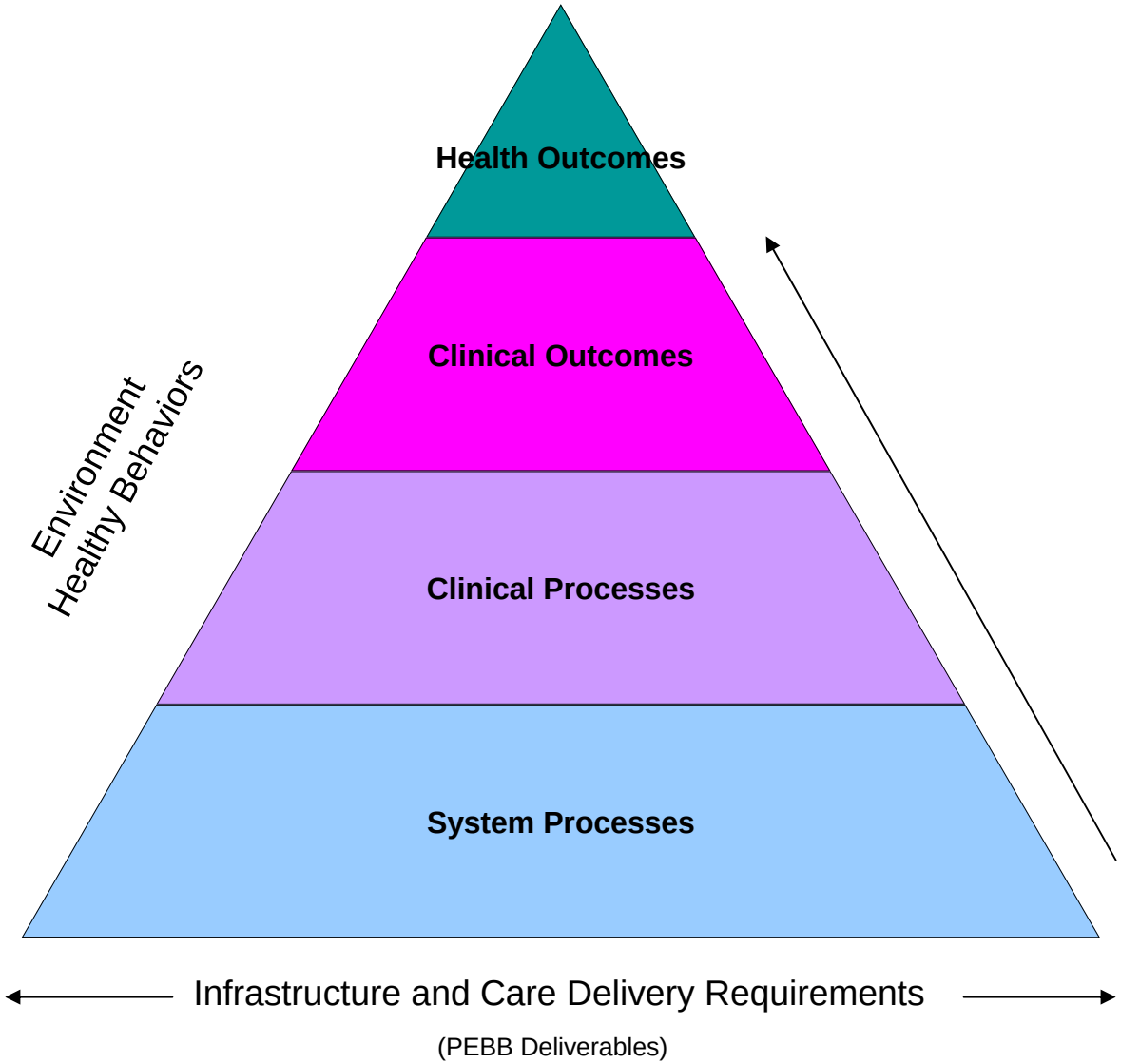
- Medical Home
- Evidence-Based Care
- Member Self-Management
- Service Integration
- Infrastructure
- Transparency
- Managing for Quality

Medical Plans for 2006 and Beyond

- Kaiser Permanente HMO, Added Choice Point of Service (POS) plan – Multnomah, Washington, Clackamas, Clark (WA), Yamhill, Columbia, Marion, Polk, Linn, Benton
- Providence Choice PPO – Multnomah, Clackamas, Washington, Yamhill
- Regence BCBSO PPO – statewide
- Samaritan Select PPO – Linn, Benton, Lincoln

Challenges Ahead

- Defining quality
- Monitoring and rewarding quality
- Engaging providers
- Engaging members
- Recognize this will take time


Health Outcomes
Clinical Outcomes
Clinical Processes
System Processes
Environment
Healthy Behaviors
Infrastructure and Care Delivery Requirements
(PEBB Deliverables)

The Role of Other Purchasers in Supporting Value-Based Purchasing

- PEBB can't do it alone
- The more purchasers demand and incentivize quality, the more likely the market will respond
- The eValue8™ RFI provides a tool to assess health plan quality

What is eValue8™?

- Evidence-based request for information
- Uses standard annual survey to gather hundreds of benchmarks in critical areas
- Offered through National Business Coalition on Health (NBCH)
- Offered in Oregon in 2007 through the Oregon Coalition of Health Care Purchasers (OCHCP)

eValue8™ Objectives

- Implement standardized performance expectations that
  - Are evidence-based, defendable in the Board Room
  - Increase the “signal strength” for multiple purchasers
  - Align with major stakeholders: HHS/CMS, OPM
- Reduce redundancy by consolidating purchaser requests
- Promote health plan accountability
- Differentiate plan performance
- Encourage health plans to evaluate the delivery systems that comprise the network
- Promote consumer engagement and informed decision making
- Provide a community-based forum for communication between purchasers and plans

eValue8™ Collaborators

- Centers for Disease Control (CDC)
- Centers for Medicare and Medicaid Services (CMS)
- Substance Abuse and Mental Health Services Administration (SAMHSA)
- Agency for Healthcare Research and Quality (AHRQ)
- National Committee on Quality Assurance (NCQA)
- Joint Commission for the Accreditation of Health Care Organizations (JCAHO)
- URAC
- American Board of Internal Medicine (ABIM)
- eHealthInitiative (eHI)
- The Leapfrog Group
- Pennsylvania State University
- George Washington University

Participating Oregon Plans in 2007

- HMOs
  - Kaiser
- PPOs
  - CIGNA
  - HealthNet
  - LifeWise
  - ODS
  - Providence
  - Regence BCBS
  - United

