HEALTH EQUITIES COMMITTEE

Cultural competence refers to the process by which individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, disabilities, religions, genders, sexual orientation and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families and communities and protects and preserves the dignity of each.

Policy Recommendations on Preventing Health Disparities through Targeted and Culturally-Specific Programs of Health Promotion and Chronic Disease Prevention/ Management.

As identified by the Delivery System Committee of the Oregon Health Fund Board, there are few incentives in the current health care system to prevent disease and truly promote a healthy population. Even fully-capitated managed care organizations do not always see direct benefit from investing in prevention efforts that pay off in the long run because of movement in and out, and between, healthcare plans. The Oregon Health Fund program has the opportunity to save money with long-term prevention investments that improve the overall health of Oregonians as they move in and out, or between plans, while remaining in the overall Health Fund Program.

1. The Health Equities Committee recommends an on-going, substantial investment in public health activities that will prevent disease, and promote the health of Oregonians. We believe that part of this investment should be directed towards using culturally-specific approaches to disease prevention and health promotion.

- a. *Initiatives that target health disparities should be guided by members from the communities experiencing health disparities.*
    - i. *The Quality Institute and the Public Health Department would provide data to support decision-making on establishing funding and program priorities.*
    - ii. *Priorities will likely vary by region.*
    - iii. *Multiple granting approaches should be used:*
        1. *Planning grants should be made available for regional collaboratives to develop around a proposed intervention.*
        2. *Competing grants should be designed to encourage creativity and collaboration.*
        3. *Non-competitive continuation grants should be available to maintain funding support for programs that have demonstrated success at meeting the goals of the grant.*
        4. *Emerging Issue grants should be available for communities to develop strategies and interventions around newly identified problems impacting population health.*
- b. *Regional collaboratives consisting of social service organizations, culturally-specific organizations, healthcare organizations, and other community partners and community-based organizations would apply for grants that address targeted disparities with community-driven and implemented approaches.*
    - i. *Matching regional funds may be required.*

  - ii. *Funding should be administered in a way that supports the necessary steps to achieving targeted outcomes, and the outcomes themselves. Data & evaluation support will be provided through partnership with Public Health.*
  - iii. *Effective programs will be shared and problem-solving will be facilitated through convening regional collaborative leadership (in person or virtually) on a quarterly basis in learning collaboratives.*

Health focused community-based organizations have been very successful and providing culturally-specific programs that promote health, prevent disease, and help manage chronic diseases. These programs are overly reliant on federal grant priorities and struggle with sustainability. Providing a truly integrated healthcare home for multicultural communities requires a stronger relationship between these organizations and primary care clinics that serve vulnerable populations.

2. The Health Equities Committee recommends designing a contracting mechanism that will empower primary clinics who primarily serve vulnerable populations to build financial agreements with health-focused community-based organizations that provide culturally-specific health promotion and disease management services.

Renewable contracts will be awarded to health care clinics that partner with culturally-specific social service organizations (including organizations that focus on Persons with Disabilities, GLBT populations, and homeless youth or adults) to provide an integrated health care home. Clinics that have established in-house capacity for culturally-specific approaches would not be required to contract out for services already being rendered.

- a. *Partnership must include contractual financial agreements.*
  - i. *Social service organizations will provide culturally-specific approaches to health promotion, self-management for chronic diseases, and disease prevention. These approaches may include:*
    1. *peer-to-peer health education programs*
    2. *Community Health Workers*
- b. *Contracts will be based on a rate, adjusted to reflect the needs of the population, for serving a specified number of individuals in that population.*
  - i. *Organizations will be accountable on measures of process and outcomes that will reflect realistic timelines of:*
    1. *preventing chronic disease*
    2. *promoting population health*
    3. *chronic care management*
    4. *accessibility to patients*
- c. *Contracts can be administered directly through the Health Fund Program or through a managed care organization.*

Recognizing that not every organization providing an integrated healthcare home is focused on serving vulnerable populations, an alternative should exist to renewable contracts that will enable a provider to purchase community-based and/or culturally-specific services.

3. The Health Equities Committee recommends that high-value community-based health promotion, disease prevention, and chronic disease management services, be eligible for direct reimbursement.

For organizations that want to provide an integrated healthcare home but do not wish to participate in direct contracts, accountable health plans must reimburse the following community and home-based services:

a. *Community Health Workers*
b. *Peer-led disease management support groups*
c. *Culturally-specific programs to maximize the health and function of individuals, families, and communities.*

Recommendations from the Health Equities Committee

Policy Recommendations on Benefit Design that Reduce Health Disparities

1. **Promote equitable and fair sharing of health care costs.** Health insurance coverage with high deductibles and out-of-pocket costs disproportionately hurt low-income individuals ability to obtain needed care, further contributing to health disparities. Equitable cost-sharing policies take into account and attempt to minimize the uneven impact that cost-sharing arrangements may have on health care access.

    - Include public contributions for those with low incomes to purchase health insurance, sliding fee scales for premiums, and limits on copayments and other out-of-pocket costs so that people at the lowest income levels will face only nominal charges. Premiums are the preferred form of cost-sharing for public programs because people can regularly budget those costs.
    - Benefits should be extended to all Oregonians that protect against devastating financial losses and bankruptcy due to unforeseen catastrophic illness or injury.
    - Utilization and quality data should be regularly accessed to determine if cost-sharing policies are worsening or increasing health disparities. For example, cost sharing thresholds should be evaluated to determine when and if those thresholds become barriers to necessary care.
    - Design public programs for health care assistance that do not disenroll beneficiaries or deny primary care services to people who do not pay required cost-sharing costs but rather, maintain health coverage while taking action to collect debt. Oregon's experience with administratively disenrolling individuals from its Medicaid program who did not meet cost-sharing requirements led to massive loss of coverage with adverse affect. Results from the baseline Oregon Health Plan (OHP) cohort survey indicate that nearly one half (45%) of the OHP Standard population experienced disrupted or lost coverage in the first 10 months after the OHP redesign in 2003. OHP beneficiaries who lost coverage reported significantly worse health care as well as medication access and had significantly higher medical debt than those with stable coverage.[1]

2. **Remove any financial barriers and increase reimbursement for preventive services, chronic disease management, patient education programs and after-hours/walk-in primary care.** The benefit program designed should improve access to and utilization of appropriate services in an integrated health home and support community-based organizations to assist in health promotion. The benefit program should also reward patients who actively participate in their own care, through incentives for patients who follow through with the medical treatment plan agreed upon with their health care provider. Encouraging patients to receive treatment for early disease in the less expensive outpatient setting, rather than waiting until disease progression requires requires extensive inpatient care will benefit both individuals and society. The state

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[1] *Carlson, Matthew J., DeVoe, Jennifer, Wright, Bill J. "Short-Term Impacts of Coverage Loss in a Medicaid Population: Early Results From a Prospective Cohort Study of the Oregon Health Plan" Annals of Family Medicine 4(5): 391-398, 2006*

should also encourage providers to expand availability to patients (e.g. operating during evening and weekend hours?). Patient education programs can help reduce health care disparities by providing patients with skills to effectively navigate health care systems and ensure that their needs and preferences are met. For example, patient education programs have been found to be effective in reducing racial and ethnic disparities in pain control.

3. **Support direct reimbursement of community health workers for publicly sponsored health programs.** Community health workers, also known as lay health navigators or *promotoras*, are trained members of medically underserved communities who work to improve community health outcomes. Several community health worker models have proved effective in training people to teach disease prevention, to conduct simple assessments of health problems, and to help their neighbors obtain appropriate health and human resources. Oregon can stimulate these programs by recognizing community health workers as billable providers. Generally, requirements would be specific as to the education, training, and certification of recognized workers and fee charts would detail allowable reimbursement rates. California secured funding for Community Health Workers and promotoras through a Section 1115 Medicaid Demonstration Program family planning waiver, allowing these services to be provided on a per-unit basis[2].

4. **Request that the Health Resources Commission investigate including traditional Chinese medicine and other complementary medicine that have been shown to be effective in publicly sponsored health programs.** The Oregon Health Plan created the Health Resources Commission (HRC) to help achieve its goal of assuring all Oregonians have access to high quality, effective health care at an affordable cost, whether that care is purchased by the state or by the private sector. The HRC's role is to encourage the rational and appropriate allocation and use of medical technology in Oregon. The HRC informs and influences health care decision makers through its analysis and dissemination of information concerning the effectiveness and cost of medical technologies and their impact on the health and health care of Oregonians. Through its activities, the HRC can contribute to reducing the cost and improving the effectiveness of health care, thereby increasing the ability of public and private sources to provide more Oregonians with financial access to that care. These activities should include the investigation of including traditional Chinese medicine health services in the benefit design of publicly sponsored health programs as extending these services promotes cultural accessibility and may advance health equity.

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[2] *Advancing Community Health Worker Practice and Utilization: The Focus on Financing. National Fund for Medical Education, The Center for the Health Professions, University of California, San Francisco.*

Oregon Health Fund Board

Quality Institute Work Group

Report to the Delivery Systems Committee

April 10, 2008

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Oregon Health Fund Board — Delivery Systems Committee Quality Institute Work Group

Report Index

Oregon Health Fund Board — Delivery Systems Committee Quality Institute Work Group

Preamble

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.

I. Background

Based on recommendations from the Oregon Health Policy Commission (OHPC), Senate Bill 329 (2007), the Healthy Oregon Act, directs the Administrator of the Office for Oregon Health Policy and Research to develop a model Quality Institute for Oregon as part of the larger health reform planning process established by the bill. The Oregon Health Fund Board assigned this task to the Delivery Systems Committee and chartered a Quality Institute Work Group to develop recommendations regarding the appropriate structure and roles for an Oregon Quality Institute. The Quality Institute would coordinate the creation, collection and reporting of cost and quality information to improve health care purchasing and delivery.

The preamble of SB 329 calls for health reform policies that encourage the use of quality services and evidence-based treatments that are appropriate, safe and discourage unnecessary treatment. Research illustrates that the current health care delivery system in Oregon does not consistently deliver high-quality care or effectively use resources to deliver evidence-based care to Oregonians. For instance, only 40% of adults over 50 receive recommended preventive care, and only 84% of hospitalized patients receive recommended care for myocardial infarction, congestive heart failure, and pneumonia.[1] In addition, quality of care varies significantly depending on where in the state a patient receives care, as does the utilization of specific procedures and treatment options.[2] While there are numerous public and private efforts underway across the state to

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[1] Cantor JC, Schoen C, Belloff D, How SKH, and McCarthy D. Aiming Higher: Results from a State Scorecard on Health System Performance. The Commonwealth Fund Commission on a High Performance Health System, June 2007.

[2] Performance Report for Chronically Ill Beneficiaries in Traditional Medicare: Hospitals – Oregon. Provided by Elliot Fischer and the Dartmouth Atlas Project.

improve health care quality, SB 329 points to the need for a Quality Institute to serve as a leader and to unify existing efforts in the state around quality and transparency.

The availability of clear and transparent information is the keystone to any health care reform plan, including the current effort to improve the quality of care delivered by Oregon's health care system. The Institute of Medicine's Ten Rules to Redesign and Improve Care calls for shared knowledge and the free flow of information and transparency across the health care system.[3] In addition, President Bush's Four Cornerstones for Healthcare Improvement Executive Order of 2006 calls for greater health system transparency through wider availability of health care quality and price data.[4] Providers need better information to benchmark their performance, identify opportunities for quality improvement and design effective quality improvement initiatives. Purchasers need ways to identify and reward high-performing providers who delivery high-quality, high-value care to their patients. Consumers need better cost and quality information to help guide critical health care decisions. Therefore, an Oregon Quality Institute is needed to ensure that appropriate and actionable information is available across the health care system and that stakeholders have the tools and knowledge needed to use this information to improve quality of care. A collaborative and well-supported effort to improve quality and increase transparency is a vital part of any effort to transform Oregon's health care delivery system into a high-performing, high-quality system that meets the health care needs of all Oregonians.

II. Recommendations for a Model Oregon Quality Institute

The Quality Institute Work Group of the Oregon Health Fund Board Delivery Systems Committee recommends the formation of a Quality Institute for Oregon. The Institute will be established as a publicly chartered public-private organization, giving it legitimacy and a well-defined mission, while allowing for flexibility in operations and funding. In addition, this structure will allow the Quality Institute to accept direct state appropriations and have 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.

The Work Group makes the following recommendations about the structure, governance and funding for a Quality Institute for Oregon:

- A Board of Directors of the Quality Institute will be appointed by the Governor and confirmed by the Senate and include no more than 7 members. Members must be knowledgeable about and committed to quality improvement and

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[3] Institute of Medicine. Crossing the Quality Chasm: A New Health System for the 21st Century. (2001). National Academy Press: Washington, DC.

[4] U.S. Department of Health and Human Services, Value-Driven Health Care Home. http://www.hhs.gov/valuedriven/index.html

represent a diverse constituency. The Board should be supported by advisory committees that represent a full range of stakeholders. The Administrator of the Office for Oregon Health Policy & Research, or a designee, shall serve as an Ex-Officio member of the Board.

- The Quality Institute will have an Executive Director, who is appointed by and serves at the pleasure of the Board. The Quality Institute will have a small professional staff, but should partner or contract with another organization to provide administrative support.
- In order for the Quality Institute to be stable, state government must make a substantial long-term financial investment in the Quality Institute by providing at least $2.3 million annually for a period of at least 10 years (See Appendix C). Following the 2009-11 biennium, this budget should be adjusted to account for inflation.
- The Quality Institute will partner and collaborate with other stakeholders to maximize output and minimize duplication of efforts. In addition, nothing precludes the Quality Institute from seeking additional voluntary funding from private stakeholders and grant-making organizations to supplement state appropriations.

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. Some of this work will be directly carried out by the Quality Institute, while some will be completed in partnership with existing organizations (e.g. The Oregon Health Care Quality Corporation or Oregon Patient Safety Commission). To achieve its goals, the Quality Institute will first pursue the following priorities:

1. Set and prioritize ambitious goals for Oregon in the areas of quality improvement and transparency. Progress toward achieving these goals will be measured and publicly reported, and goals will be regularly updated to encourage continuous improvement.

2. Convene public and private stakeholders to align all groups around common quality metrics for a range of health care services. Metrics adopted for Oregon will be aligned with nationally accepted measures that make sense for Oregon. In developing common metrics, the benefit of reporting particular datasets to align with adopted quality metrics must be balanced against the burden of collecting and reporting these measures from health care facilities.

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.

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. Data should provide comparable information about quality of care, utilization of health care resources and patient outcomes. To the extent practicable and appropriate, data should be easily accessible to providers, health care purchasers, health plans, and other members of the public in appropriate formats that support the use of data for health care decision-making and quality improvement (right information to the right people at the right time). The Quality Institute shall establish a system for data collection, which shall be based on voluntary reporting whenever possible, but may include mandatory reporting if necessary. The Quality Institute may directly publish data and/or may support other organizations in publishing data.

5. Advise the Governor and the Legislature on an ongoing basis on policy changes/regulations to improve quality and transparency. Produce a report to be delivered each legislative session about the state of quality of care in Oregon to be provided to the Governor, Speaker of the House and the President of the Senate.

As the budget of the Quality Institute allows, the Board of the Quality Institute 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):

- Participate in the development and assessment of new quality improvement strategies by championing, coordinating, funding and/or evaluating quality improvement demonstration and pilot projects. In addition to projects focused on improving the delivery of care, projects that explore opportunities to provide incentives for quality improvement should be considered.

- Convene public and private stakeholders to identify opportunities to 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 for using data to drive quality improvement. Disseminate proven strategies of quality improvement.

- Support the development and facilitate the adoption of health information technology that builds provider capacity to collect and report data and ensure that the right information is available at the right time to patients, providers, and payers.