Participating Oregon Purchasers

- A-dec, Inc.
- Benton County
- Bethel School District
- Blount International
- City of Corvallis
- City of Eugene
- City of Springfield
- Eugene School District 4J
- Evraz Oregon Steel Mills
- Harry & David Operations Corporation
- Intel Corporation
- Lane County
- Lane Transit District
- Oregon Educators Benefit Board
- Oregon School Boards Association
- Portland General Electric
- Public Employees' Benefit Board
- SAIF Corporation
- SEIU Local-49
- Seneca Sawmill
- Tektronix, Inc.
- TOC Management Services
- United Metal Trade Association Trust

2007 Evaluation Areas

- Plan Profile
- Consumer Engagement
- Provider Measurement
- Prevention & Health Promotion
- Pharmaceutical Management
- Chronic Disease Management
- Behavioral Health

Use of eValue8™ in Oregon

- Used to identify plan performance against other plans in Oregon and against national benchmarks
- In 1st year, use is for quality improvement (no public sharing of results)
- OCHCP uses to establish priorities for plan action (site visits)

How Purchasers Can Support Value

- Look beyond short-term (one year) cost savings
- Join together with other purchasers to form a common voice in support of quality
- Consider requiring eValue8™ participation as a condition of RFPs and/or contracts
- Consider using eValue8™ results as a measure of continuous improvement for contract renewal
- Communicate the importance of quality to your members

How to Join with Others in Support of Quality Health Care

- Join the Oregon Coalition of Health Care Purchasers (OCHCP)

  www.ochcp.org

- Support the Oregon Health Care Quality Corporation

  www.q-corp.org

VALUE-BASED HEALTH CARE PURCHASING
Oregon Health Fund Board
Delivery Systems Committee
November 15, 2007

Jean Thorne, Administrator
Public Employees' Benefit Board (PEBB) and
Oregon Educators Benefit Board (OEBB)

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- Why PEBB chose to change its focus
- PEBB's Vision for changes in health care delivery
- PEBB's RFP and results
- Challenges for PEBB
- eValue8™ as a tool for value-based purchasing
- What you can do

2

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9

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11

Some Guiding Principles

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- Each member should have a medical home
- Set expectations for improved clinical and population-based outcomes
- Establish benchmarks against which to measure improved health status
- Recognize role of technology in supporting better clinical decision-making and patient information

12

RFP Domains

- Medical Home
- Evidence-Based Care
- Member Self-Management
- Service Integration
- Infrastructure
- Transparency
- Managing for Quality

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Medical Plans for 2006 and Beyond

- Kaiser Permanente HMO, Added Choice Point of Service (POS) plan – Multnomah, Washington, Clackamas, Clark (WA), Yamhill, Columbia, Marion, Polk, Linn, Benton
- Providence Choice PPO – Multnomah, Clackamas, Washington, Yamhill
- Regence BCBSO PPO – statewide
- Samaritan Select PPO – Linn, Benton, Lincoln

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Challenges Ahead

- Defining quality
- Monitoring and rewarding quality
- Engaging providers
- Engaging members
- Recognize this will take time

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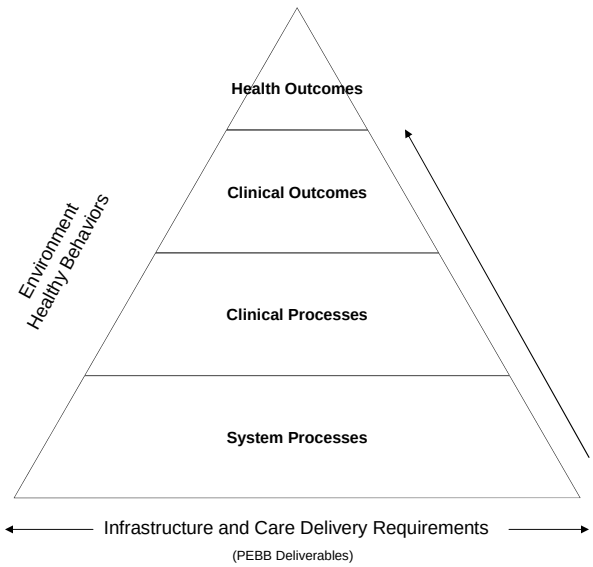

The Role of Others in Supporting Value-Based Purchasing

- PEBB can't do it alone
- The more purchasers and payers demand and incentivize quality, the more likely the market will respond
- The eValue8™ RFI provides a tool to assess health plan quality

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What is eValue8™?

- Evidence-based request for information
- Uses standard annual survey to gather hundreds of benchmarks in critical areas
- Offered through National Business Coalition on Health (NBCH)
- Offered in Oregon in 2007 through the Oregon Coalition of Health Care Purchasers (OCHCP)

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eValue8™ Objectives

- Implement standardized performance expectations that
  - Are evidence-based, defendable in the Board Room
  - Increase the "signal strength" for multiple purchasers
  - Align with major stakeholders: HHS/CMS, OPM
- Reduce redundancy by consolidating purchaser requests
- Promote health plan accountability
- Differentiate plan performance
- Encourage health plans to evaluate the delivery systems that comprise the network
- Promote consumer engagement and informed decision making
- Provide a community-based forum for communication between purchasers and plans

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eValue8™ Collaborators

- Centers for Disease Control (CDC)
- Centers for Medicare and Medicaid Services (CMS)
- Substance Abuse and Mental Health Services Administration (SAMHSA)
- Agency for Healthcare Research and Quality (AHRQ)
- National Committee on Quality Assurance (NCQA)
- Joint Commission for the Accreditation of Health Care Organizations (JCAHO)
- URAC
- American Board of Internal Medicine (ABIM)
- eHealthInitiative (eHI)
- The Leapfrog Group
- Pennsylvania State University
- George Washington University

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Participating Oregon Plans in 2007

- HMOs
  - Kaiser
- PPOs
  - CIGNA
  - HealthNet
  - LifeWise
  - ODS
  - Providence
  - Regence BCBS
  - United

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Participating Oregon Purchasers

- A-dec, Inc.
- Benton County
- Bethel School District
- Blount International
- City of Corvallis
- City of Eugene
- City of Springfield
- Eugene School District 4J
- Evraz Oregon Steel Mills
- Harry & David Operations Corporation
- Intel Corporation
- Lane County
- Lane Transit District
- Oregon Educators Benefit Board
- Oregon School Boards Association
- Portland General Electric
- Public Employees' Benefit Board
- SAIF Corporation
- SEIU Local-49
- Seneca Sawmill
- Tektronix, Inc.
- TOC Management Services
- United Metal Trade Association Trust

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2007 Evaluation Areas

- Plan Profile
- Consumer Engagement
- Provider Measurement
- Prevention & Health Promotion
- Pharmaceutical Management
- Chronic Disease Management
- Behavioral Health

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Use of eValue8™ in Oregon

- Used to identify plan performance against other plans in Oregon and against national benchmarks
- In 1st year, use is for quality improvement (no public sharing of results)
- OCHCP uses to establish priorities for plan action (site visits)