- The Governor's Health Information Infrastructure Advisory Committee (HIIAC) will be making recommendations to the Oregon Health Fund Board about a strategy for implementing a secure, interoperable computerized health network to connect patients and health care providers across Oregon. The Quality Institute should align itself with these recommendations and support efforts to develop and facilitate the adoption of health information technology that builds on provider capacity to collect and report data and ensure that the right information is available at the right time to patients, providers, and payers. The Quality Institute should also partner with the HIIAC and other efforts within Oregon and across the country to build provider and system capacity to effectively use health information technology to measure and maximize quality of care and evaluate quality improvement initiatives.

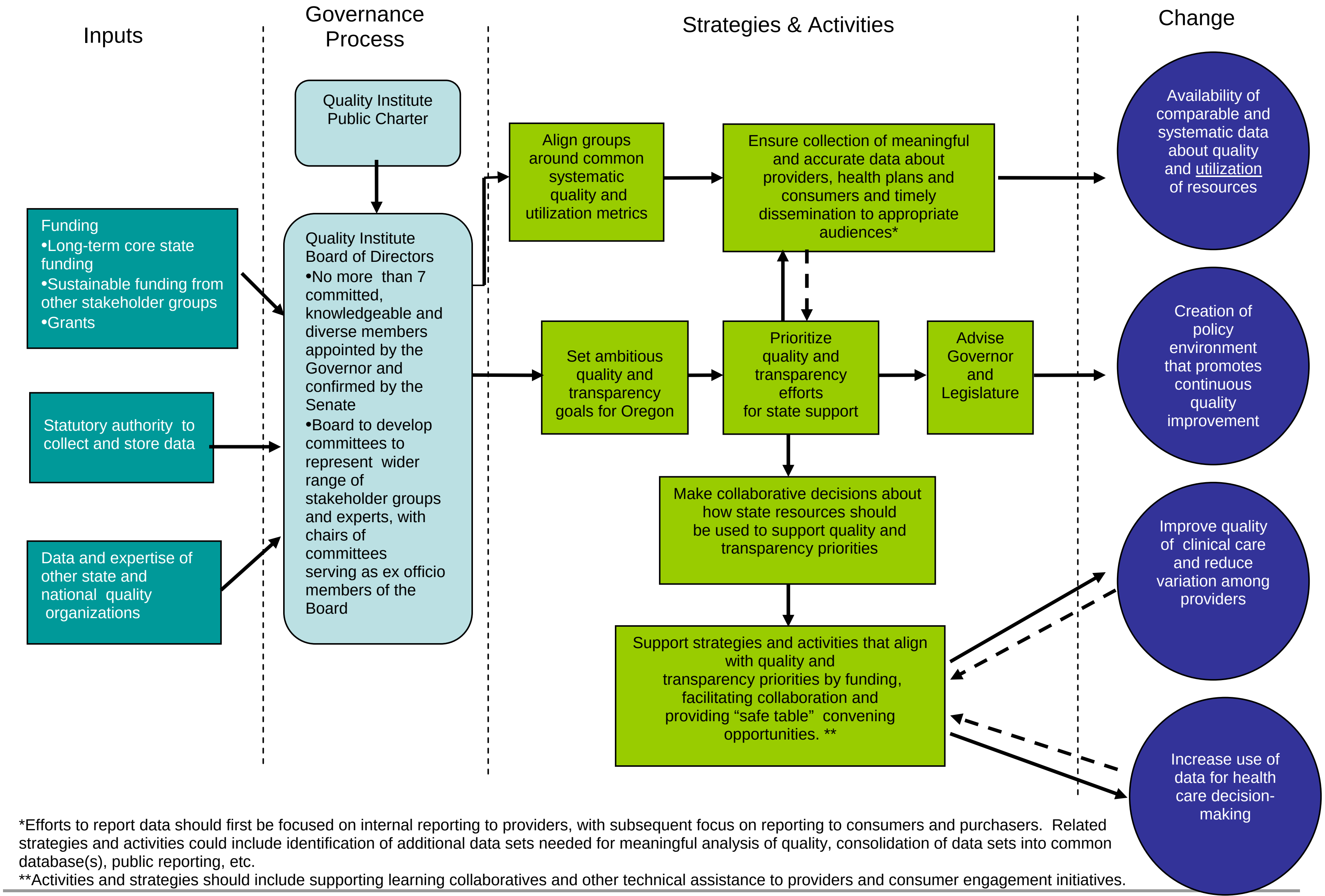
- Support efforts, in partnership with providers, to engage consumers in the use of quality and utilization data and evidence-based guidelines to make health decisions. Support efforts to engage patients in taking responsibility for their own health.

III. Logic Model for an Oregon Quality Institute

The Quality Institute Work Group constructed a "theory of change" logic model to provide a pictorial representation of its recommendations for an Oregon Quality Institute. The logic model attempts to represent the range of inputs, governance process, strategies and activities the group believes would be required to develop a Quality Institute successful in achieving the following goals:

- Ensure availability of comparable and systematic data about quality and utilization of resources;
- Create a policy environment that promotes continuous quality improvement;
- Improve the quality of clinical care; and
- Increase the use of quality data for health care decision-making.

Logic Model for a Quality Institute for Oregon



Inputs

Governance Process

Strategies & Activities

Change

Funding
- Long-term core state funding
- Sustainable funding from other stakeholder groups
- Grants

Statutory authority to collect and store data

Data and expertise of other state and national quality organizations

Quality Institute Public Charter

Quality Institute Board of Directors
- No more than 7 committed, knowledgeable and diverse members appointed by the Governor and confirmed by the Senate
- Board to develop committees to represent wider range of stakeholder groups and experts, with chairs of committees serving as ex officio members of the Board

Align groups around common systematic quality and utilization metrics

Ensure collection of meaningful and accurate data about providers, health plans and consumers and timely dissemination to appropriate audiences*

Set ambitious quality and transparency goals for Oregon

Prioritize quality and transparency efforts for state support

Advise Governor and Legislature

Make collaborative decisions about how state resources should be used to support quality and transparency priorities

Support strategies and activities that align with quality and transparency priorities by funding, facilitating collaboration and providing “safe table” convening opportunities. **

Availability of comparable and systematic data about quality and utilization of resources

Creation of policy environment that promotes continuous quality improvement

Improve quality of clinical care and reduce variation among providers

Increase use of data for health care decision-making

*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.

IV. Work Group Process

The Quality Institute Work Group began their formal deliberations in December of 2007 and held seven meetings. Membership was drawn from a wide range of stakeholder groups and included many of the same people who served on the Oregon Health Policy Commission Quality and Transparency Work Group.

At its first substantive meeting in January 2008, the group was joined by Dennis Scanlon, Assistant Professor in Health Policy and Administration at Penn State University, who is a member of the team evaluating the Robert Wood Johnson Foundation's Aligning Forces for Quality program. Dr. Scanlon suggested a framework for approaching the Work Group's charge, discussed 'Theory of Change' models of behavior change and presented examples and results of quality improvement efforts from around the country. Carol Turner, a facilitator from Decisions Decisions in Portland, facilitated five of the work group's meetings.

In an effort to identify existing gaps in quality and transparency efforts in Oregon and identify possible areas for collaboration and coordination, the work group built on efforts of the Oregon Health Policy Commission Quality and Transparency Work Group to assess the current landscape in Oregon. The following organizations and collaborative initiatives dedicated to quality improvement and transparency were identified and discussed:

- Acumentra Health
- Advancing Excellence in America's Nursing Homes
- Compare Hospital Costs Website
- Department of Human Services
- The Foundation for Medical Excellence
- Health Insurance Cost Transparency Bill – HB 2213 (2007)
- The Health Care Acquired Infections Advisory Committee
- Independent Practice Associations and Medical Groups
- Oregon Association of Hospitals and Health Systems
- Oregon Chapter of the American College of Surgeons
- Oregon Coalition of Health Care Purchasers
- Oregon Community Health Information Network (OCHIN)
- Oregon Health Care Quality Corporation
- Oregon Health and Sciences University Medical Informatics
- Oregon Hospital Quality Indicators
- Oregon IHI 5 Million Lives Network
- Oregon Patient Safety Commission
- Oregon Primary Care Association
- Oregon Quality Community
- Patient Safety Alliance

- Public Employees Benefits Board and Oregon Educators Benefits Board
- Regence Blue Cross Blue Shield

Appendix A provides a matrix that describes these efforts.

The Work Group also examined quality and transparency efforts in other states, focusing on initiatives in Maine, Massachusetts, Minnesota, Pennsylvania, Washington, and Wisconsin. Appendix B provides a description of select quality and transparency efforts in these states.

V. Definitions of "Quality" and "Transparency"

When the Work Group reviewed its charter from the Oregon Health Fund Board at its first meeting, members quickly identified a need to develop standard definitions of *quality* and *transparency*.

Members noted that a number of organizations in Oregon, including the Oregon Health Care Quality Corporation, have incorporated the Institute of Medicine's (IOM) definition of quality, which includes the six domains of safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity. Members also acknowledged the work of the U.S. Department of Human Services' Agency for Healthcare Research and Quality (AHRQ) in the area of quality. On January 3, the Work Group approved the definition of *quality* found below, which combines definitions presented by the IOM and AHRQ.

Quality

As defined by the Institute of Medicine (IOM), quality is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. In the 2001 Crossing the Quality Chasm, the IOM defined a high quality health care system as one that is:

- **Safe** – avoiding injuries to patients from the care that is intended to help them.
- **Effective** – providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively).
- **Patient-centered** – providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
- **Timely** – reducing waits and sometimes harmful delays for both those who receive and those who give care.
- **Efficient** – avoiding waste, including waste of equipment, supplies, ideas, and energy.

- **Equitable** – providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

AHRQ has summarized this definition of quality as meaning doing the right thing at the right time, in the right way, for the right person and getting the best results.

The group could not identify a widely accepted definition of *transparency* and had to combine language from various sources with members' best thinking. The concept of "clarity in relationships" was taken from a 2006 article about transparency in health care that appeared in the American Heart Hospital Journal.[5] The Work Group approved the definition below on January 10.

Transparency
A transparent health care system provides clarity in relationships among patients, providers, insurers and purchasers of health care. ***To the extent practicable and appropriate, a transparent system makes appropriate information about patient encounters with the health care system, including quality and cost of care, patient outcomes and patient experience, available to various stakeholders in appropriate formats.*** This includes, but is not limited to, providing consumers and other health care purchasers with the information necessary to make health care decisions based on the value of services (value = quality/cost) provided and giving providers the tools and information necessary to compare performance. In a transparent system, health care coverage and treatment decisions are supported by evidence and data and made in a clear and public way.

VI. Problem Statement

The Quality Institute Work Group also drafted a statement of the problems in the current health care system that could potentially be addressed by an Oregon Quality Institute:

- Need for a robust mechanism to coordinate statewide quality improvement and transparency efforts. Currently, we have:
    - Multiple agencies, organizations, providers and other stakeholder groups furthering quality and transparency efforts, without unifying coordination
    - No mechanism for setting common goals around health care quality or a public quality agenda
    - A need for stronger mechanism for sharing of best practices, successes and challenges across efforts

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[5] Weinberg SL. Transparency in Medicine: Fact, Fiction or Mission Impossible? Am Heart Hosp J. 2006 Fall;4(4):249-51.

  - Missed opportunities for synergy, efficiency, and economies of scale possible through partnership along common goals
- No comprehensive measurement development and measurement of quality across the health care delivery system
  - Consumers and purchasers have limited access to comparable information about cost and quality
  - Providers have limited ability to compare their own performance with peers and to make referral decisions based on quality and cost data
  - Providers are required to report different measures to different health plans and purchasers
- Limited resources dedicated to quality improvement and transparency
  - Lack of resources to support coordination across quality and transparency efforts
  - Providers have limited resources to build infrastructure needed to support data collection, reporting and analysis
  - Need for systemic mobilization and planning for use of resources in a manner that maximizes system wide impact and reduces duplicative efforts
- Wide variability between providers in quality and cost of care
- Lack of infrastructure (both human and technology) necessary to assess system wide performance and use data to develop a systemic approach to quality improvement
- Lack of systematic feedback and credible data to improve clinical care systems
- Need for new tools to help consumers, purchasers, and providers effectively use data to make treatment and coverage decisions

VII. Assumptions

The Quality Institute Work Group next worked to clarify the starting assumptions that the group would use to identify the appropriate roles and structure of an Oregon Quality Institute. The starting assumptions went through a number of iterations and the group approved the set below.

Assumption 1*:* The Quality Institute will coordinate, strengthen and supplement current and ongoing initiatives across Oregon to create a unified effort to improve quality, increase transparency, and reduce duplication across stakeholder groups. Quality improvement and increased transparency will lead to a health care system that is safer, more effective, patient-centered, timely, efficient and equitable, and better able to contain costs.

Assumption 2: The Quality Institute will be an essential element of any sustainable health care reform plan and should play an integral and long-term role in improving quality and increasing transparency across Oregon.

Assumption 3: The collaborative nature of the Quality Institute and the strengths of the range of stakeholders will allow the Institute to capitalize on a variety of strategies to further the quality and transparency agenda. These strategies include, but are not limited to, market based approaches, provider collaboration, consumer engagement and regulatory approaches. Different partners will have the authority and capacity to utilize different strategies, depending on function and target audience. These partnerships should be developed in a manner that allows for assessment of the fundamental capabilities of the health care system in Oregon, identification of opportunities to effect change across the system, and monitoring of quality improvement and cost savings from quality improvement across the entire system.

Assumption 4: The Quality Institute will need to be supported by sustainable, stable and sufficient resources if it is to be an effective agent for change in improving quality and increasing transparency in the health care system. A broad base of funding, including dedicated public resources and resources from other stakeholders, will be necessary to make progress in quality and transparency.

VIII. Roles of the Quality Institute

The next task for the Quality Institute Work Group was to make recommendations about the appropriate roles of a Quality Institute for Oregon, given the group's problem statement and assumptions. Staff created a draft list of potential roles, based on quality improvement strategies used in other states, as well as other published sources, including the IOM's 2005 report to Congress calling for the establishment of a National Quality Coordination Board.[6] The initial draft list included twelve possible roles, which were categorized using a framework presented by Dennis Scanlon. Each option was categorized by the primary strategies it would utilize (market-based approach, collaborative quality improvement approach, patient/consumer education/engagement, and regulatory approaches), domains of improvement it would address (safety, effectiveness, patient-centeredness, timeliness, efficiency, equity) and target audience(s).

The facilitator led the group in several rounds of discussion and revision of the role options, with the group analyzing each proposed role, adding additional roles, scoring roles, eliminating roles that were not appropriate for a Quality Institute and combining roles that were redundant. In addition, the group developed a framework for categorizing roles that fall under the auspices of the Quality Institute. The categories

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[6] Institute of Medicine. (2005). Performance Measurement: Accelerating Improvement. National Academies of Press. Washington, D.C.

the group settled on were *Coordination and Collaboration, Systematic Measurement of Quality, Provider Improvement and Technical Assistance, Consumer Engagement and Policy Advising.*

The Work Group also identified some of the roles as priorities that should guide the Quality Institute in its initial work. These roles focus on establishing a coordinated quality and transparency agenda for Oregon and developing a systematic performance measurement process. Once the Quality Institute is successful in achieving these goals, members felt that the Quality Institute should use data and evidence to determine where initiatives related to the remaining roles could be most effective. The Quality Institute's budget will determine the extent to which the Institute is able to pursue these additional roles.

Overarching Role
The Quality Institute will 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. Some of this work will be directly carried out by the Quality Institute, while some will be completed in partnership with existing organizations (e.g. The Oregon Health Care Quality Corporation or Oregon Patient Safety Commission).

To achieve its goals, the Quality Institute will first pursue the following priorities:

1. Set and prioritize ambitious goals for Oregon in the areas of quality improvement and transparency. Progress toward achieving these goals will be measured and publicly reported and goals will be regularly updated to encourage continuous improvement (Coordination and Collaboration).