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How Purchasers Can Support Value

- Look beyond short-term (one year) cost savings
- Join together with other purchasers to form a common voice in support of quality
- Consider requiring eValue8™ participation as a condition of RFPs and/or contracts
- Consider using eValue8™ results as a measure of continuous improvement for contract renewal
- Communicate the importance of quality to members

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What You Can Do

- Don't reinvent the wheel; build on existing collaborations
- Recognize that state government – as a purchaser – can impact the health care delivery system
- Find ways to encourage or incentivize change that increases quality
- Recognize that one size doesn't fit all – different purchasers and different consumers have different needs

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Modeling Health Care Reform

An Overview of Jonathan Gruber's Microsimulation Model

Alyssa Holmgren

Presentation to the Finance Committee

November 19, 2007

Goals of Modeling Health Care Reform

- To analyze comprehensive models for increasing access to health insurance
- Elements to consider in designing reform
  - Costs
    - State and Federal
    - Other
  - Movement (including crowd-out)
  - Participation rates
  - Revenue estimates

Source: A. Lischko, "Modeling Health Care Reform: What States Need to Know," Presentation at SCI Modeling Workshop, November 10, 2004.

Questions to Answer before Modeling Can Begin

- What policy options do you want to evaluate?
- What output do you require? Who is your audience?
- What data are available?
  - State, Federal, other
- Does the work require outside expertise?

Source: A. Lischko, "Modeling Health Care Reform: What States Need to Know," Presentation at SCI Modeling Workshop, November 10, 2004.

The Gruber Microsimulation Model

- Shows how policy changes affect the economy
- Inputs
  - Policy parameters
- Outputs
  - Impact on public sector costs
  - Distribution of insurance coverage
  - Effect on public sector revenues
- Similar to approach used by Treasury Department, CBO, and other government entities

Source: J. Gruber, *Modeling Health Care Reform in California*, prepared for The California Endowment and the California HealthCare Foundation, February 2, 2007. Available at http://gov.ca.gov/pdf/press/Gruber_Modeling_Health_Care_Reform_In_California_final_study_020207.pdf

The Gruber Microsimulation Model

- Demonstrates the effect of government interventions in health insurance markets
  - Impact of tax subsidies on employer insurance
  - Impact of public coverage on private insurance take-up (crowd-out)
  - Impact of lower health insurance costs for employers on employee wages

Source: J. Gruber, *Modeling Health Care Reform in California*, prepared for The California Endowment and the California HealthCare Foundation, February 2, 2007. Available at http://gov.ca.gov/pdf/press/Gruber_Modeling_Health_Care_Reform_In_California_final_study_020207.pdf

Strengths of the Model

- Holistic approach
  - Considers the effect of interventions on all firms and individuals in the state
- Focuses on price
  - Can address multiple integrated policy approaches by converting their effects into price changes
  - Determines how firms and individuals will react to those price changes based on behavioral evidence from health economics
- Assesses firm reactions by looking at a set of workers within the firm and aggregating impacts to the firm level

Source: J. Gruber, *Modeling Health Care Reform in California*, prepared for The California Endowment and the California HealthCare Foundation, February 2, 2007. Available at http://gov.ca.gov/pdf/press/Gruber_Modeling_Health_Care_Reform_In_California_final_study_020207.pdf

Potential Weaknesses of the Model

- Most reliable when comparing similar proposals that only differ along a small number of dimensions
- Relative impacts are more reliable than absolute impacts
- Estimates become more uncertain as we depart farther from existing experience in the insurance market

Source: J. Gruber, "Modeling Health Care Reform in California," Presentation, May 16, 2007. Available at http://calhealthreform.org/pdf/GruberStudy062807Addendum.pdf

Data Needed for Modeling Reform

- State
  - Individual Data
  - Employer Data
  - Insurance Market
  - Medicaid and other public program cost data
- Federal
  - Current Population Survey (CPS)
  - Medical Expenditure Panel Survey (MEPS)
- Other
  - Behavioral responses from literature
  - State-specific behavioral responses

Source: A. Lischko, "Modeling Health Care Reform: What States Need to Know," Presentation at SCI Modeling Workshop, November 10, 2004.

California-Specific Model

- California sample of the Feb/Mar 2001 CPS
- Updated with 2005 CA Health Insurance Survey data
- Premiums, cost-sharing, and offer rates by firm size updated with 2004 California-specific MEPS data, updated to 2007
- Cost of non-group policies difficult to determine

Source: J. Gruber, *Modeling Health Care Reform in California*, prepared for The California Endowment and the California HealthCare Foundation, February 2, 2007. Available at http://gov.ca.gov/pdf/press/Gruber_Modeling_Health_Care_Reform_In_California_final_study_020207.pdf

CA Specific Model – Policy Decisions

- Public insurance expansion
  - To what level?
  - Adults and kids?
  - Documented and undocumented?
- Central purchasing mechanism
  - Who is eligible?
  - Cost of policies available?
  - Cost sharing required?
- Individual mandate?
  - What qualifies as the minimum coverage required?
  - Effective for both documented and undocumented populations?
- Non-offering assessment
  - Which employers pay?
  - How much?

Source: J. Gruber, *Modeling Health Care Reform in California*, prepared for The California Endowment and the California HealthCare Foundation, February 2, 2007. Available at http://gov.ca.gov/pdf/press/Gruber_Modeling_Health_Care_Reform_In_California_final_study_020207.pdf

Population Flows Pre- and Post-Reform

Table 1: Population Flows for Children & Documented Adults					
	FROM: Old Source of Insurance				
TO: New Source of Insurance	Public Insurance	Employer-Provided Insurance	Non-Group Insurance	Uninsured	New Totals
Public Insurance	5.9	0.3	0.1	1.2	7.6
Employer-Provided Insurance	*	17.5	*	0.8	18.3
Non-Group Insurance	0	0	1.6	0.8	2.4
New Pool	0.2	0.6	0.1	1	1.9
Uninsured	0	0	0	*	*
Old Totals	6.1	18.3	1.9	3.8	30.1

Note: Population counts shown in millions. Totals may not sum due to rounding

Source: J. Gruber, *Modeling Health Care Reform in California*, prepared for The California Endowment and the California HealthCare Foundation, February 2, 2007. Available at http://gov.ca.gov/pdf/press/Gruber_Modeling_Health_Care_Reform_In_California_final_study_020207.pdf

Net Changes in Insurance Status Due to Reform

Table 2: Net Changes in Population for Entire Population (Under Age 65)			
Insurance Source	Before	After	Change
Public Insurance	6.6	8.1	1.5
Employer-Provided Insurance	18.8	18.8	0
Non-Group Insurance	2	2.7	0.7
New Pool	0	1.9	1.9
Uninsured	4.9	0.8 *	-4.1
Total	32.2	32.2	0

Note: Population counts shown in millions. Totals may not sum due to rounding.

* These individuals will be covered by the counties.

Source: J. Gruber, *Modeling Health Care Reform in California*, prepared for The California Endowment and the California HealthCare Foundation, February 2, 2007. Available at http://gov.ca.gov/pdf/press/Gruber_Modeling_Health_Care_Reform_In_California_final_study_020207.pdf

Effects of Reform on Public Spending

Table 3: Effects on Public Insurance Spending			
Eligibility Category	Net Change in Public Enrollment (millions)	PMPM ($/month)	Total Cost ($ millions /year)
Children Under 100% FPL	0.25	103	310
Children 100-250% FPL	0.55	103	655
Children 250-300% FPL	0.1	103	125
Adults, Previously Eligible	0.25	177	530
Adults, Newly Eligible	0.4	177	830
Total	1.5		2450

Source: J. Gruber, *Modeling Health Care Reform in California*, prepared for The California Endowment and the California HealthCare Foundation, February 2, 2007. Available at http://gov.ca.gov/pdf/press/Gruber_Modeling_Health_Care_Reform_In_California_final_study_020207.pdf

POLICY PLAYBOOK

AND INITIATIVE GUIDE

GAINING SUSTAINABLE ADVANTAGE

5th ANNUAL
LEADERSHIP SUMMIT
January 4, 2007

Oregon Business Plan .org

CONTENTS

6. HEALTH CARE

RECOMMENDATIONS

In order to lower health care costs, improve quality, and expand access to care, the Oregon Business Plan recommends the following:

- **Use value-based purchasing strategies by employers and public sector purchasers to improve quality and lower costs. Employers should encourage a culture of wellness and personal responsibility, and design benefit plans to improve health, including coverage of preventive services, management of chronic conditions, protection from catastrophic costs, and incentives for wellness. Employers should also create an effective market for health care: consumer choice of health plans, better consumer information, and appropriate consumer cost sharing. Employers should develop expectations and incentives for health plans and providers to encourage higher quality and use of evidence-based care.**
- **Encourage investment in health care information infrastructure: electronic medical records, secure exchange of health information among providers, standardized measures of quality, and transparent information on costs and quality.**
- **Expand Medicaid to reduce the number of uninsured and improve access to care. Use additional state revenue to maximize federal matching funds. Increase payments to providers who serve Medicaid patients to improve access to care. In exchange, providers and health plans should reduce the cost shift by lowering charges to privately-insured employers and individuals.**
- **Increase access to coverage for individuals and small businesses: require individuals to have health insurance, subsidize low-income workers and individuals to enable them to afford coverage, and create an "insurance exchange" to make it easier for individuals and employees of small businesses to purchase insurance.**

Vision

We support actions to give all Oregonians access to quality health care. This can best be accomplished by creating a fair market where everybody is motivated to improve health, ensure quality, and control costs. In such a system, individuals, employers, health plans, and providers have incentives to encourage good health, and consumers make informed choices about health practices and treatment options based on understandable health information and transparent prices and quality.

The Problem

The current health care system in the U.S. and Oregon is not delivering value.

- The U.S. spends a much higher share of its GDP on health care than other developed countries.
- Health insurance premiums have been increasing at an unsustainable rate.
- The quality of care in the U.S. is inconsistent

ACCOMPLISHMENTS TO DATE

- √ **Published a white paper summarizing the problems and root causes of high health care costs and inconsistent quality**
- √ **Developed the business case for a pilot project to enhance the exchange of health information among providers and locations of care.**
- √ **Supported efforts to develop websites to provide comparative information on hospital prices and quality.**
- √ **Collaborated with initiative to develop standardized quality measures for outpatient care.**
- √ **Developed a partnership with the Oregon Coalition of Health Care Purchasers (OCHCP) to educate employers and encourage them to use more effective purchasing strategies for health benefits.**

and often below the standards of other developed countries.

- Our health care system leaves many people – nearly one-sixth of the population -- without health insurance coverage.

Why is this important for businesses and all Oregonians? The Oregon business community has identified health care as one of the most serious cost problems it faces. The high cost of health benefits:

- Makes it more expensive for Oregon businesses to compete in a global market
- Reduces funds for business investment
- Dampens economic recovery and job growth
- Reduces funds available for cash compensation to employees

The Oregon business community has identified health care as one of the most serious cost problems it faces.

In addition, the high cost of publicly-financed health care crowds out needed public investment in education and transportation.

Lack of consistently high quality care also is a serious concern. Employee productivity is reduced, and – much more importantly – lives are being lost. The lack of access to coverage for many Oregonians is unacceptable in our society, and the costs for caring for the uninsured are shifted to those who have insurance, putting an additional cost burden on businesses and individuals.

Health Care Task Force

In response to these concerns, the OBC Health Care Task Force was commissioned in the spring of 2004.

The task force had four primary objectives:

- Understand the health care problem in Oregon and the impact on businesses and the community
- Educate businesses and the community regarding the problem and its impact
- Develop a long-term vision and principles to address these problems
- Create a proposal for comprehensive redesign of the health care system.

Challenges

The health care system is badly broken and needs to be redesigned. The problems of cost, quality and access are driven by three closely related factors:

- Fundamental cost drivers
- Lack of effective market forces
- The vicious cycle of costs and access to care

[Note: These factors are described in more detail in the OBC's white paper, "A New Vision for Health Care," December 2004.]

Fundamental Cost Drivers

- *Aging.* The percentage of the population over 65 is increasing steadily.

- *Chronic conditions.* It is estimated that five conditions (heart disease, mental disorders, pulmonary disorders, cancer, and trauma) have driven a large portion of overall cost increases during the past 15 years.
- *Technology.* New advancements in diagnostic and treatment technologies are providing new alternatives, many of which extend life or improve health, but at increased cost.
- *Unhealthy lifestyles.* Poor health choices and the lack of personal accountability for health -- exacerbated by limitations on public health initiatives – contribute to higher costs. For example, the scope and impact of the obesity epidemic are well-documented.

Lack of Effective Market Forces

There are four important levers that have the potential to drive improvements in the value – cost, quality and service – delivered by our health care system:

- Consumer choice
- Price sensitivity
- Information to support informed consumer choice
- Healthy competition between providers

How is this working in the current U.S. health care system?

Choice. The majority of employed Americans do not have a choice of health plans offered by their employers.

Price sensitivity. Most consumers are shielded from the real costs of health care. In this situation, consumers lack financial incentives to manage their demand for health care services, and they lack strong economic incentives to shop for efficient health care providers. (Although new benefit plans with considerably higher cost sharing – often known as "high deductible health plans" – have been introduced in recent years, they are still a relatively small share of the market.) Furthermore, many employers pay the full premium or a high percentage of the full premium, regardless of the cost. As a result, there is little incentive for employees to choose the most efficient health plan. In addition, many physicians are unaware of the costs of providing services and are not in a position to assist patients in making cost-effective choices.