2. Convene public and private stakeholders to align all groups around common quality metrics for a range of health care services. Metrics adopted for Oregon will be aligned with nationally accepted measures that make sense for Oregon. In developing common metrics, the benefit of reporting particular datasets to align with adopted quality metrics must be balanced against the burden of collecting and reporting these measures from health care facilities (Coordination and Collaboration).

3. 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. Data should provide comparable information about quality of care, utilization of health care resources and patient outcomes. To the extent practicable and appropriate, data should be easily accessible to providers, health care purchasers, accountable health plans, and other members of the public in

appropriate formats that support the use of data for health care decision-making and quality improvement (right information to the right people at the right time). The Quality Institute shall establish a system for data collection, which shall be based on voluntary reporting to the greatest extent possible, but may include mandatory reporting if necessary. The Quality Institute may directly publish data or may support other organizations in publishing data (Systematic Measurement of Quality).

When developing a system and methods for public disclosure of performance information, the Quality Institute should consider the following criteria[7]:

- ➢ Measures and methodology should be transparent;
- ➢ Those being measured should have the opportunity to provide input in measurement systems (not be "surprised") and have opportunities to correct errors;
- ➢ Measures should be based on national standards to the greatest extent possible;
- ➢ Measures should be meaningful to consumers and reflect a robust dashboard of performance;
- ➢ Performance information should apply to all levels of the health care system – hospitals, physicians, physician groups/integrated delivery systems, and other care setting; and
- ➢ Measures should address all six improvement aims cited in the Institute of Medicine's Crossing the Quality Chasm (safe, timely, effective, equitable, efficient, and patient-centered).

4. 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 (Provider Improvement and Technical Assistance).

5. Advise the Governor and the Legislature on an ongoing basis on policy changes/regulations to improve quality and transparency. Produce a report to be delivered each legislative session about the state of quality of care in Oregon to be provided to the Governor, Speaker of the House and the President of the Senate (Policy Advising).

As the budget of the Quality Institute allows, the Board of the Quality Institute 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):

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[7] Adopted from the Consumer-Purchaser Disclosure Project, a group of leading employer, consumer, and labor organizations working toward a common goal to ensure that all Americans have access to publicly reported health care performance information. For more information, see http://healthcaredisclosure.org.

- Participate in the development and assessment of new quality improvement strategies by championing, coordinating, funding and/or evaluating quality improvement demonstration and pilot projects. In addition to projects focused on improving the delivery of care, projects that explore opportunities to provide incentives for quality improvement should be considered (Coordination and Collaboration).

- Convene public and private stakeholders to identify opportunities to develop a collaborative process for endorsing and disseminating guidelines of care and assessing the comparative effectiveness of technologies and procedures (Coordination and Collaboration).

- Lessen the burden of reporting that currently complicates the provision of health care (Provider Improvement and Technical Assistance).

- Support learning collaboratives and other technical assistance for providers to develop and share best practices for using data to drive quality improvement. Disseminate proven strategies of quality improvement (Provider Improvement and Technical Assistance).

- The Governor's Health Information Infrastructure Advisory Committee (HIIAC) will be making recommendations to the Oregon Health Fund Board about a strategy for implementing a secure, interoperable computerized health network to connect patients and health care providers across Oregon. The Quality Institute should align itself with these recommendations and support efforts to develop and facilitate the adoption of health information technology that builds on provider capacity to collect and report data and ensure that the right information is available at the right time to patients, providers, and payers. The Quality Institute should also partner with the HIIAC and other efforts within Oregon and across the country to build provider and system capacity to effectively use health information technology to measure and maximize quality of care, and evaluate quality improvement initiatives. (Provider Improvement and Technical Assistance).

- 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. Support efforts to engage patients in taking responsibility for their own health (Consumer Engagement).

Discussion: Much of the discussion surrounding the roles of a Quality Institute focused on the need to take a long-term approach to quality improvement and to establish an institute with at least a 10-year vision, supported by the funding and resources required to achieve that vision. Members expressed the need to ensure that all stakeholder groups and policymakers maintain realistic expectations about how quickly quality improvement efforts could move ahead and how difficult it is to move the needle in the quality arena. While the group discussed the need for the Quality Institute to find some short-term wins, there was consensus that the state government, as well as all other stakeholders will need to make a long-term commitment to the goals of improved quality and increased transparency.

In developing recommendations for the appropriate roles for a Quality Institute, the group spent significant time discussing the types of data that would be most useful to stakeholders in assessing quality and driving quality improvement efforts. There was general agreement that cost is one of the potential factors important to the assessment of efficiency. An example considered by the group was the use of generic medication. Cost is part of the value equation (value = quality/cost), but members were aware that it is also a more complex indicator than often realized. Some members cautioned that reporting cost data alone does not provide useful "apples to apples" comparisons, as costs associated with particular medical services are influenced by many different factors including patient mix, negotiated rates, staff mix and the burden of uncompensated care. For instance, simply comparing the average price of normal births at two different hospitals would not account for these differences. There were a few members that expressed the view that this information should still be made available with clear explanations of its limitations, but there was general consensus among the members that the Quality Institute should focus on collecting and reporting data directly related to the quality and efficiency of care. The group agreed that an analysis of geographic variations in utilization of health care resources can provide important insight into quality and thus is an appropriate role of a Quality Institute. Members highlighted the value of work done at the Dartmouth Atlas Project in describing variation in health resource utilization between hospitals serving Medicare patients. [8]

The Work Group discussed a number of different strategies and activities that the Quality Institute might decide to use to ensure the collection and timely dissemination of systematic data about quality and utilization. While the group decided that the Board of the Quality Institute will determine how best to fulfill this role, the group discussion highlighted some important decisions that will have to be made by the Quality Institute Board. While some members believed it would be appropriate for the Quality Institute to build and maintain (either directly or through a vendor contract) a common database to consolidate all of the quality data in the state and reduce duplicative reporting to various sources, others believed that this would not be the best way to utilize resources. Alternatively, members suggested that the Quality Institute could analyze data sets already collected by various stakeholder groups and identify

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[8] For more information, see http://www.dartmouthatlas.org/

additional data sets needed for meaningful and complete analysis of quality. In particular, the group highlighted the need for the Quality Institute to identify opportunities to use and/or develop data sources that provide information about patient experience and measure quality of life and functionality from health care interventions. Members did agree that in its analysis of quality and resource utilization, the Quality Institute will first use administrative data sets, as these are currently available, but that the Institute must acknowledge the limitations of this type of data. The Quality Institute should support efforts of other organizations and clinical societies to develop more robust and representative data sets that are validated, use national benchmarks that are based on prospective, risk-adjusted, physiologic data, and it should utilize these data sets as they become widely available.

After confirming the list of roles, the group talked about the need to stage the work of the Quality Institute and prioritize certain roles over others. The group decided there were three main audiences for the work of the Quality Institute – providers, purchasers and consumers – and that each would benefit from different types of information presented in different formats. In general, the group decided that the first goal must be to develop the infrastructure necessary to systematically measure quality over time and in a timely manner. The group then reached general consensus that the Quality Institute would be most effective if it first focused on the provider community and subsequently on purchasers and consumers (see logic model above).

Members acknowledged the ambitious agenda they established for the Quality Institute and emphasized the need for the Quality Institute Board to prioritize its work based on the quality and transparency goals it sets out for the state. In developing systematic measurements of quality, the Work Group suggested that the Board select particular areas of initial focus, such as the five most prevalent chronic conditions, the integrated health home and/or behavioral health. In addition, members suggested that as the Quality Institute begins its effort to support the provider community in quality improvement, the group should look to expand participation in evidence-based, validated programs that have already been developed and tested by professional associations and organizations. For instance, members highlighted the success of the National Surgical Quality Improvement Program (NSQIP), as an example of a program that has been able to get various stakeholders to collaborate around common quality improvement goals and has been widely tested, validated and benchmarked (See Oregon Chapter of the American College of Surgeons in Appendix A.)

IX. Financing, Structure and Governance

In an attempt to build a framework in which to make decisions about the best governance structure for a Quality Institute, the Work Group determined the following set of criteria:

- Mission – The Institute must have clear and focused mission;

- Stable and adequate funding – The Institute must have long-term core funding from public sources;
- Legislative support – Government must be a leader and a better partner that challenges other stakeholders to join a unified effort to improve quality;
- Unbiased – Stakeholders must be represented in the planning, execution and evaluation processes;
- Legitimacy – The Institute must be trusted by stakeholder groups;
- Accountable – The Institute must be required to measure and demonstrate effectiveness of efforts; and
- Flexibility – The Institute must be able to utilize an efficient and timely decision-making process and have the capacity to drive change.

The Work Group discussed the advantages and disadvantages of various governance models including public, public-private and strictly private models by analyzing the structure, funding and governance of existing organizations within each category. The group ultimately decided that a publicly chartered public-private organization would give the Quality Institute legitimacy and a well-defined mission, while allowing for flexibility in operations and funding. In addition, this structure will allow the Quality Institute to accept direct state appropriations and have rulemaking abilities and statutory authority and protections. The Quality Institute must provide strong confidentiality protections for the data it collects and reports, and it must provide these same protections to the information submitted by other organizations.

In discussing the makeup of a Board of Directors for the Quality Institute, the Work Group members stressed the importance of limiting the size of the group in order to allow for efficient decision-making. Therefore, the Work Group recommends that the Board be appointed by the Governor and confirmed by the Senate and be comprised of no more than seven members. Members must be committed to and knowledgeable about quality improvement and represent diverse interests (geographic diversity, public/private mix, experts and consumer advocates, etc). In an effort to ensure that a full range of stakeholders are given the opportunity to participate in the work of the Quality Institute, the Board should be able to create stakeholder and technical advisory committees, with chairs of these representative groups serving as ex officio members of the Board. In addition, the group recommends that the Board appoint the Executive Director, to serve at the pleasure of the Board.

In looking at the relationships the Quality Institute would have with other initiatives working to improve quality and transparency, Work Group members attempted to differentiate a number of different approaches the Institute would take in fulfilling its roles. Members agreed that in some cases the Institute would act as a "doer", while in others the Institute would be more likely to act as a "convener", "facilitator" or a "funder". The Quality Institute should act first and foremost as a convener that facilitates "safe table" opportunities for stakeholder groups to collaborate and work towards consensus on quality-related issues and should be directly involved in setting the quality and transparency policy agenda for Oregon. It is likely that the Quality Institute will often direct, support and fund other organizations in implementing specific initiatives aligned with this agenda, as well as directly carrying out these efforts.

Work Group members agreed that the Quality Institute should be a lean organization, supported by a small professional staff, but that the Institute should partner or contract with a state organization or group with a similar mission to provide human resources, office operations and other administrative support. Members suggested that the Quality Institute explore opportunities to consolidate these functions with the Oregon Patient Safety Commission, Oregon Health Care Quality Corporation or another organization with a mission closely aligned to that of the Quality Institute. However, members noted that if the Quality Institute plans to provide grants and other assistance to outside organizations it would be important for these relationships to be designed in a way that did not create a conflict of interests.

The Work Group stressed the need for state government to provide long-term and sustainable funding for a Quality Institute and to lead other stakeholders in making a robust investment in quality improvement. In addition, nothing would preclude the Quality Institute from seeking additional voluntary funding from private sources to supplement state appropriations. However, Work Group members pointed out that many private stakeholders are already supporting quality improvement organizations and that the Quality Institute should strive to partner with those organizations rather than create parallel and duplicative efforts. The Quality Institute should also be able to receive grants from state and national foundations and agencies, but the Work Group warned that grants alone cannot provide a sustainable or sufficient funding source.

The group estimated that an investment from state government of at least $2.3 million per year over a 10-year period is needed to establish a Quality Institute for Oregon. This budget should be adjusted using the consumer price index or another tool that adjusts for inflation. Appendix C provides budgets for three options for a Quality Institute, one that focuses on data collection and reporting, a second that focuses on convening stakeholders, providing grants and technical assistance and a third combines all of these functions. The Quality Institute Work Group firmly believes that only the third model will provide the infrastructure and support needed to truly drive change and improve the quality and transparency of care delivered to Oregonians.

Appendix A: Organizations and Collaborative Efforts Dedicated to Quality Improvement and Increased Transparency in Oregon

Initiative/Quality Organization Name	Lead Stakeholders/General Structure	Description of Quality Initiative(s)	Major Funding Source(s)	Target Audience(s)
Acumentra Health	Acumentra Health is a physician-led, nonprofit organization that serves as the state's Quality Improvement Organization; partners with various state agencies, research organizations, professional associations and private organizations	Provides resources and technical assistance to Oregon's Medicare providers, including nursing homes, hospitals, home health agencies, medical practices, Medicare Advantage plans, and Part D prescription drug plans to support quality improvement (QI) efforts. Initiatives include: • Doctor’s Office Quality–Information Technology (DOQ–IT) - Helps Oregon medical practices implement and optimize electronic health record systems • Culture and Medicine Project - helps providers recognize and respond to culture-based issues that affect communications with patients and their ability to follow a treatment plan • Performance improvement project training for managed mental health organizations • Rural Health Patient Safety Project	CMS Medicare contracts, state Medicaid contracts, project-base state and private funding	Providers, including nursing homes, hospitals, home health agencies, medical practices, Medicare Advantage plans, Part D Prescription drug plans
Advancing Excellence in America’s Nursing Homes	National campaign initiated by CMS. Oregon's Local Area Network for Excellence (LANE) includes Acumentra Health, The Oregon Alliance of Senior and Health Services, the Oregon Health Care Association, the Hartford Center for Geriatric Nursing Excellence at OHSU's School of Nursing, the Oregon Pain Commission, the Oregon Patient Safety Commission and Seniors and People with Disabilities; Over 23 nursing homes in the state have registered	Voluntary campaign aimed at improving quality of care in nursing homes. Oregon's LANE focusing on reducing high risk pressure ulcers, improving pain management for longer-term and post-acute nursing home residents, assessing resident and family satisfaction with quality of care and staff retention.	Support from LANE network	Providers -Nursing homes

Compare Hospital Costs Web Site	Joint effort of Department of Consumer and Business Services (DCBS) and OHPR	DCBS requires insurers in Oregon to report on payments made to Oregon hospitals. OHPR makes information on the average payments for inpatient claims for patients in Oregon acute-care hospitals available on a public website. The Website contains data on the average payments for 82 common conditions or procedures.	DCBS and OHPR agency budgets	Consumers and Researchers
Department of Human Services (DHS)	State agency made up of five divisions: Children, Adults and Families Division, Addictions and Mental Health Division, Public Health Division, Division of Medical Assistance Programs, and Seniors and People with Disabilities Division.	• Public health chronic disease department has convened plan and provider quality groups to develop a common approach to population-based guidelines including diabetes, asthma and tobacco prevention. • Heart, stroke, diabetes, asthma, and tobacco-use prevention associations and DHS all have educational and collaborative programs that encourage compliance with evidence-based guidelines. • Division of Medical Assistance Programs measures, reports and assists with quality improvement through its Quality Improvement Project • Office of Health Systems Planning and Public Health Division have a patient safety policy lead dedicated to providing leadership, information and skills, support and resources to health care providers and patients so that they can ensure patient safety	Agency budget	Providers
HB 2213 (2007) - Health Insurance Cost Transparency Bill	Department of Consumer and Business Services	Effective July 1, 2009 insurers will be required to provide a reasonable estimate (via an interactive Web site and toll-free telephone) of an enrollee's cost for a procedure before services are incurred for both in-network and out-of-network services.	Requirement of health plans to provide service to enrollees	Consumers, Health Plans, Providers

Oregon Association of Hospitals and Health Systems (OAHHS)	Oregon Association of Hospitals and Health Systems is a statewide health care trade association representing hospitals and health systems	• Posts comparative information about hospital performance on quality indicators on OAHHS website • Supports website, www.orpricepoint.org, that provides comparative charge information for Oregon hospitals • Implementing colored coded wrist band system in Oregon hospitals to improve patient safety • Convenes multi-stakeholder group to define common measures and common expectations of hospital quality ▪ Co-founder, with OMA of Oregon Quality Community	OAHHS budget largely supported through member dues	Consumers, Hospitals and Health Systems
Oregon Chapter of the American College of Surgeons (ACS)	State chapter of ACS, a professional association established to improve the care of the surgical patient by setting high standards for surgical education and practice	Championing National Surgical Quality Improvement Program (NSQIP) in Oregon hospitals • NSQIP collects data on 135 variables, including preoperative risk factors, intraoperative variables, and 30-day postoperative mortality and morbidity outcomes for patients undergoing major surgical procedures in both the inpatient and outpatient setting • ACS provides participating hospitals with tools and reports needed to compare its performance with performance of other hospitals and develop performance improvement initiatives • Started the NSQIP Consortium to identify, implement, and disseminate best practices using clinical evidence sharing aggregate data with Consortium hospitals and educating the community about NSQIP. Currently includes 5 hospitals in Portland and 1 in Eugene with hope to expand statewide	Participating hospitals (currently four in Oregon, soon expanding to 6) pay fee for participating in NSQIP; American College of Surgeons	Providers - Hospitals and Surgeons
Oregon Coalition of Health Care Purchasers (OCHCP)	Non-profit organization of private and public purchasers of group health care benefits in Oregon or Southwest Washington	Uses the joint purchasing power of the public and private membership to improve health care quality across the state and give employers the tools they need to purchase benefits for their employees based on quality. In 2007, the OCHCP started to use eValue8, an evidence-based survey tool which collects and compiles information from health plans on hundreds of process and outcome measures. In 2007, results were shared only with OCHCP members but may be released to larger audience in future.	Member dues, corporate sponsors	Purchasers, Health Plans, Providers
Oregon Community Health Information Network (OCHIN)	Not-for-profit organization that supports safety-net clinics; collaborative of 21 members serving rural and urban populations of uninsured or under-insured	• Using collaborative purchasing power to make health information technology products more affordable to safety net clinics • Offers consulting services, technical services to help staff in member clinics more effectively use health information technology to improve quality	Current funding from HRSA and AHRQ, Cisco Systems, Inc., State of Oregon, PSU and Kaiser	Providers - Clinics serving vulnerable populations

Oregon Health and Sciences University Medical Informatics	Partnership with American Medical Informatics Association, which started a 10 x 10 initiative to get 10,000 health care professionals trained in health care informatics by 2010	Offers a 10x10 certificate program which helps health care providers get training in medical informatics, the use of information technology to improve the quality, safety, and cost-effectiveness of health care	Student fees	Providers - Current and future health care providers
Oregon Health Care Quality Corporation	Multi-stakeholder non-profit organization; Collaboration of health plans, physician groups, hospitals, public sector health care representatives, public and private purchasers, health care providers, consumers and others with a commitment to improving the quality of health care in Oregon	• Aligning Forces for Quality - building community capacity to use market forces to drive and sustain quality improvement by:(1) Providing physicians with technical assistance and support to help them build their capacity to report quality measures and use data to drive quality improvement (2) Working with providers and other stakeholders to provide consumers with meaningful clinic-level comparisons of primary care quality, which includes identifying a common set of quality measures for the state(3) Educating consumers about the importance of using quality information to make health care decisions and building a consumer-friendly website to provide quality information and self-management resources • Developing private and secure health information technology systems that allow individuals and their providers to access health information when and where they are needed	Robert Wood Johnson Foundation supporting Aligning Forces grant; Health Insurers, PEBB, OCHCP also providing funding for efforts to make quality info available to customers	Consumers, Providers, Purchasers

Oregon Health Policy Commission (OHPC)	The OHPC was created by statute in 2003 to develop and oversee health policy and planning for the state. The Commission is comprised of ten voting members appointed by the Governor, representing all of the state's congressional districts and including four legislators (one representing each legislative caucus) who serve as non-voting advisory members.	OHPC has a Quality and Transparency Workgroup which is working towards making meaningful health care cost and quality information available to inform providers, purchasers and consumers.	OHPC Budget	Consumers, Providers, Purchasers, Consumers
Oregon Hospital Quality Indicators	Joint effort of Office for Oregon Health Policy and Research (OHPR) and Oregon Health Policy Commission (OHPC) with input from various stakeholders	Produces annual web-based report on death rates in hospitals for selected procedures and medical conditions	OHPR agency budget	Consumers, Purchasers
Oregon IHI 5 Million Lives Network	Joint effort of Oregon Association of Hospitals and Health Systems, Oregon Patient Safety Commission, Oregon Medical Association, Acumentra, Oregon Nurses Association, CareOregon; leading statewide expansion of Institute for Healthcare Improvement 10,000 Lives Campaign	6 statewide organizations working together to champion the use of 12 evidence-based best practices in over 40 hospitals across Oregon	Funding from six sponsor organizations	Providers – Hospitals

Oregon Patient Safety Commission	Created by the Oregon Legislature in July 2003 as a "semi-independent state agency." Board of Directors appointed by Governor and approved by Senate, to reflect the diversity of facilities, providers, insurers, purchasers and consumers that are involved in patient safety.	• Developing confidential, voluntary serious adverse event reporting systems for hospitals, nursing homes, ambulatory surgery centers, retail pharmacies, birthing centers and outpatient real dialysis facilities in Oregon with main goal of providing system level information • Using information collected through reporting to build consensus around quality improvement techniques to reduce system errors • Developing evidence-based prevention practices to improve patient outcomes information from hospitals on adverse events and reports to public	Fees on eligible hospitals, nursing homes, ambulatory surgery centers, retail pharmacies, birthing centers, outpatient renal dialysis facilities; Grants	Providers including hospitals, nursing homes, ambulatory surgery centers and retail pharmacies, Consumers
Oregon Primary Care Association	A nonprofit member association representing federally qualified health centers (FQHC)	Provides quality improvement technical assistance to its FQHC members, who also participate in Bureau of Primary Care learning collaborative	OPCA budget, funded primarily through membership fees	Providers serving vulnerable populations
Oregon Quality Community	Joint effort of Oregon Association of Hospitals and Health Systems and Oregon Medical Association; Steering Committee comprised of hospital and health system representatives	• Working with hospitals across the state to improve patient safety through improved hand hygiene. • Medication reconciliation project in planning stages.	OAHHS and OMA funding	Providers – Hospitals
Patient Safety Alliance	Partnership of Acumentra Health, Oregon Chapter of the American College of Physicians, Oregon Chapter of the American Collage of Surgeons, Northwest Physicians Insurance Company, Oregon Academy of Family Physicians and Oregon Chapter of the Society of Hospital Medicine	• Building multidisciplinary teams, including senior leadership, at Oregon hospitals to identify quality problems and build skills and models to be used for hospital-based process and quality improvement activities. Ultimate goal is to improve performance on CMS/Joint Commission medical care and surgical care measures.	Funding from six sponsor organizations	Providers – Hospitals

Public Employees Benefits Board	PEBB currently contracts with Kaiser, Regence, Samaritan and Providence to provide health care benefits to state employees	• With implementation of PEBB Vision for 2007, PEBB makes contracting decisions based on value and quality of care provided through health plans. Plans who contract with PEBB must agree to make an ongoing commitment to implement specific quality improvement initiatives, including requiring participating hospitals to report annual performance measures and national and local level quality indicators (i.e. the Leapfrog survey, Oregon Patient Safety Commission, HCAHPS survey), and developing long-term plans to implement information technology that will improve quality of care. • PEBB Council of Innovators brings the medical directors and administrative leaders from the four plans with contracts together to identify and share best practices.	State funds used to purchase employee benefits	Consumers, Health Plans, Providers
Regence Blue Cross Blue Shield	Not-for-profit health plan	Provides feedback on 40+ indicators of quality evidence based care to patients to nearly 40% of clinicians. This Clinical Performance Program includes patient specific data to allow correction and support improvement.	Regence budget	Providers
The Foundation for Medical Excellence	Public non-profit foundation, whose mission is to promote quality healthcare and sound health policy	Promoting quality healthcare through collaboration, education and leadership training opportunities for physicians	Support from individuals, foundations, health care organizations, consumer advocates and other Oregon businesses	Providers

The Health Care Acquired Infection Advisory Committee	Statutorily mandated committee comprised of seven health care providers with expertise in infection control and quality and nine other members who represent consumers, labor, academic researchers, health care purchasers, business, health insurers, the Department of Human Services, the Oregon Patient Safety Commission and the state epidemiologist.	Advising the Office for Oregon Health Policy on developing a mandatory reporting program for health care acquired infections to start in January 2009 for subsequent public reporting.	Additional appropriations made to OHPR in 2007 Legislative Session	Consumers, Providers

Other Initiatives

- The newly formed Oregon Educators Benefits Board is currently determining how to build quality improvement requirements into contracts with health plans
- Independent Practice Associations and Medical Groups are investing millions of dollars to assist their clinicians in implementing electronic health records, registries and other electronic support resources to measure and improve quality

Appendix B: Select State Quality Improvement and Transparency Efforts

This document does not provide a comprehensive description of all quality improvement across the country. Rather, it is meant to provide descriptions of some of the most innovative and influential activities in select states.

Maine

Maine Quality Forum **(MQF)** – an independent division of Dirigo Health (a broad strategy to improve Maine's health care system by expanding access to coverage, improving systems to control health care costs and ensuring the highest quality of care statewide) created by the Legislature and Governor in 2003

- Governed by a Board chaired by surgeon and includes members representing government agencies and labor, as well as an attorney. The Maine Quality Forum Advisory Council (MQF-AC) is a multi-stakeholder group consisting of consumers, providers, payers and insurers that advises the MQF.
- Consumer-focused organization established to provide reliable, unbiased information, user-friendly information to consumers. Website serves as a clearinghouse of best practices and information to improve health, and acts as an informational resource for health care providers and consumers
- Website provides data charts comparing geographical variation in chronic disease prevalence and number of surgeries performed for various conditions, as well as information about quality of hospital care reported by hospital peer groups
- Key tasks:
    - Assess medical technology needs throughout the state and inform the Certificate of Need process
    - Collect research on health care quality, evidence based medicine and patient safety
    - Promote the use of best medical practices
    - Coordinate efficient collection of health care data – data to be used to assess the health care environment and facilitate quality improvement and consumer choice
    - Promote healthy lifestyles
    - Promote safe and efficient care through use of electronic administration and data reporting

Maine Health Care Claims Data Bank – nation's first comprehensive statewide database of all medical, pharmacy and dental insurance claims, as well as estimated payments made by individuals (including co-pays, deductibles and co-insurance)

- Public-private partnership between ***Maine Health Data Organization*** and ***Maine Health Information Center*** – jointly created ***Maine Health Processing Center*** in 2001
    - Maine Health Data Organization (MHDO) - created by the state Legislature in 1996 as an independent executive agency (see below for more information)
    - Maine Health Information Center - independent, nonprofit, health data organization focused on providing healthcare data services to a wide range of clients in Maine and other states
- Beginning in January 2003, every health insurer and third party administrator that pays claims for Maine residents required to submit a copy of all paid claims to the MHDO. Maine Health Processing Center serves as technical arm and has built and maintains the data bank, collects claims information and submits a complete dataset

to MHCO. Database now includes claims from MaineCare (Medicaid) and Medicare.
- New Hampshire, Massachusetts and Vermont are all working with Maine (through contracts with either Maine Health Processing Center or Maine Health Information Center) to develop or modify claims databases so that all states collect same information, use same encryption codes, etc.

Maine Health Data Organization ***(MHDO)-*** independent executive agency created by state legislature to collect clinical and financial health care information to exercise responsible stewardship in making information available to public
- Maintains databases on: hospital discharge inpatient data, hospital outpatient data, hospital emergency department data, hospital and non-hospital ambulatory services as well as complete database of medical, dental and pharmacy claims (see above).
- Makes rules for appropriate release (for fee) of information to interested parties. Recent rule changes allows for release of information that identifies practitioners by name (except Medicare data).
- Directed by Maine Quality Forum to collect certain data sets of quality information – currently collecting information on care transition measures (CTM-3), Healthcare Associated Infections and Nursing Sensitive Indicators.
- Currently developing database of price information

Maine Health Management Coalition - coalition of employers, doctors, health plans and hospitals working to improve the safety and quality of Maine health care
- Goals: collect accurate, reliable data to measure how Maine is doing, evaluate data to assign quality ratings, present data in a way that is easy to understand and use
- Website provides individual primary care doctor quality ratings based on use of clinical information systems, results of diabetes care, and results of care for health disease. Blue ribbon distinction given to highest performers.
- Website provides hospital quality rankings based on patient satisfaction, patient safety, and quality of care for heart attack, heart failure, pneumonia, and surgical infection
- Established Pathways to Excellence programs to provide employees with comparative data about the quality of primary care and hospital care and reward providers (financially and through recognition) for quality improvement efforts. Plans to expand to specialty care.

Quality Counts – regional health care collaborative with range of stakeholder members including providers, employers and purchasers, state agencies
- Initiated as effort to educate providers about the Chronic Care Model
- Funded by membership contributions, as well as funding from Robert Wood Johnson Foundation
- Grantee of Robert Wood Johnson Aligning Forces for Quality - collaborating with other quality improvement organizations in the state on Aligning Forces goals:
    - Help providers improve their own ability to deliver quality care.
    - Help providers measure and publicly report their performance.
    - Help patients and consumers understand their vital role in recognizing and demanding high-quality care
- Contract from Maine Quality Forum to create a learning collaborative for stakeholders involved in quality improvement

Massachusetts

***Massachusetts Health Quality Partners* (MHQP)** - broad-based independent coalition of physicians, hospitals, health plans, purchasers, consumers, and government agencies working together to promote improvement in quality and health care services in MA

- Members include: Blue Cross Blue Shield of Massachusetts, Fallon Community Health Plan, Harvard Pilgrim Health Care, Health New England, Tufts Health Plan, Massachusetts Hospital Association, Massachusetts Medical Society, Massachusetts Executive Office of Health and Human Services, MHQP Physician Council, two consumer representatives, CMS Regional Office, and one employer representative.
- 5 strategic areas of focus:
  - Taking leadership role in building collaboration and consensus around a common quality agenda
  - Aggregating and disseminating comparable performance data
  - Increasing coordination and reducing inefficiencies to improve quality of care delivery
  - Developing and disseminating guidelines and quality improvement tools
  - Educating providers and consumers in the use of information to support quality improvement
- The MHQP web site compares performance of providers, reported at the group level, against state and national benchmarks on select HEDIS measures. Started with a focus on quality measurement for primary care providers and now expanded to include specialists and resource use measurements.
- MHQP website also allows the public to compare results of patient satisfaction surveys across doctors' offices.
- Convenes multi-disciplinary groups to work collaboratively to develop and endorse a single set of recommendations and quality tools for MA clinicians in order to streamline adherence to high quality, evidence-based decision making and care. Guidelines have been developed in the areas of Adult Preventative Care and Immunization, Pediatric Preventative Care and Immunization, Perinatal Care, Massachusetts Pediatric Asthma and Adult Asthma. MassHealth promotes use of guidelines for treatment of all enrollees.

Massachusetts Health Care Quality and Cost Council – a council of diverse stakeholder representatives established under recent statewide reform charged with setting statewide goals and coordinating improvement strategies.

- Established within, but not subject to the control of the Massachusetts Executive Office of Health and Human Services. Receives input and advise from an Advisory Committee that includes representation from consumers, business, labor, health care providers, and health plans.
- Charged assigned to the Council by the reform legislation include:
  - To establish statewide goals for improving health care quality, containing health care costs, and reducing racial and ethnic disparities in health care
    - Vision established by the Council: By June 30, 2012, Massachusetts will consistently rank in national measures as the state achieving the highest levels of performance in case that is safe, effective, patient-centered, timely, efficient, equitable, integrated, and affordable.