Information. It is difficult to obtain useful and reliable data to compare the cost and quality of health plans and providers. Consumers are often not in a position to make informed decisions about the diagnosis and treatment of diseases, and must rely on providers to tell them what medication or treatment is needed. Publicly available information on health care costs and quality is gradually reaching consumers, but it is currently inadequate to support informed decision-making by most of them.

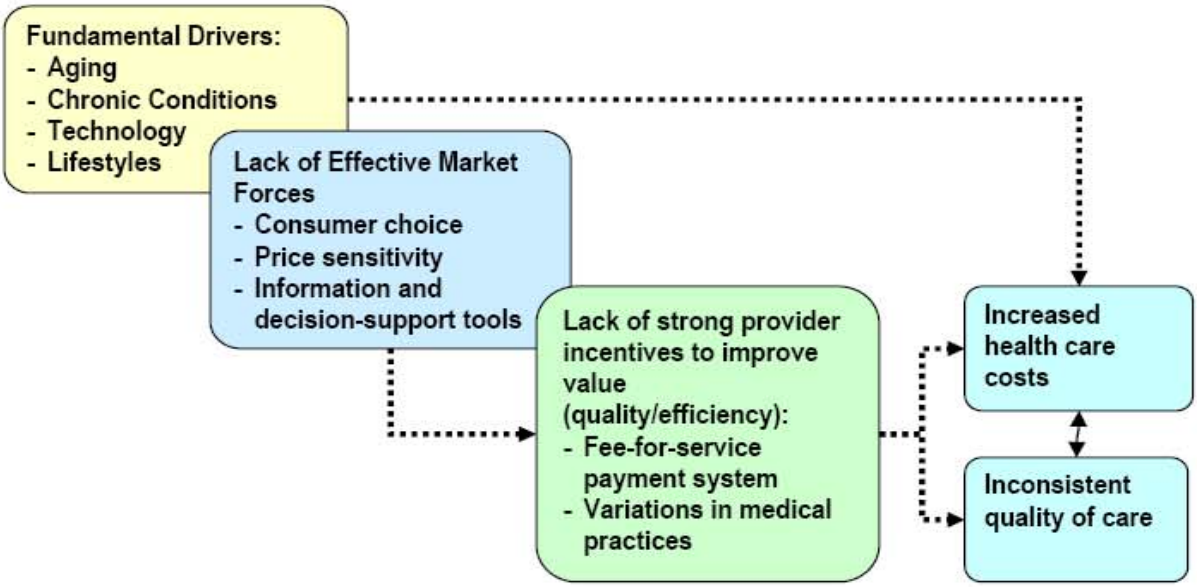
Healthy Competition. Given this situation, there is little incentive for health plans or providers to differentiate themselves and compete on cost or quality. Exacerbating this problem is the fact that most providers – especially physicians – are paid on a fee-for-service basis, i.e., a fee for each service delivered. This compounds the effects of the fundamental drivers of demand for medical care. For a physician to be successful financially, s/he is driven to provide a greater number of services. While this may or may

not result in improved health outcomes, it can cause more services to be delivered than are necessary. In some cases, over-treatment can also cause poor medical outcomes. (See Figure 1 for a graphic summary of these factors.)

The problems of lack of consumer choice, useful information and healthy competition are

Figure 1.

THE ROOT CAUSES OF HEALTH CARE COST INCREASES



especially acute for employees of small businesses and non-employed individuals. Health plans will usually provide coverage to small groups only on an exclusive basis, thereby eliminating the opportunity for consumers to make choices. The lack of choice also reduces "portability" by making it more difficult for employees to stay with a particular health plan when they move from one job to another. Small businesses seldom have the time or expertise to shop effectively for health insurance, thereby weakening their purchasing power. From the health plans' perspective, small group and individual coverage incurs higher administrative and selling costs, and the claims costs for this segment are subject to higher risk variation. As a result, the rates charged to small groups and individuals are higher and less stable year-to-year, although rate regulations dampen these problems to some degree.

Other Factors

- The medical care delivery system is very fragmented. Most physicians are self-employed in solo practices, and only 25 percent are in practices of eight or more. This is an obstacle to creating more efficient care delivery processes, investing in electronic health information systems, and coordinating care more effectively for patients. It also has contributed to the slow and inconsistent adoption of "evidence-based guidelines" for medical practice, leading to both under- and over-treatment of

common conditions. It has also delayed the implementation of initiatives to reduce serious medical errors.

- The U.S. health care system has very complicated administrative processes. As a result, administrative costs are high – 7 percent of total health care expenditures according to government statistics. Some researchers estimate that total system administrative costs – including costs hidden in hospital and physician costs – are much higher (31 percent). Part of this is due to the market fragmentation among providers, health plans, and purchasers. As a result, the system has a high level of duplication and a lack of standardization.
- The lack of a well-developed infrastructure or standards for health care information systems has also been a major obstacle. Health care information exists in a multitude of places in varying formats, some paper, some electronic. This has created inefficiency because information flow between consumers, providers, employers and health plans is not timely. This adds expense due to redundancy and re-work. Furthermore, the delays in the availability of health information can lead to compromised safety and quality.

There is a complex but powerful relationship between rising costs and deteriorating access to care.

The Vicious Cycle of Costs and Access

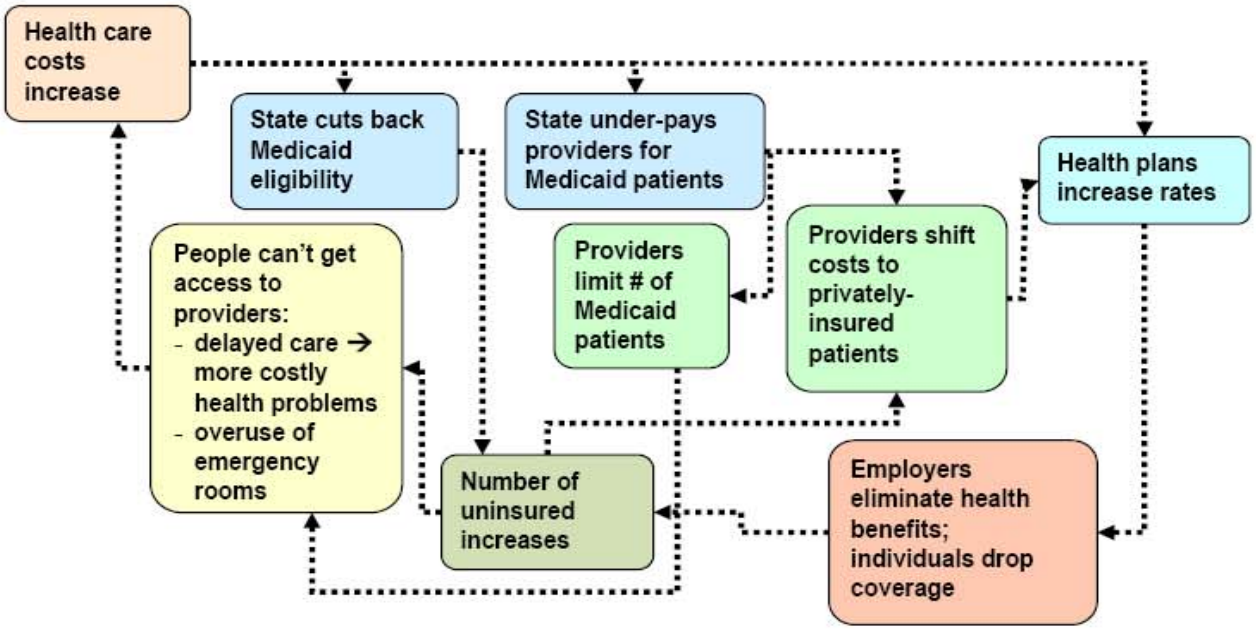
There is a complex but powerful relationship between rising costs and deteriorating access to care.