        - Specific cost and quality goals for 2008 established in areas of cost containment, patient safety and effectiveness, improved screening for chronic disease management, reducing disparities, and promoting quality improvement through transparency.
    - To demonstrate progress toward achieving those goals
        - Council mandated to report annually to the legislature on its progress in achieving the goals of improving quality and containing or reducing health care costs, and promulgates additional rules and regulations to promote its quality improvement and cost containment goals
    - To disseminate, through a consumer-friendly website and other media, comparative health care cost, quality, and related information for consumers, health care providers, health plans, employers, policy-makers, and the general public.
        - Website publishes information about cost and quality of care listed by medical topic. Depending on condition or procedure, quality information is reported by provider and/or hospital and provides information about mortality (death) rates, volume and utilization rates and whether appropriate care guidelines are followed.

Minnesota

***Buyers Health Care Action Group* (BHCAG) –** coalition of private and public employers working to redirect the health care system to focus on a collective goal of optimal health and total value

- Founding member of the **Leapfrog Group**, a national organization of private and public employers and purchasing coalitions who reinforce "big leaps" in health care safety, quality and customer value - "leaps" that can prevent avoidable medical errors. The Leapfrog Group's online reports allows consumers and purchasers of health care can track the progress hospitals are making in implementing four specific patient safety practices proven to save lives and prevent some of the most common medical mistakes
- One of eight organizations who joined together to develop the **eValue8™** Request for Information tool - a set of common quality performance expectations for health plans that purchasers can use to evaluate plans based on the value of care delivered. eValue8 collects information on plan profile, consumer engagement, disease management, prevention and health promotion, provider measurements, chronic disease management, pharmacy management and behavioral health. BHCAG, on behalf of the Smart Buy Alliance and its members, conducts a rigorous annual evaluation of major Minnesota health plans using eValue8 and makes results available to the public in an annual report (see **Minnesota Purchasers Health Plan Evaluation** below for more information)
- In 2004, introduced Bridges to Excellence (BTE), an employer directed pay-for-performance initiative that pays doctors cash bonuses for providing optimal care to patients with chronic diseases. BHCAG initiated a collaborative community plan to implement BTE, which includes 12 Minnesota private employers and public

purchasers (including Minnesota Department of Human Services) that have signed on as "Champions of Change" for a diabetes rewards program. Champions reward medical groups and clinics that provide high quality diabetes care. In 2007, BHCAG added a reward program for optimal coronary artery disease and is considering adding rewards for optimal care in depression and radiology.

***Minnesota Smart Buy Alliance* –** voluntary health care purchasing alliance formed in 2004 by the State of Minnesota, business and labor groups to pursue common market-based purchasing principles.

- Alliance set up as a "Coalition of Coalitions" – Original members included The State of Minnesota Department of Employee Relations (purchaser of state employees benefits), Minnesota Department of Human Services (Medicaid, SCHIP, and MinnesotaCare), Buyer's Health Care Action Group (large private and public employers) Labor/Management Health Care Coalition of the Upper Midwest (union and management groups), Minnesota Business Partnership (large employers) Minnesota Chamber of Commerce (primarily small to mid-size employers) Minnesota Association of Professional Employees, Employers Association and CEO Roundtable. Original co-chairs were the leaders of three core member groups: the Department of Human Services, BHCAG, and the Labor/Management Health Care Coalition. The Labor/Management Health Care Coalition withdrew from the Alliance in 2007.
- Together, members of the Alliance buy insurance for more than 60% of Minnesota residents (3.5 million people).
- Alliance work is guided by four main principles:
    - Adopting uniform measures of quality and results
    - Rewarding "best in class" certification
    - Empowering consumers with easy access to information
    - Requiring health care providers to use the latest information technology for purposes of greater administrative efficiency, quality improvement and protecting patient's safety

***QCare* –** Created by the Governor of Minnesota by executive order in July 2006 to accelerate state health care spending based on provider performance and outcomes using a set of common performance measures and public reporting

- All contracts for MinnesotaCare, Medicaid and Minnesota Advantage will include incentives and requirements for reporting of costs and quality, meeting targets, attaining improvements in key areas, maintaining overall accountability
- Initial focus in four areas: diabetes, hospital stays, preventative care, cardiac care
- Private health care purchasers and providers are encouraged to adopt QCare through the Smart Buy Alliance

The Institute for Clinical Systems Improvement (ICSI) – An independent, non-profit organization that facilitates collaboration on health care quality improvement by medical groups, hospitals and health plans that provide health care services to people in Minnesota.

- 62 medical groups and hospital systems are currently members of ICSI, representing more than 7,600 physicians.
- Funding is provided by all six Minnesota health plans

- Produces evidence-based best practice guidelines, protocols, and order sets which are recognized as the standard of care in Minnesota
- Facilitates "action group" collaboratives that bring together medical groups and hospitals to share strategies and best practices to accelerate their quality improvement work.

Governor's Health Cabinet - comprised of members of Governor's Administration and representatives from business and labor groups

- Created minnesotahealthinfo.org, a clearinghouse website designed to offer a wide range of information about the cost and quality of health care in Minnesota. The site is now maintained by the Minnesota Department of Health and provides links to organizations that provide cost and quality information about Minnesota providers, as well as information about buying health care, managing health care conditions and staying healthy. The site provides links to the following state-based quality and cost public reports (links to national efforts, such as AHRQ, CMS, Leapfrog Hospital Survey Results, NCQA, are also provided):
    - **MN Community Measurement™** - a non-profit organization that publicly reports health performance at the provider group and clinic level. MN Community Measurement recently launched D5.org, a website that specifically focuses on providing information about quality of diabetes care at clinics around the state.
    - Private insurance companies, including **HealthPartners**, **Medica** and **Blue Cross and Blue Shield of Minnesota** provide members and the public with information about provider quality and costs, as well as information about costs associated with individual procedures or total cost of treating certain conditions.
    - **Patient Choice Care System Comparison Guide** –consumer guide to care system quality, cost and service published on the web by Medica that allows consumers to compare provider organizations on factors such as their management of certain conditions, patient satisfaction, cost and special programs and capabilities.
    - **Minnesota Hospital Price Check** – web site sponsored by the Minnesota Hospital Association as the result of 2005 legislation that provides hospital charges for the 50 most common inpatient hospitalizations and the 25 most common same-day procedures.
    - **Minnesota Hospital Quality Report** – web site sponsored by the Minnesota Hospital Association and Stratis Health that provides easy access to quality measures for heart attack, heart failure, and pneumonia care at Minnesota hospitals.
    - **Healthcare Facts®** - site supported by Blue Cross Blue Shield of Minnesota that provides easy-to-read information on costs, safety and quality, and service information for large hospitals in Minnesota.
    - **Health Facility Investigation Reports** – web site supported by the Minnesota Department of health that allows the public to access complaint histories and investigation reports for a variety of Minnesota health care providers. The list includes nursing homes, board and care homes, home care providers, home health agencies, hospice facilities and services, hospitals, facilities that offer housing with services, and supervised living facilities. Searches can be done

for complaint information by date, provider type, provider name, and the county or city where the provider is located.

  - **Adverse Health Events in Minnesota** – web-accessible reports, administered by the Minnesota Department of Health, on preventable adverse events in Minnesota hospitals (more information provided below).
  - **Minnesota Purchasers Health Plan Evaluation** – web-accessible report, prepared by the Buyers Health Care Action Group (BHCAG), compares health plan performance in the following areas: health information technology, consumer engagement and support, provider measurement, primary prevention and health promotion, chronic disease management, behavioral health, and pharmacy management based on eValue8 survey results.
  - **Minnesota's HMO Performance Measures** – site supported by Minnesota Department of Health's Manage Care Systems section links consumers to quality of care information reported by Minnesota HMOs on common health care services for diabetes, cancer screenings, immunizations, well-child visits, and high blood pressure.
  - **Minnesota Nursing Home Report Card** – an interactive report card from the Minnesota Department of Health and the Department of Human Services allows the public to search by geographic location and rank the importance of several measures on resident satisfaction, nursing home staff and quality of care.
  - **Minnesota RxPrice Compare** - web site displays local pharmacy prices for brand name, generic equivalent and therapeutic alternative medication options. The consumer tool compares the "usual and customary" prices of 400 commonly used prescription medications. Some of the brand name medications on this site include a list of generic medications that may be cost effective alternatives to the more expensive brand name medication. The site provides information about accessing lower-cost prescription medicine from Canada.

Adverse Health Care Events Reporting System **–** established in 2003 in response to 2003 state legislation requiring hospitals, ambulatory surgical centers and regional treatment centers to report whenever one of 27 "never events" occurs

- Website maintained by the Department of Health allows public to access annual report of adverse events and search for adverse events at specific hospitals. The report must also include an analysis of the events, the corrections implemented by facilities and recommendations for improvement.
- In September, 2007, the Governor of Minnesota announced a statewide policy, created by the Minnesota Hospital Association and Minnesota Council of Health Plans and endorsed by the Governor's Health Care Cabinet, which prohibits hospitals from billing insurance companies and others for care associated with an adverse health event.

Pennsylvania

Pennsylvania Health Care Cost Containment Council ***(PH4C)*** - independent state agency responsible for addressing the problem of escalating health costs, ensuring the quality of health care, and increasing access for all citizens regardless of ability to pay.

- Funded through the Pennsylvania state budget and sale of datasets
- Includes labor and business representatives and health care providers
- Seeks to contain costs and improve health care quality by stimulating competition in the health care market by giving comparatives information about the most efficient and effective providers to consumers and purchasers
- Hospitals and ambulatory surgery centers are mandated to provide PH4C with charge and treatment information. PH4C also collects information from HMOs on voluntary basis.
- Produces free comparative public reports on hospital quality and average charge. Reports on diagnosis include number of cases, mortality rating (ratings reported as significantly higher than expected, expected or significantly lower than expected), average length of stay, length of stay for short and long stay outliers, readmission ratings for any reason and for complication and infection, and average charge. Reports on specific procedures include number of cases, mortality rating, length of stay, readmission ratings and average charge.
- HMO quality reports also available on website. Interactive website tool allows consumers to find comparative information about plan profiles, plan ratings (based on utilization data and clinical outcomes data), plan performance on preventative measures, and member satisfaction.
- Website also provides reports on utilization by county, quality of heart bypass and hip and knee replacement reported by hospital and surgeon, and hospital financials. In addition, an interactive hospital inquired infection database can be searched by hospital, by infection, and by peer group.

Washington

Puget Sounds Health Alliance – Regional partnership involving more than 150 participating organizations, including employers, public purchasers, every health plan in the state, physicians, hospitals, community groups, and individual consumers across five counties

- Financed through county and state funding, as well as member fees - participating health plans pay a tiered fee based on their market share; providers pay according to their number of full-time employees; and purchasers and community groups pay a fee for each "covered life"—the number of employees and their families receiving employer-based health benefits. Individual consumers can join the alliance for $25 per year.
- Plans to release region's first public report on quality, value and patient experience at the end of January 2008
    - The first report will compare performance on aspects of care provided in doctors offices or clinics, using measures that reflect best-practices particularly for people with chronic conditions such as diabetes, heart disease, back pain and depression – a first draft of the report has been posted on the Alliance website for public comment

    - Future plans to expand report to include results for all doctors' offices and clinics over a certain size in the five-county region. Future reports will also compare hospital care and efficiency.
- Convenes expert clinical improvement teams to: identify and recommend evidence-based guidelines for use by physicians and other health professionals; choose measures that will be used to rate the performance of medical practices and hospitals regarding care they provide; and identify specific strategies that will help improve the quality of care and the health and long-term wellbeing for people in the Puget Sound region
    - Clinical improvement reports have been released on heart disease, diabetes, prescription drugs, depression and low back pain. Teams currently developing asthma and prevention reports.

Wisconsin

Wisconsin Department of Employee Trust Funds - purchases health care for more state and local employees, retirees and their dependents, making it the largest purchaser of employer coverage in the state.

- Publishes "It's Your Choice" guide in print and on website intended to assist state employees in choosing health plan based on quality. The 2007 guide provides information about how many of a health plan's network hospitals have: submitted data to Leapfrog; fully implemented or made good progress on implementing patient safety measures endorsed by the National Quality Forum; provided data for prior year's error prevention measures and clinical measures reported through CheckPoint (see below); and provided data on Medication Reconciliation through CheckPoint. The guide also reports health plan quality improvement efforts, whether the plan has a 24-hour nurse line or an electronic diabetes registry, and responsiveness to enrollee calls.
- Health plans are assigned to one of three tiers, based on cost and quality and member premium contributions vary by tier. Tier designation originally based mainly on cost, but more emphasis has been put on quality by incorporating scores on patient safety, customer satisfaction, diabetes and hypertension care management, and rates of childhood immunizations and cancer screenings.
- "Quality Composite System" provides enhanced premiums to health plans displaying favorable patient safety and quality measures.

***Wisconsin Hospital Association CheckPoint and Price Point* –** comparative web-based reports on hospital cost and quality based on data voluntarily reported by hospitals

- Check Point - provides comparative reports of hospital performance. Reports can be created to compare hospital performance on 14 interventions for heart attacks, heart failure, and pneumonia, 8 surgical service measures, and 5 error prevention goals.
    - Prevention measures recently expanded to include medication reconciliation measure, which indicates hospital's progress toward identifying the most complete and accurate list of medications a patient is taking when admitted to the hospital and using that list to provide correct medication for patient anywhere within the health care system.
- Price Point - allows health care consumers to receive basic, facility-specific information about services and charges associated with inpatient and outpatient services

***Wisconsin Health Information Organization* (WHIO)** - non-profit collaborative of managed care companies/insurers, employer groups, health plans, physician associations, hospitals,

- Building a statewide, centralized health repository based on voluntary reporting of private health insurance claims and pharmacy and lab data from health insurers, self-funded employers, health plans, Medicaid, and the employee trust fund
- Planning to use information to develop reports on the costs and quality of care in ambulatory settings.

***Wisconsin Collaborative for Healthcare Quality* (WCHQ) -** voluntary consortium of organizations, including physician groups, hospitals, health plans, employers and labor organizations learning and working together to improve the quality and cost-effectiveness of healthcare for the people of Wisconsin

- Governed by an assembly, comprised of CEOs, CMOs and Senior Quality Executives from each of the member institutions; Board of directors comprised of CEOs (or designees) from each member organization plus two delegates from Business Partners; receives input from workgroup of experts and business partners and business coalitions
- Web-based public Performance and Progress Reports provide comparative information on its member physician practices, hospitals, and health plans. Interactive tool allows for searches by provider types and region, clinical topic or IOM quality category (safety, timeliness, effectiveness, patient-centeredness), as well as comparison against WQHC averages and national performance.
- Set goal for providers to score above JCAHO 90 percentile performance.
- Tools designed to allow members to report data through website
- http://www.wisconsinhealthreports.org - set up as single source of quality and cost data for Wisconsin and includes links to WQHC, as well as Price Point and Check Point

Appendix C: Quality Institute Budget

Assumptions

- The following budgets assume the Quality Institute will have an unpaid voluntary Board of Directors, and voluntary advisory committees as appointed by the Board. The budgets below will have to be adjusted if the state decides the Quality Institute should have a paid Board.
- The Quality Institute will pursue all of the priority roles established in the accompanying report. The budget of the Quality Institute will determine the Institute's ability to pursue a range of other functions.
- The budget allocation for strategic investments will be used to fund projects, in partnership with other quality improvement organization, that align with the mission of the Quality Institute. A significant amount of staff and Quality Institute Board member time will have to be dedicated to developing strategic alliances with other organizations and making transparent decisions about how these dollars can be used 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 and Technical Assistance and Consumer Engagement	
Strategic Investments*	$750,000
Total	$2,305,000

The Quality Institute Work Group recommends that the state provide at least $4.6 million per biennium ($2.3 million annually) to establish and operate a Quality Institute able to significantly improve the quality and transparency of Oregon's health care system.