- The most basic dynamic starts with cost increases that drive higher health insurance rates. As a result, many employers are reducing coverage, especially for dependents, or are dropping employee health benefits altogether. Similarly, increasing health care costs have forced the state to reduce the number of people in the Medicaid program (Oregon Health Plan). These actions by employers and state government have increased the number of uninsured, for whom it is much more difficult to get access to care.
- The increase in the number of uninsured and the resulting access problems results in delayed treatment and inappropriate use of hospital emergency departments for non-emergency care. This further increases costs, creating a vicious cycle by increasing insurance rates and putting additional pressure on employers and the state to reduce coverage.
- The increasing number of uninsured non-paying patients in hospital emergency departments also forces hospitals to charge higher rates for insured patients. This cost shift results in higher insurance rates, creating another vicious cycle by forcing employers to reduce coverage, thereby increasing the number of uninsured.
- Higher costs have also forced the state and federal governments to under-pay for care provided to Medicare and Medicaid patients. This has led many providers to set caps on the number of Medicare/Medicaid patients they will see, thereby exacerbating the access problem. This also contributes to the cost shift, as providers increase charges for insured patients to offset the low payments for Medicare and Medicaid patients.

As a result, employers and individuals with health insurance carry an additional burden. In addition to higher insurance rates caused by the fundamental cost drivers described earlier, the rates are increased further due to the cost shift. The magnitude of the cost shift is estimated to be 10 to 15 percent in addition to basic health insurance rates. (See Figure 2 for a graphic summary of these factors.)

Figure 2

THE VICIOUS CYCLE OF HEALTH CARE COSTS AND ACCESS



The linkage between costs and access is further complicated by the complex health care financing system in the United States. There are three primary ways in which health benefits are financed:

- *The employer-based system, which covers 52 percent of the total population in Oregon.* Employees and their dependents receive benefits that are largely paid by employers. The benefits are determined by the employer or through collective bargaining. The value of the health benefits is exempt from personal income taxes. (Individuals who purchase health insurance directly account for an additional 6 percent of the population.)
- *Medicaid, which covers 12 percent of Oregonians.* Low-income people in certain eligibility categories receive benefits. The eligibility rules and benefits are set by the federal government, with some flexibility at the state level.
- *Medicare, which covers 13 percent of Oregonians.* Elderly and disabled people are eligible to receive benefits. The benefits are established and administered by the federal government.

Each of these major categories has different funding mechanisms, eligibility requirements, benefit designs and administrative jurisdiction. As a result, many people fall between the cracks of these categories. For example, many part-time or seasonal employees, dependents, and employees of small businesses do not have benefits. Many

low-income people are not eligible for Medicaid because they do not fit into one of the aid categories, but they are unable to afford health coverage. By limiting eligibility to the very poorest, we effectively discourage work.

Agenda for 2007 and Beyond

The OBC Health Care Task Force has developed a set of recommendations to address the problems with the current health care system. The proposals are built upon an understanding of the root causes and a set of core principles:

Principles

1. There are three essential issues to address: cost, quality and access. Many reform proposals focus only on access. We believe this is insufficient. Any proposal that does not address the system changes needed to reduce costs will be unaffordable. We are committed to finding solutions that are economically sustainable.

2. The health care system is badly broken and needs fundamental change. Fixing the problems of high costs, inconsistent quality, and poor access will take sustained and focused effort over many years. Ultimately, the system of delivering health care services requires major restructuring. Some improvements can be driven by changes in health care financing and purchasing, but those changes alone will not be sufficient to improve the cost and quality of health care services.

3. This is a systemic problem that requires collaborative problem-solving. It's easy to look for and blame villains, but that won't fix the problem. All of the key stakeholders – consumers, employers, providers, health plans and government – are part of the systemic problem, so we all must step up to be part of the solution. The business leaders working on this initiative are committed to collaborating with key stakeholders and policy-makers to achieve reform.

All of the key stakeholders – consumers, employers, providers, health plans and government – are part of the systemic problem, so we all must step up to be part of the solution.

4. All stakeholders must accept their responsibilities for improving the system. Consumers have a responsibility to keep themselves healthy and be well-informed purchasers. Providers have a responsibility to help keep their patients healthy and to offer evidence-based, cost-effective care to all who need it – including publicly-subsidized as well as privately-insured patients. Employers have a responsibility to offer health benefits to their employees and dependents, if they can afford it, and help keep their employees healthy and productive. Health plans have a responsibility to offer coverage to all who need it and work with providers to reduce costs and improve health outcomes. The government has a responsibility to ensure access to coverage and care to all who need it and use value-based purchasing strategies to encourage efficiency and quality.

5. We believe that a system that is built on the private health care delivery system and uses market forces is most likely to achieve the goals of cost control and quality. While there is an appropriate role for government as a facilitator, regulator and purchaser/sponsor for low income and elderly persons, we believe that the private

delivery system – with the right incentives for providers – is the best way to improve quality and cost effectiveness. Consumer engagement and personal accountability are critical. Consumers must have real choices, an appropriate level of price sensitivity, and access to information and decision support tools.

6. We need practical solutions that can be implemented. Although it is necessary to have a long-term vision for a redesigned health care system, it isn't fruitful to imagine an ideal future system that is impossible to achieve. We must find pragmatic approaches that build a bridge from the existing health care system to a future system that delivers value and provides access to evidence-based care. We recognize that investments in basic infrastructure, e.g., development and publication of standardized quality data, electronic health records, and the exchange of health information among providers, etc., are needed to support a new health care system.