Reference Budgets Consulted
Population of Oregon: 3.7 million

Maine Quality Forum (See Appendix B for full description)

- Budget: MQF has an operating budget of $1 million annually, with administrative and staff salaries funded by the Dirigo Health Authority
- Population of Maine: 1.3 Million (2.4 million less than Oregon)
- Functions: MQF has convening and public reporting functions and advises state government on quality improvement issues. MQF does not directly collect data.

Utah Statewide All Claims Database (as proposed by Utah Department of Health)

- Budget: $1 million annually (includes software costs, vendor contract to clean, merge and maintain data securely and create public reports, one FTE to oversee and manage project and travel)
- Population : 2.6 Million (1.1 million less than Oregon)
- Functions: Create an all-claims database of all medical, pharmacy and dental claims processed for Utah residents and enrollment data for all health plan member. Create public cost and quality reports.

The Pennsylvania Health Care Cost Containment Council (PHC4)

- Budget: Approximately $5 million annually
- Population: 12.4 million (~3 times population of Oregon)
- Functions: Maintains a database of all hospital discharge and ambulatory/outpatient procedure records each year from hospitals and freestanding ambulatory surgery centers. Reports data about the cost and quality of health care to public. Studies quality and access issues. Advises state government on quality improvement issues.

HEALTH EQUITIES COMMITTEE

Cultural competence refers to the process by which individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, disabilities, religions, genders, sexual orientation and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families and communities and protects and preserves the dignity of each.

Policy Recommendations on Data Collection and Quality Initiatives

In Oregon there is such a dearth of data related to race, ethnicity, and primary language in healthcare that it difficult to identify, let alone address, disparities in healthcare access, healthcare utilization, disease status, and/or quality of care. Where data exists, sources of are difficult to combine or compare due to differences in definitions and data collection protocols.

- **All healthcare providers and health plans participating in the Oregon Health Fund Program must be required to collect and report data on race, ethnicity, and primary language. These measures need to be included when assessing quality and ensuring transparency.**
- **In its role as convener and collaborator, the Quality Institute should be responsible for:**
    - **Training provider organizations and health plans on protocols for collecting race, ethnicity, and primary language data based on the highest national standards. This will ensure consistency and comparability among data sources and will additionally reduce provider discomfort with collecting this kind of information from patients.**
    - **Developing a multicultural healthcare agenda that utilizes data to identify disparities and assist communities with evaluating interventions to reduce disparities.**
    - **Aligning resources to support quality healthcare across all demographic populations in Oregon.**
    - **Disseminating meaningful and accurate information on health quality and utilization of healthcare resources in a manner that is accessible and understandable to individuals from a variety of cultural, ethnic, and educational backgrounds.**

Cultural competence refers to the process by which individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, disabilities, religions, genders, sexual orientation and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families and communities and protects and preserves the dignity of each.

Policy Recommendations on Providing Incentives for Healthy Individual Lifestyle Choices

- **Individuals purchasing healthcare with the assistance of a state subsidy will be provided with a Wellness Account where the state will deposit cash incentives for behaviors that will promote the individual's health.**
    - Developing a wellness plan with provider
    - Meeting weight loss goals established in partnership with a provider
    - Participating in a smoking-cessation program
    - Getting recommended tests and procedures
    - Chronic disease management activities
- **Each individual will be issued a debit card for the Wellness Account that will enable them to use earned monies towards premium payments, co-payments, other forms of healthcare cost-sharing, and towards healthcare services not included in the individual's benefit plan.**

The Wellness Account is modeled after Enhanced Benefit Accounts (EBAs) that are currently being implemented in several state Medicaid programs and are generally used to pay for covered Medicaid services. Enhanced Benefit Accounts pay for benefits provided in addition to a beneficiary's Medicaid coverage, as an incentive to engage in healthy behaviors.

States implement EBAs with the goal of achieving several objectives, including promotion of healthy behaviors to support improved health status and to achieve potential cost savings through disease prevention. Some states also use EBAs to provide incentives for recipients to enroll in new alternative benefit packages under alternative benefit (tiered) programs. Individuals who opt in to alternative benefit packages consistent with a state's policy goals would receive additional benefits through an Enhanced Benefit Account.

Under an EBA, a process is established for verifying achievement or completion of the desired outcomes. Recipients or providers typically provide the verification. Once verified or established, recipients have access to account funds enabling them to access additional services or products identified by the Medicaid program

State Innovations in Prevention and Wellness Programs

State	Prevention and Wellness Program	Eligibility/Participation	Incentives	Personal Responsibility
California Pending California Legislative Assembly Enactment	Healthy Action Rewards/Incentives (part of Governor Schwarzenegger's health care reform plan)	Californians with private or public health insurance are eligible for the program.	Includes gym memberships, weight management programs and reductions in health insurance premiums to promote prevention, wellness and healthy lifestyles.	Benefits and incentives, including premium reduction, are only available to people who meet certain health goals. Examples include: Obtaining preventive health screenings, such as breast and colorectal cancer screening, getting immunized against diseases and attending classes such as smoking cessation or weight management.
Florida Medicaid Waiver Approved by CMS in 2005	Enhanced Benefit Account (EBA)	Initially the program is mandatory for TANF[1] and Aged and Disabled eligibility groups in Medicaid from certain counties; phased in over time for other Medicaid beneficiaries.	The state deposits funds into account to reward healthy behaviors, such as weight management, smoking cessation, and diabetes management. These funds could be used for health care related expenses at a participating pharmacy. "Opt-in" option to create financial incentive to access employer-sponsored insurance.	The EBA program verifies achievement or completion of the desired outcomes. Recipients or providers typically provide the verification. Once verified, recipients can access account funds, enabling them to access additional services or products identified by the Medicaid program.

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[1] "TANF" is the Temporary Assistance for Needy Families program.

State Innovations in Prevention and Wellness Programs

State	Prevention and Wellness Program	Eligibility / Participation	Incentives	Personal Responsibility
Idaho Medicaid Waiver Approved by CMS in 2006	Idaho Preventive Health Assistance Program (PHA) Wellness & Behavioral	Wellness PHA: State Children's Health Insurance Program (SCHIP) beneficiaries (up to 185%FPL) Behavioral PHA: Medicaid beneficiaries Children 185%FPL[2] Pregnant Women 133%FPL Parents 25%FPL SSI Disabled 78%FPL	Wellness PHA beneficiaries can use their rewards to make delinquent premium payments, to buy athletic safety equipment, or obtain sports and gym memberships. After participants reach an interim goal agreed upon by the patient and doctor, another $100 in points is awarded. The program is capped at $200 worth of points per year.	Participants in the Wellness PHA must keep child wellness exams and immunizations up to date in order to earn points. Idaho's Behavioral PHA requires that beneficiaries sign a "personal responsibility contract" to receive points that is based on achieving specified goals that are verified by a state agency. Behavioral PHA beneficiaries indicate they want to change a behavior (such as by quitting smoking or losing weight), getting 100 points, worth $100, once they visit a doctor and agree on a treatment plan.
Indiana Pending Medicaid Waiver Approval by CMS	Personal Wellness Responsibility (POWER) Accounts	Uninsured who earn less than 200%FPL and who are without access to employer-sponsored health insurance. Uninsurance and residency requirement of six months. Program is separate from the state's Medicaid program.	Annually, up to $500 of unspent funds in excess of $500 may be returned to participants if preventive services are completed. Services that are covered with limited or no copayments include: annual physicals, mammograms, colorectal screenings, and smoking patches.	Legislation establishes a $1,100 personal health spending account with state and individual contributions to be used on qualified health expenditures. Participants contribute up to 5% of their gross family income. Monthly required contributions range from $42 for a single adult at 200% FPL to $167 for a family of four with two adults and two children.

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[2] "FPL" is the Federal Poverty Level Guidelines

State Innovations in Prevention and Wellness Programs

State	Prevention and Wellness Program	Eligibility/Participation	Incentives	Personal Responsibility
Kansas Medicaid Waiver Approved by CMS in 2006	Working Healthy	Categorically eligible Individuals ages 15 to 65 years old with developmental disabilities, physical disabilities, and traumatic brain injuries, determined by Social Security who need Personal Assistance Services (PAS) and related services including those who are not eligible to receive Social Security Income due to income and asset limits up to 300%FPL; and have assets up to $15,000.	In addition to Medicaid coverage: Personal assistance services, which can be agency directed or self-directed including a "Cash and Counseling" model; Assessment to determine personal assistance and related service needs; Independent living counseling; and Assistive services such as items or equipment to improve independence, employment and/or health and safety.	Participants must be employed (with verified earned income from competitive employment). Individuals with incomes above 100%FPL contribute to premiums.
Kentucky Medicaid Waiver Approved by CMS in 2006	KyHealth Choices; Governor's Council on Wellness and Physical Activity	Medicaid beneficiaries Children 200%FPL Pregnant Women 185%FPL Parents 25%FPL SSI Disabled 74%FPL	Get Healthy accounts provide incentives to beneficiaries who are engaging in healthy behaviors. Funds are deposited in accounts to offset specific health care-related costs, such as co-payments, smoking cessation and weight loss programs. Initially, participation in the program will be limited to pulmonary disease, diabetes and cardiac conditions. Beneficiaries do not have co-payments for preventive services, such as annual check-ups and vaccinations.	Most beneficiaries pay a portion of their covered services through co-payments and premiums on an income-based sliding fee scale. (Cost-sharing requirements do not apply to certain member categories, such as pregnant women, children and members who have already reached their annual cap.)

State Innovations in Prevention and Wellness Programs

State	Prevention and Wellness Program	Eligibility / Participation	Incentives	Personal Responsibility
Michigan Approved by the Legislative Assembly and was signed by the Governor in September 2006	Act No. 412, Public Acts of 2006 (Insurance Code Reform) "Wellness Coverage"	All employers and consumers purchasing health insurance in Michigan.	The insurance code was amended to allow group health plans and insurance carriers to give premium rebates of up to 10 percent if workers or members participate in group wellness programs. Individuals and families are also eligible for reduced cost-sharing if they commit to healthier lifestyles.	Wellness coverage policies vary by group health plans insurance carriers and employer or group purchaser. The employer must provide evidence of maintenance or improvement of agreed-upon health status indicators in order to receive premium discounts and employees must meet health goals to receive reduced cost-sharing.
Missouri Law passed Legislative Assembly and was signed by the Governor in May 2007. Pending CMS approval.	Health Improvement Plans	Medicaid beneficiaries Children 300%FPL Pregnant Women 185%FPL Parents 23%FPL SSI Disabled 74%FPL	Medicaid recipients to sign a "health improvement participant agreement," engage in "healthy practices," and make "reasonable lifestyle choices" in order to earn points to pay for approved health care expenses. Earned points may be used for expenses, such as Medicaid-eligible services, copayments, and over-the- counter drugs based on the participants' unique health goals. The details of these plans are to be developed by the Missouri Department of Social Services with the approval of the MO HealthNet Oversight Committee beginning in 2008 and completed by 2011.	A vendor shall issue electronic access cards to participants. Such cards may be used to satisfy cost-sharing and health improvement points earned at the hospital, physician's office, pharmacy, or any other health care professionals. Each recipient will also have a health care advocate to advise on health expenditures and to create individual health goals based on medical, behavioral and psychosocial needs.

State Innovations in Prevention and Wellness Programs

State	Prevention and Wellness Program	Eligibility / Participation	Incentives	Personal Responsibility
Rhode Island Law passed in 2006	Wellness Health Benefit Plans	Rhode Island employees working at businesses with 50 or fewer employees. The health insurers will offer a "basic plan" and an "advantage plan," with the same premiums.	Advantage plan members will have lower deductibles, copayments and out-of-pocket contributions, but they will be required to participate in a wellness program, such as smoking cessation, weight-loss and disease-management programs, if it is deemed necessary. As of Jan. 1, 2009, beneficiaries will get financial incentives for choosing high-quality and efficient care providers.	In the second year, advantage plan beneficiaries will be required to prove that they participated in required programs. Details on methods to confirm participation still are being determined. Advantage plan beneficiaries also will be required to obtain a primary care physician, undergo a health assessment and follow recommendations from that assessment.
South Carolina Pending Medicaid Waiver Approval by CMS	Personal Health Accounts (PHA)	All Medicaid beneficiaries included in program except dually eligible for Medicare Children (ages 0-1) 185% FPL (ages 1-19) 150% FPL Pregnant Women 185% FPL Parents 50% FPL SSI Disabled 74% FPL	Beneficiaries with positive health outcomes would receive reward cards provided by vendors of health and wellness products.	Beneficiaries must choose one of four plans, ranging from self-directed plans to employer-sponsored insurance. Proposal essentially eliminates mandatory benefits. State liability is limited, but beneficiary liability is unlimited once PHA is exhausted.

State Innovations in Prevention and Wellness Programs

State	Prevention and Wellness Program	Eligibility/Participation	Incentives	Personal Responsibility
Vermont Medicaid Waiver Approved by CMS in 2006	*Vermont Health Care Reform of 2006* Office of Vermont Health Access (OVHA) Chronic Care Management Program Coordinated Healthy Activity, Motivation and Prevention Program (CHAMPPS) Catamount Health Plan Vermont Department of Health Inventory of programs within state government	OVHA: Medicaid beneficiaries Children 300%FPL Pregnant Women 200%FPL Parents 185%FPL Childless Adults 150%FPL SSI Disabled 74%FPL CHAMPPS: Communities throughout Vermont submit grant proposals to the state Catamount Health: Sliding-scale subsidy up to 300%FPL State government programs: various populations within Vermont	The Catamount Health Plan allows a waiver of the deductible and other cost-sharing payments for chronic care for individuals participating in chronic care management and for preventive care. It also allows carriers that offer insurance plans in the individual or small group market throughout the state to provide premium discounts (up to 15% of premiums) or other economic rewards for people who participate in health promotion and disease prevention programs.	The state has new authority under its 2006 federal waiver to limit its responsibilities and exposure to costs by reducing benefits, increasing cost sharing, and capping enrollment, subject to some requirements. Currently, the state does not have plans to make these changes, but the fiscal incentives built into the waiver could encourage such action, because the state can use federal Medicaid funds it does not spend on Medicaid services for other purposes.
West Virginia Medicaid Waiver Approved by CMS in 2006	Healthy Rewards Accounts	All Medicaid members who have the ability and capability to partner in their personal health decisions. Children 200% FPL Pregnant Women 150% FPL Parents 18% FPL SSI Disabled 74% FPL	Credits for copayments and services (i.e. smoking cessation classes) added by state to an individual account based on the individual's healthy behaviors. Credits given for: prenatal care, Well-child check-ups, vaccinations, and disease management for treatment of cardiovascular, asthma and diabetes care.	Credits deducted for: Non-emergent use of emergency services, missed medical appointments, non-compliance with preferred drug list, and smoking.

Sources: Federal Poverty Level Guidelines from http://www.statecoverage.net/profiles/, California http://www.stayhealthycalifornia.com/,
Florida http://ahca.myflorida.com/Medicaid/medicaid_reform/enhab_ben/enhanced_benefits.shtml, Idaho http://healthandwelfare.idaho.gov/site/4161/default.aspx,
Indiana http://www.in.gov/ichla/pdf/governorsPlanEng.pdf, Kansas http://www.workinghealthy.org/, Kentucky https://kyhealthchoices.fhsc.com/,
Michigan Insurance Code of 1956 Act 218 Chapter 34 Section 500.3426,
Missouri http://www.senate.mo.gov/07info/BTS_Web/Summary.aspx?SessionType=r&SummaryID=581950&BillID=28834,
Rhode Island http://www.dbr.ri.gov/divisions/healthinsurance/, South Carolina Medicaid Waiver South Carolina Health Connections 1115 (http://www.cms.hhs.gov)
Vermont http://hcr.vermont.gov/improve_quality/promote_wellness, West Virginia http://www.wvdhhr.org/medRed/handouts/HealthAccts92705Draft.pdf.

Oregon Health Fund Board

Quality Institute Work Group

Report to the Delivery Systems Committee

April 10, 2008

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Oregon Health Fund Board — Delivery Systems Committee Quality Institute Work Group

Report Index

Oregon Health Fund Board — Delivery Systems Committee Quality Institute Work Group

Preamble

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.

I. Background

Based on recommendations from the Oregon Health Policy Commission (OHPC), Senate Bill 329 (2007), the Healthy Oregon Act, directs the Administrator of the Office for Oregon Health Policy and Research to develop a model Quality Institute for Oregon as part of the larger health reform planning process established by the bill. The Oregon Health Fund Board assigned this task to the Delivery Systems Committee and chartered a Quality Institute Work Group to develop recommendations regarding the appropriate structure and roles for an Oregon Quality Institute. The Quality Institute would coordinate the creation, collection and reporting of cost and quality information to improve health care purchasing and delivery.

The preamble of SB 329 calls for health reform policies that encourage the use of quality services and evidence-based treatments that are appropriate, safe and discourage unnecessary treatment. Research illustrates that the current health care delivery system in Oregon does not consistently deliver high-quality care or effectively use resources to deliver evidence-based care to Oregonians. For instance, only 40% of adults over 50 receive recommended preventive care, and only 84% of hospitalized patients receive recommended care for myocardial infarction, congestive heart failure, and pneumonia.[1] In addition, quality of care varies significantly depending on where in the state a patient receives care, as does the utilization of specific procedures and treatment options.[2] While there are numerous public and private efforts underway across the state to

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[1] Cantor JC, Schoen C, Belloff D, How SKH, and McCarthy D. Aiming Higher: Results from a State Scorecard on Health System Performance. The Commonwealth Fund Commission on a High Performance Health System, June 2007.

[2] Performance Report for Chronically Ill Beneficiaries in Traditional Medicare: Hospitals – Oregon. Provided by Elliot Fischer and the Dartmouth Atlas Project.

improve health care quality, SB 329 points to the need for a Quality Institute to serve as a leader and to unify existing efforts in the state around quality and transparency.

The availability of clear and transparent information is the keystone to any health care reform plan, including the current effort to improve the quality of care delivered by Oregon's health care system. The Institute of Medicine's Ten Rules to Redesign and Improve Care calls for shared knowledge and the free flow of information and transparency across the health care system.[3] In addition, President Bush's Four Cornerstones for Healthcare Improvement Executive Order of 2006 calls for greater health system transparency through wider availability of health care quality and price data.[4] Providers need better information to benchmark their performance, identify opportunities for quality improvement and design effective quality improvement initiatives. Purchasers need ways to identify and reward high-performing providers who delivery high-quality, high-value care to their patients. Consumers need better cost and quality information to help guide critical health care decisions. Therefore, an Oregon Quality Institute is needed to ensure that appropriate and actionable information is available across the health care system and that stakeholders have the tools and knowledge needed to use this information to improve quality of care. A collaborative and well-supported effort to improve quality and increase transparency is a vital part of any effort to transform Oregon's health care delivery system into a high-performing, high-quality system that meets the health care needs of all Oregonians.

II. Recommendations for a Model Oregon Quality Institute

The Quality Institute Work Group of the Oregon Health Fund Board Delivery Systems Committee recommends the formation of a Quality Institute for Oregon. The Institute will be established as a publicly chartered public-private organization, giving it legitimacy and a well-defined mission, while allowing for flexibility in operations and funding. In addition, this structure will allow the Quality Institute to accept direct state appropriations and have 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.

The Work Group makes the following recommendations about the structure, governance and funding for a Quality Institute for Oregon:

- A Board of Directors of the Quality Institute will be appointed by the Governor and confirmed by the Senate and include no more than 7 members. Members must be knowledgeable about and committed to quality improvement and

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[3] Institute of Medicine. Crossing the Quality Chasm: A New Health System for the 21st Century. (2001). National Academy Press: Washington, DC.

[4] U.S. Department of Health and Human Services, Value-Driven Health Care Home. http://www.hhs.gov/valuedriven/index.html

represent a diverse constituency. The Board should be supported by advisory committees that represent a full range of stakeholders. The Administrator of the Office for Oregon Health Policy & Research, or a designee, shall serve as an Ex-Officio member of the Board.

- The Quality Institute will have an Executive Director, who is appointed by and serves at the pleasure of the Board. The Quality Institute will have a small professional staff, but should partner or contract with another organization to provide administrative support.
- In order for the Quality Institute to be stable, state government must make a substantial long-term financial investment in the Quality Institute by providing at least $2.3 million annually for a period of at least 10 years (See Appendix C). Following the 2009-11 biennium, this budget should be adjusted to account for inflation.
- The Quality Institute will partner and collaborate with other stakeholders to maximize output and minimize duplication of efforts. In addition, nothing precludes the Quality Institute from seeking additional voluntary funding from private stakeholders and grant-making organizations to supplement state appropriations.

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. Some of this work will be directly carried out by the Quality Institute, while some will be completed in partnership with existing organizations (e.g. The Oregon Health Care Quality Corporation or Oregon Patient Safety Commission). To achieve its goals, the Quality Institute will first pursue the following priorities:

1. Set and prioritize ambitious goals for Oregon in the areas of quality improvement and transparency. Progress toward achieving these goals will be measured and publicly reported, and goals will be regularly updated to encourage continuous improvement.

2. Convene public and private stakeholders to align all groups around common quality metrics for a range of health care services. Metrics adopted for Oregon will be aligned with nationally accepted measures that make sense for Oregon. In developing common metrics, the benefit of reporting particular datasets to align with adopted quality metrics must be balanced against the burden of collecting and reporting these measures from health care facilities.

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.

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. Data should provide comparable information about quality of care, utilization of health care resources and patient outcomes. To the extent practicable and appropriate, data should be easily accessible to providers, health care purchasers, health plans, and other members of the public in appropriate formats that support the use of data for health care decision-making and quality improvement (right information to the right people at the right time). The Quality Institute shall establish a system for data collection, which shall be based on voluntary reporting whenever possible, but may include mandatory reporting if necessary. The Quality Institute may directly publish data and/or may support other organizations in publishing data.

5. Advise the Governor and the Legislature on an ongoing basis on policy changes/regulations to improve quality and transparency. Produce a report to be delivered each legislative session about the state of quality of care in Oregon to be provided to the Governor, Speaker of the House and the President of the Senate.

As the budget of the Quality Institute allows, the Board of the Quality Institute 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):

- Participate in the development and assessment of new quality improvement strategies by championing, coordinating, funding and/or evaluating quality improvement demonstration and pilot projects. In addition to projects focused on improving the delivery of care, projects that explore opportunities to provide incentives for quality improvement should be considered.

- Convene public and private stakeholders to identify opportunities to 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 for using data to drive quality improvement. Disseminate proven strategies of quality improvement.

- Support the development and facilitate the adoption of health information technology that builds provider capacity to collect and report data and ensure that the right information is available at the right time to patients, providers, and payers.

- The Governor's Health Information Infrastructure Advisory Committee (HIIAC) will be making recommendations to the Oregon Health Fund Board about a strategy for implementing a secure, interoperable computerized health network to connect patients and health care providers across Oregon. The Quality Institute should align itself with these recommendations and support efforts to develop and facilitate the adoption of health information technology that builds on provider capacity to collect and report data and ensure that the right information is available at the right time to patients, providers, and payers. The Quality Institute should also partner with the HIIAC and other efforts within Oregon and across the country to build provider and system capacity to effectively use health information technology to measure and maximize quality of care and evaluate quality improvement initiatives.

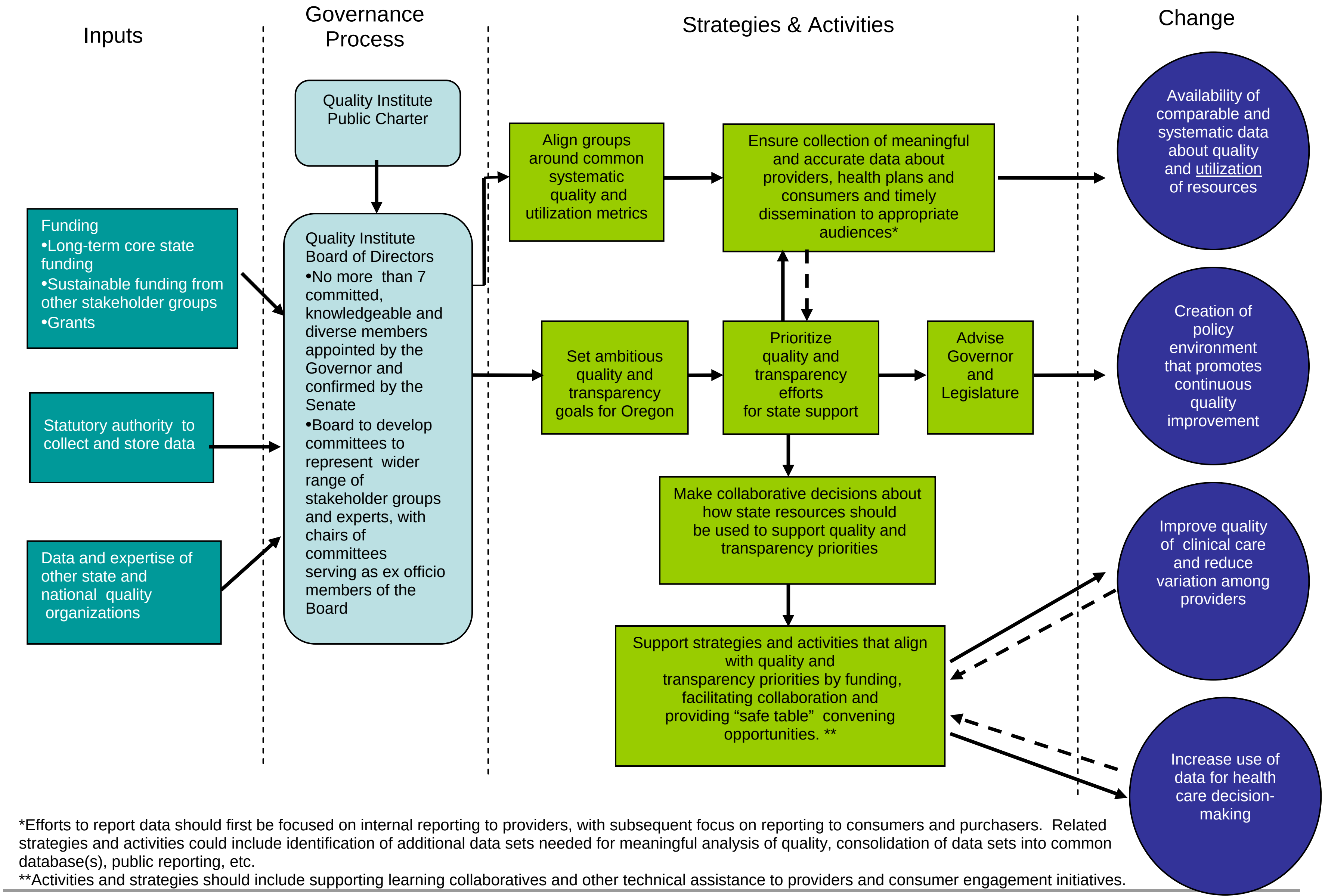
- Support efforts, in partnership with providers, to engage consumers in the use of quality and utilization data and evidence-based guidelines to make health decisions. Support efforts to engage patients in taking responsibility for their own health.

III. Logic Model for an Oregon Quality Institute

The Quality Institute Work Group constructed a "theory of change" logic model to provide a pictorial representation of its recommendations for an Oregon Quality Institute. The logic model attempts to represent the range of inputs, governance process, strategies and activities the group believes would be required to develop a Quality Institute successful in achieving the following goals:

- Ensure availability of comparable and systematic data about quality and utilization of resources;
- Create a policy environment that promotes continuous quality improvement;
- Improve the quality of clinical care; and
- Increase the use of quality data for health care decision-making.

Logic Model for a Quality Institute for Oregon



Inputs

Funding
•Long-term core state funding
•Sustainable funding from other stakeholder groups
•Grants

Statutory authority to collect and store data

Data and expertise of other state and national quality organizations

Governance Process

Quality Institute Public Charter

Quality Institute Board of Directors
•No more than 7 committed, knowledgeable and diverse members appointed by the Governor and confirmed by the Senate
•Board to develop committees to represent wider range of stakeholder groups and experts, with chairs of committees serving as ex officio members of the Board

Strategies & Activities

Align groups around common systematic quality and utilization metrics

Ensure collection of meaningful and accurate data about providers, health plans and consumers and timely dissemination to appropriate audiences*

Set ambitious quality and transparency goals for Oregon

Prioritize quality and transparency efforts for state support

Advise Governor and Legislature

Make collaborative decisions about how state resources should be used to support quality and transparency priorities

Support strategies and activities that align with quality and transparency priorities by funding, facilitating collaboration and providing "safe table" convening opportunities. **

Change

Availability of comparable and systematic data about quality and <u>utilization</u> of resources

Creation of policy environment that promotes continuous quality improvement

Improve quality of clinical care and reduce variation among providers

Increase use of data for health care decision-making

*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.

IV. Work Group Process

The Quality Institute Work Group began their formal deliberations in December of 2007 and held seven meetings. Membership was drawn from a wide range of stakeholder groups and included many of the same people who served on the Oregon Health Policy Commission Quality and Transparency Work Group.

At its first substantive meeting in January 2008, the group was joined by Dennis Scanlon, Assistant Professor in Health Policy and Administration at Penn State University, who is a member of the team evaluating the Robert Wood Johnson Foundation's Aligning Forces for Quality program. Dr. Scanlon suggested a framework for approaching the Work Group's charge, discussed 'Theory of Change' models of behavior change and presented examples and results of quality improvement efforts from around the country. Carol Turner, a facilitator from Decisions Decisions in Portland, facilitated five of the work group's meetings.

In an effort to identify existing gaps in quality and transparency efforts in Oregon and identify possible areas for collaboration and coordination, the work group built on efforts of the Oregon Health Policy Commission Quality and Transparency Work Group to assess the current landscape in Oregon. The following organizations and collaborative initiatives dedicated to quality improvement and transparency were identified and discussed:

- Acumentra Health
- Advancing Excellence in America's Nursing Homes
- Compare Hospital Costs Website
- Department of Human Services
- The Foundation for Medical Excellence
- Health Insurance Cost Transparency Bill – HB 2213 (2007)
- The Health Care Acquired Infections Advisory Committee
- Independent Practice Associations and Medical Groups
- Oregon Association of Hospitals and Health Systems
- Oregon Chapter of the American College of Surgeons
- Oregon Coalition of Health Care Purchasers
- Oregon Community Health Information Network (OCHIN)
- Oregon Health Care Quality Corporation
- Oregon Health and Sciences University Medical Informatics
- Oregon Hospital Quality Indicators
- Oregon IHI 5 Million Lives Network
- Oregon Patient Safety Commission
- Oregon Primary Care Association
- Oregon Quality Community
- Patient Safety Alliance

- Public Employees Benefits Board and Oregon Educators Benefits Board
- Regence Blue Cross Blue Shield

Appendix A provides a matrix that describes these efforts.

The Work Group also examined quality and transparency efforts in other states, focusing on initiatives in Maine, Massachusetts, Minnesota, Pennsylvania, Washington, and Wisconsin. Appendix B provides a description of select quality and transparency efforts in these states.

V. Definitions of "Quality" and "Transparency"

When the Work Group reviewed its charter from the Oregon Health Fund Board at its first meeting, members quickly identified a need to develop standard definitions of *quality* and *transparency*.

Members noted that a number of organizations in Oregon, including the Oregon Health Care Quality Corporation, have incorporated the Institute of Medicine's (IOM) definition of quality, which includes the six domains of safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity. Members also acknowledged the work of the U.S. Department of Human Services' Agency for Healthcare Research and Quality (AHRQ) in the area of quality. On January 3, the Work Group approved the definition of *quality* found below, which combines definitions presented by the IOM and AHRQ.