7. Business leadership is needed to drive improvements in the health care system. As the primary purchaser of health benefits, employers – on behalf of their employees –have a major stake in ensuring that the money spent is producing value. Building on the employer-based system makes sense; it already covers the majority of Oregonians reasonably well. In addition, this will help to ensure that employers continue to have a stake in keeping employees healthy and productive. Building on the employer-based system also allows employers to customize their health benefit programs to meet their employees' needs.

A Responsible Plan for Sustainable Reform

The following are the key elements of a comprehensive redesign of the health care system in Oregon. We have focused on state-level initiatives at this time, recognizing that even greater improvements could be made with reform at the national level. The first two elements focus on actions by purchasers – working with health plans and providers – to improve the quality and lower the costs of the health care system. The remaining four elements address the vicious cycle of costs and access to care.

Improve Quality and Lower Costs Through Purchaser Action

Use value-based purchasing by employers and public sector purchasers. Private and public sector employers can play a major role in driving improved quality and lower costs. There are several general principles and approaches that purchasers should use:

Private and public sector employers can play a major role in driving improved quality and lower costs.

- Encourage a culture of wellness and personal responsibility in the workplace.
- Offer benefits that are designed to improve health; coverage should include:
  - Preventive services
  - Management of chronic conditions
  - Protection from catastrophic costs
  - Incentives for wellness
- Create an effective market for health care:
  - Offer employees a choice of health plans and providers

- Engage employees in their health care decision making by using a defined contribution approach to fund employees' health benefits and requiring cost sharing at the time of service – while avoiding financial barriers to preventive services or chronic care management Provide employees with decision support tools, including understandable cost and quality data, to support their ability to make informed choices of health plans, providers, and alternative treatments and services.

- Contract more effectively with health plans, using standardized RFI tools and setting expectations for health plans and providers to improve transparency, cost-effectiveness, quality of care, and use of evidence-based care.

In addition, public sector programs such as Medicaid must operate as efficiently as possible to ensure that beneficiaries and taxpayers are getting the best value for the money. The Medicaid program should be allowed to use the same tools (e.g., use of a preferred drug list, integration of mental and physical health programs) that businesses use in managing their health benefit programs. With these tools, any expansion of the Medicaid program would be more cost-effective.

Invest in information infrastructure development. Private and public sector purchasers should work with health plans and providers to stimulate the development of health care information infrastructure, including:

- Electronic Health Records should be adopted by all health care providers.
- Providers should have access to necessary patient health information through secure data exchange mechanisms in order to provide continuity of care.
- Data transparency is needed to allow purchasers and consumers to be more informed buyers.
- Standardized and easily understood measures of quality are needed to enable purchasers and consumers to compare the performance of providers.

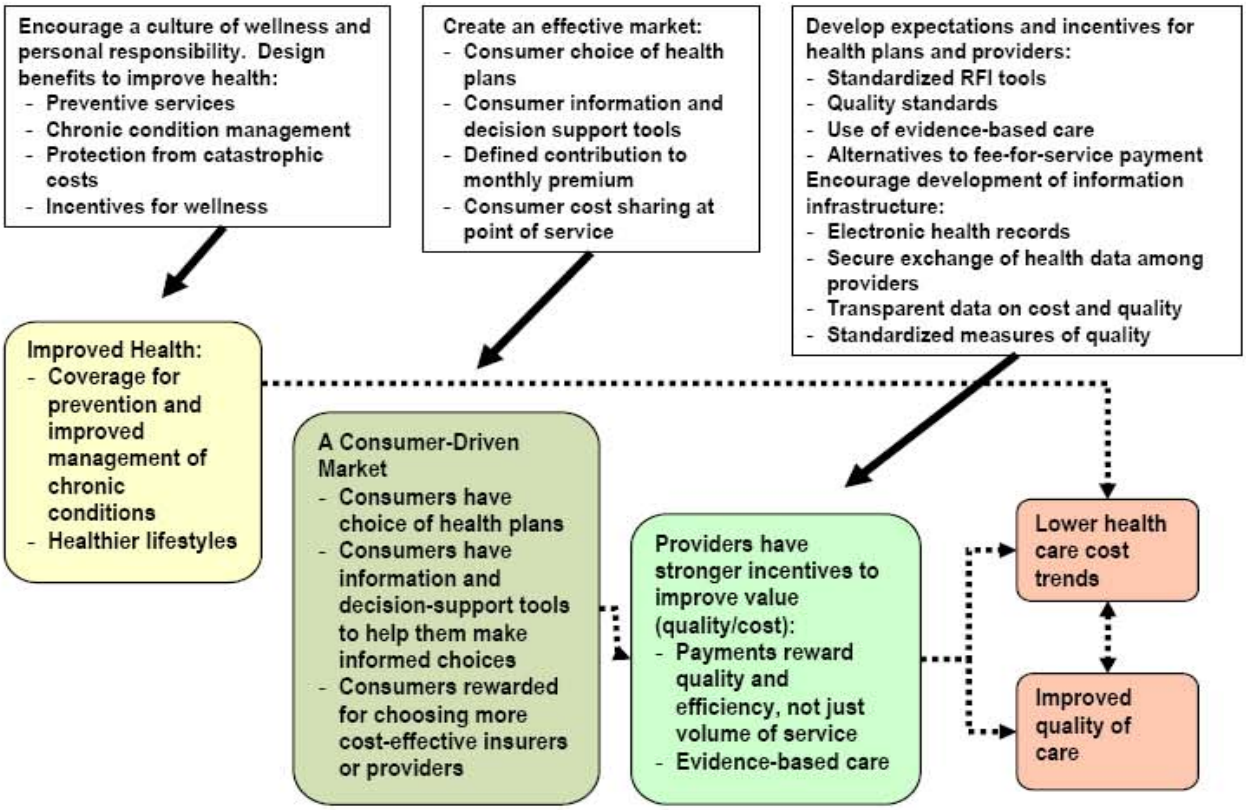
(See figure 3 for a graphic summary.)

Break the Vicious Cycle of Costs and Access.

Reduce the number of uninsured by expanding Medicaid. Use additional state revenue to maximize Federal matching funds that are currently available to the state. Increasing state funding by $700 million would generate over $1 billion in additional federal funds annually.

Improve access to care by increasing payments to providers who serve Medicaid patients. Use a portion of the additional Medicaid funds to reduce the gap between provider payments for publicly- and privately-insured services.

Figure 3
USING VALUE-BASED PURCHASING TO IMPROVE VALUE: QUALITY/COST

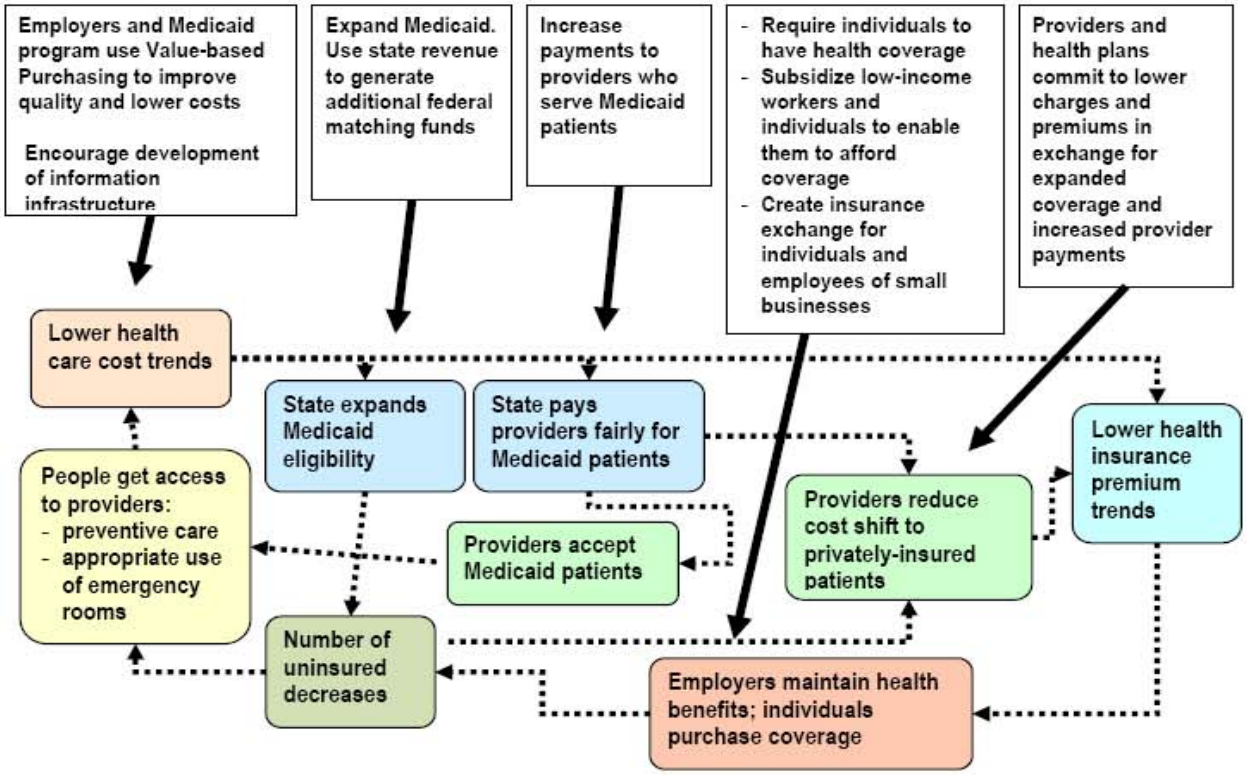


Increase access to coverage for individuals and small businesses. This is needed to address the special problems that individuals and small businesses face in obtaining coverage. For many, coverage is unaffordable. Some individuals who can afford coverage, however, choose to forego insurance. When they become seriously sick or injured, they rely on hospitals which are required to serve everyone regardless of coverage. The health care costs for these "free riders" are borne by those who have insurance, via the cost shift described above. Three specific steps are needed:

- Require individuals to have health insurance.
- Subsidize low-income workers and individuals to enable them to afford coverage.
- Create an "insurance exchange" for individuals and employees of small businesses

Reduce the cost shift to employers and individuals. In return for expanded coverage and increased provider payments, health plans and providers should reduce the cost shift by lowering charges to privately-insured employers and individuals. (See Figure 4 for a graphic summary of these recommendations.)

Figure 4
BREAKING THE VICIOUS CYCLE



Short-term Initiatives (2007-08)

Focus on Improving Quality and Reducing Costs

1. Use Value-based Purchasing by employers to improve quality and lower costs.
2. Support legislation that allows the Oregon Health Plan to implement purchasing strategies used by private employers, e.g., use of a preferred drug list, integration of mental and physical health programs
3. Continue efforts to improve health care information infrastructure: electronic health records, secure exchange of health data among providers, transparent information on costs and quality, and standardized quality measures
4. Support Medicare initiatives for improved transparency, quality improvement and pay for performance

Improve Access and Reduce the Cost Shift

5. Support the cigarette tax to fund comprehensive and affordable health coverage for children – the Healthy Kids Plan
6. Support the use of state revenue to gain federal matching funds and expand the Oregon Health Plan
7. Support efforts to increase provider payments for Oregon Health Plan patients and reduce the cost shift to privately-insured patients

8. Oppose efforts by Medicare to further reduce payment rates to providers, or other steps that would exacerbate the cost shift to privately-insured patients
9. Create a forum and collaborate with other organizations to develop a plan for comprehensive redesign of the health care system to provide all Oregonians with access to high quality and affordable care.

Measuring our Progress

We will measure our progress against the following goals [specific targets to be developed]:

Health and Wellness of Employees. Employers incorporate the value of employee health and wellness in the culture of their organizations and their decision making processes.

Outcomes:

- Employers use health risk assessments to develop wellness and prevention programs with incentives to engage employees and to take personal responsibility
- Employees and their families do not have financial barriers to needed preventive and chronic care
- Employers offer evidence-based disease management programs
- Overall health status of employees and dependents improves.

Access. Provide access to care for all Oregonians.

Outcomes:

- Reduce the number of uninsured in Oregon..
- Increase the number of providers willing to care for Medicaid and Medicare patients..

Create appropriate incentives to drive efficiency in health care. Structure the health care market to offer informed consumer choice and encourage healthy competition among providers.

Outcomes:

- All consumers have a choice of health plans
- Information regarding cost, quality and service is easily accessible for consumers and group purchasers to make informed choices between health plans and providers.
- Consumers have the appropriate degree of cost sharing, without creating barriers to needed care
- Providers have the appropriate financial incentives to provide high quality and cost effective services.

Costs. Create a health care system that is affordable and economically sustainable.

Outcomes:

- Reduce the annual increase in overall health care costs,
- Reduce the annual increase in health insurance premiums.

Quality. Improve the quality of health care services.

Outcomes:

- Patient health information is available to providers across systems.

- Employees with chronic conditions are well managed.
- Employers measure health care quality through standard metrics.
- Evidence-based guidelines are used by clinicians.

If we are able to achieve these outcomes, Oregon businesses will have a competitive advantage, thereby increasing economic growth and jobs. The people of Oregon will be healthier and lead more productive and rewarding lives. And Oregon can strengthen its reputation as an innovative leader in social and economic policies.

Health Care Initiative Leaders

Peggy Fowler, President & CEO, Portland General Electric
Mark B. Ganz, President & CEO, The Regence Group.

Background Resources

OBC white paper, "A New Vision for Health Care," December 2004.