Quality

As defined by the Institute of Medicine (IOM), quality is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. In the 2001 Crossing the Quality Chasm, the IOM defined a high quality health care system as one that is:

- **Safe** – avoiding injuries to patients from the care that is intended to help them.
- **Effective** – providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively).
- **Patient-centered** – providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
- **Timely** – reducing waits and sometimes harmful delays for both those who receive and those who give care.
- **Efficient** – avoiding waste, including waste of equipment, supplies, ideas, and energy.

- **Equitable** – providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

AHRQ has summarized this definition of quality as meaning doing the right thing at the right time, in the right way, for the right person and getting the best results.

The group could not identify a widely accepted definition of *transparency* and had to combine language from various sources with members' best thinking. The concept of "clarity in relationships" was taken from a 2006 article about transparency in health care that appeared in the American Heart Hospital Journal.[5] The Work Group approved the definition below on January 10.

Transparency
A transparent health care system provides clarity in relationships among patients, providers, insurers and purchasers of health care. ***To the extent practicable and appropriate, a transparent system makes appropriate information about patient encounters with the health care system, including quality and cost of care, patient outcomes and patient experience, available to various stakeholders in appropriate formats.*** This includes, but is not limited to, providing consumers and other health care purchasers with the information necessary to make health care decisions based on the value of services (value = quality/cost) provided and giving providers the tools and information necessary to compare performance. In a transparent system, health care coverage and treatment decisions are supported by evidence and data and made in a clear and public way.

VI. Problem Statement

The Quality Institute Work Group also drafted a statement of the problems in the current health care system that could potentially be addressed by an Oregon Quality Institute:

- Need for a robust mechanism to coordinate statewide quality improvement and transparency efforts. Currently, we have:
  - Multiple agencies, organizations, providers and other stakeholder groups furthering quality and transparency efforts, without unifying coordination
  - No mechanism for setting common goals around health care quality or a public quality agenda
  - A need for stronger mechanism for sharing of best practices, successes and challenges across efforts

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[5] Weinberg SL. Transparency in Medicine: Fact, Fiction or Mission Impossible? Am Heart Hosp J. 2006 Fall;4(4):249-51.

    - Missed opportunities for synergy, efficiency, and economies of scale possible through partnership along common goals
- No comprehensive measurement development and measurement of quality across the health care delivery system
    - Consumers and purchasers have limited access to comparable information about cost and quality
    - Providers have limited ability to compare their own performance with peers and to make referral decisions based on quality and cost data
    - Providers are required to report different measures to different health plans and purchasers
- Limited resources dedicated to quality improvement and transparency
    - Lack of resources to support coordination across quality and transparency efforts
    - Providers have limited resources to build infrastructure needed to support data collection, reporting and analysis
    - Need for systemic mobilization and planning for use of resources in a manner that maximizes system wide impact and reduces duplicative efforts
- Wide variability between providers in quality and cost of care
- Lack of infrastructure (both human and technology) necessary to assess system wide performance and use data to develop a systemic approach to quality improvement
- Lack of systematic feedback and credible data to improve clinical care systems
- Need for new tools to help consumers, purchasers, and providers effectively use data to make treatment and coverage decisions

VII. Assumptions

The Quality Institute Work Group next worked to clarify the starting assumptions that the group would use to identify the appropriate roles and structure of an Oregon Quality Institute. The starting assumptions went through a number of iterations and the group approved the set below.

Assumption 1*:* The Quality Institute will coordinate, strengthen and supplement current and ongoing initiatives across Oregon to create a unified effort to improve quality, increase transparency, and reduce duplication across stakeholder groups. Quality improvement and increased transparency will lead to a health care system that is safer, more effective, patient-centered, timely, efficient and equitable, and better able to contain costs.

Assumption 2: The Quality Institute will be an essential element of any sustainable health care reform plan and should play an integral and long-term role in improving quality and increasing transparency across Oregon.

Assumption 3: The collaborative nature of the Quality Institute and the strengths of the range of stakeholders will allow the Institute to capitalize on a variety of strategies to further the quality and transparency agenda. These strategies include, but are not limited to, market based approaches, provider collaboration, consumer engagement and regulatory approaches. Different partners will have the authority and capacity to utilize different strategies, depending on function and target audience. These partnerships should be developed in a manner that allows for assessment of the fundamental capabilities of the health care system in Oregon, identification of opportunities to effect change across the system, and monitoring of quality improvement and cost savings from quality improvement across the entire system.

Assumption 4: The Quality Institute will need to be supported by sustainable, stable and sufficient resources if it is to be an effective agent for change in improving quality and increasing transparency in the health care system. A broad base of funding, including dedicated public resources and resources from other stakeholders, will be necessary to make progress in quality and transparency.

VIII. Roles of the Quality Institute

The next task for the Quality Institute Work Group was to make recommendations about the appropriate roles of a Quality Institute for Oregon, given the group's problem statement and assumptions. Staff created a draft list of potential roles, based on quality improvement strategies used in other states, as well as other published sources, including the IOM's 2005 report to Congress calling for the establishment of a National Quality Coordination Board.[6] The initial draft list included twelve possible roles, which were categorized using a framework presented by Dennis Scanlon. Each option was categorized by the primary strategies it would utilize (market-based approach, collaborative quality improvement approach, patient/consumer education/engagement, and regulatory approaches), domains of improvement it would address (safety, effectiveness, patient-centeredness, timeliness, efficiency, equity) and target audience(s).

The facilitator led the group in several rounds of discussion and revision of the role options, with the group analyzing each proposed role, adding additional roles, scoring roles, eliminating roles that were not appropriate for a Quality Institute and combining roles that were redundant. In addition, the group developed a framework for categorizing roles that fall under the auspices of the Quality Institute. The categories

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[6] Institute of Medicine. (2005). Performance Measurement: Accelerating Improvement. National Academies of Press. Washington, D.C.

the group settled on were *Coordination and Collaboration, Systematic Measurement of Quality, Provider Improvement and Technical Assistance, Consumer Engagement and Policy Advising.*

The Work Group also identified some of the roles as priorities that should guide the Quality Institute in its initial work. These roles focus on establishing a coordinated quality and transparency agenda for Oregon and developing a systematic performance measurement process. Once the Quality Institute is successful in achieving these goals, members felt that the Quality Institute should use data and evidence to determine where initiatives related to the remaining roles could be most effective. The Quality Institute's budget will determine the extent to which the Institute is able to pursue these additional roles.

Overarching Role

The Quality Institute will 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. Some of this work will be directly carried out by the Quality Institute, while some will be completed in partnership with existing organizations (e.g. The Oregon Health Care Quality Corporation or Oregon Patient Safety Commission).

To achieve its goals, the Quality Institute will first pursue the following priorities:

1. Set and prioritize ambitious goals for Oregon in the areas of quality improvement and transparency. Progress toward achieving these goals will be measured and publicly reported and goals will be regularly updated to encourage continuous improvement (Coordination and Collaboration).

2. Convene public and private stakeholders to align all groups around common quality metrics for a range of health care services. Metrics adopted for Oregon will be aligned with nationally accepted measures that make sense for Oregon. In developing common metrics, the benefit of reporting particular datasets to align with adopted quality metrics must be balanced against the burden of collecting and reporting these measures from health care facilities (Coordination and Collaboration).

3. 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. Data should provide comparable information about quality of care, utilization of health care resources and patient outcomes. To the extent practicable and appropriate, data should be easily accessible to providers, health care purchasers, accountable health plans, and other members of the public in

appropriate formats that support the use of data for health care decision-making and quality improvement (right information to the right people at the right time). The Quality Institute shall establish a system for data collection, which shall be based on voluntary reporting to the greatest extent possible, but may include mandatory reporting if necessary. The Quality Institute may directly publish data or may support other organizations in publishing data (Systematic Measurement of Quality).

When developing a system and methods for public disclosure of performance information, the Quality Institute should consider the following criteria[7]:

- Measures and methodology should be transparent;
- Those being measured should have the opportunity to provide input in measurement systems (not be "surprised") and have opportunities to correct errors;
- Measures should be based on national standards to the greatest extent possible;
- Measures should be meaningful to consumers and reflect a robust dashboard of performance;
- Performance information should apply to all levels of the health care system – hospitals, physicians, physician groups/integrated delivery systems, and other care setting; and
- Measures should address all six improvement aims cited in the Institute of Medicine's Crossing the Quality Chasm (safe, timely, effective, equitable, efficient, and patient-centered).

4. 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 (Provider Improvement and Technical Assistance).

5. Advise the Governor and the Legislature on an ongoing basis on policy changes/regulations to improve quality and transparency. Produce a report to be delivered each legislative session about the state of quality of care in Oregon to be provided to the Governor, Speaker of the House and the President of the Senate (Policy Advising).

As the budget of the Quality Institute allows, the Board of the Quality Institute 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):

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[7] Adopted from the Consumer-Purchaser Disclosure Project, a group of leading employer, consumer, and labor organizations working toward a common goal to ensure that all Americans have access to publicly reported health care performance information. For more information, see http://healthcaredisclosure.org.

- Participate in the development and assessment of new quality improvement strategies by championing, coordinating, funding and/or evaluating quality improvement demonstration and pilot projects. In addition to projects focused on improving the delivery of care, projects that explore opportunities to provide incentives for quality improvement should be considered (Coordination and Collaboration).

- Convene public and private stakeholders to identify opportunities to develop a collaborative process for endorsing and disseminating guidelines of care and assessing the comparative effectiveness of technologies and procedures (Coordination and Collaboration).

- Lessen the burden of reporting that currently complicates the provision of health care (Provider Improvement and Technical Assistance).

- Support learning collaboratives and other technical assistance for providers to develop and share best practices for using data to drive quality improvement. Disseminate proven strategies of quality improvement (Provider Improvement and Technical Assistance).

- The Governor's Health Information Infrastructure Advisory Committee (HIIAC) will be making recommendations to the Oregon Health Fund Board about a strategy for implementing a secure, interoperable computerized health network to connect patients and health care providers across Oregon. The Quality Institute should align itself with these recommendations and support efforts to develop and facilitate the adoption of health information technology that builds on provider capacity to collect and report data and ensure that the right information is available at the right time to patients, providers, and payers. The Quality Institute should also partner with the HIIAC and other efforts within Oregon and across the country to build provider and system capacity to effectively use health information technology to measure and maximize quality of care, and evaluate quality improvement initiatives. (Provider Improvement and Technical Assistance).

- 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. Support efforts to engage patients in taking responsibility for their own health (Consumer Engagement).

Discussion: Much of the discussion surrounding the roles of a Quality Institute focused on the need to take a long-term approach to quality improvement and to establish an institute with at least a 10-year vision, supported by the funding and resources required to achieve that vision. Members expressed the need to ensure that all stakeholder groups and policymakers maintain realistic expectations about how quickly quality improvement efforts could move ahead and how difficult it is to move the needle in the quality arena. While the group discussed the need for the Quality Institute to find some short-term wins, there was consensus that the state government, as well as all other stakeholders will need to make a long-term commitment to the goals of improved quality and increased transparency.

In developing recommendations for the appropriate roles for a Quality Institute, the group spent significant time discussing the types of data that would be most useful to stakeholders in assessing quality and driving quality improvement efforts. There was general agreement that cost is one of the potential factors important to the assessment of efficiency. An example considered by the group was the use of generic medication. Cost is part of the value equation (value = quality/cost), but members were aware that it is also a more complex indicator than often realized. Some members cautioned that reporting cost data alone does not provide useful "apples to apples" comparisons, as costs associated with particular medical services are influenced by many different factors including patient mix, negotiated rates, staff mix and the burden of uncompensated care. For instance, simply comparing the average price of normal births at two different hospitals would not account for these differences. There were a few members that expressed the view that this information should still be made available with clear explanations of its limitations, but there was general consensus among the members that the Quality Institute should focus on collecting and reporting data directly related to the quality and efficiency of care. The group agreed that an analysis of geographic variations in utilization of health care resources can provide important insight into quality and thus is an appropriate role of a Quality Institute. Members highlighted the value of work done at the Dartmouth Atlas Project in describing variation in health resource utilization between hospitals serving Medicare patients. [8]

The Work Group discussed a number of different strategies and activities that the Quality Institute might decide to use to ensure the collection and timely dissemination of systematic data about quality and utilization. While the group decided that the Board of the Quality Institute will determine how best to fulfill this role, the group discussion highlighted some important decisions that will have to be made by the Quality Institute Board. While some members believed it would be appropriate for the Quality Institute to build and maintain (either directly or through a vendor contract) a common database to consolidate all of the quality data in the state and reduce duplicative reporting to various sources, others believed that this would not be the best way to utilize resources. Alternatively, members suggested that the Quality Institute could analyze data sets already collected by various stakeholder groups and identify

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[8] For more information, see http://www.dartmouthatlas.org/

additional data sets needed for meaningful and complete analysis of quality. In particular, the group highlighted the need for the Quality Institute to identify opportunities to use and/or develop data sources that provide information about patient experience and measure quality of life and functionality from health care interventions. Members did agree that in its analysis of quality and resource utilization, the Quality Institute will first use administrative data sets, as these are currently available, but that the Institute must acknowledge the limitations of this type of data. The Quality Institute should support efforts of other organizations and clinical societies to develop more robust and representative data sets that are validated, use national benchmarks that are based on prospective, risk-adjusted, physiologic data, and it should utilize these data sets as they become widely available.

After confirming the list of roles, the group talked about the need to stage the work of the Quality Institute and prioritize certain roles over others. The group decided there were three main audiences for the work of the Quality Institute – providers, purchasers and consumers – and that each would benefit from different types of information presented in different formats. In general, the group decided that the first goal must be to develop the infrastructure necessary to systematically measure quality over time and in a timely manner. The group then reached general consensus that the Quality Institute would be most effective if it first focused on the provider community and subsequently on purchasers and consumers (see logic model above).

Members acknowledged the ambitious agenda they established for the Quality Institute and emphasized the need for the Quality Institute Board to prioritize its work based on the quality and transparency goals it sets out for the state. In developing systematic measurements of quality, the Work Group suggested that the Board select particular areas of initial focus, such as the five most prevalent chronic conditions, the integrated health home and/or behavioral health. In addition, members suggested that as the Quality Institute begins its effort to support the provider community in quality improvement, the group should look to expand participation in evidence-based, validated programs that have already been developed and tested by professional associations and organizations. For instance, members highlighted the success of the National Surgical Quality Improvement Program (NSQIP), as an example of a program that has been able to get various stakeholders to collaborate around common quality improvement goals and has been widely tested, validated and benchmarked (See Oregon Chapter of the American College of Surgeons in Appendix A.)

IX. Financing, Structure and Governance

In an attempt to build a framework in which to make decisions about the best governance structure for a Quality Institute, the Work Group determined the following set of criteria:

- Mission – The Institute must have clear and focused mission;

- Stable and adequate funding – The Institute must have long-term core funding from public sources;
- Legislative support – Government must be a leader and a better partner that challenges other stakeholders to join a unified effort to improve quality;
- Unbiased – Stakeholders must be represented in the planning, execution and evaluation processes;
- Legitimacy – The Institute must be trusted by stakeholder groups;
- Accountable – The Institute must be required to measure and demonstrate effectiveness of efforts; and
- Flexibility – The Institute must be able to utilize an efficient and timely decision-making process and have the capacity to drive change.

The Work Group discussed the advantages and disadvantages of various governance models including public, public-private and strictly private models by analyzing the structure, funding and governance of existing organizations within each category. The group ultimately decided that a publicly chartered public-private organization would give the Quality Institute legitimacy and a well-defined mission, while allowing for flexibility in operations and funding. In addition, this structure will allow the Quality Institute to accept direct state appropriations and have rulemaking abilities and statutory authority and protections. The Quality Institute must provide strong confidentiality protections for the data it collects and reports, and it must provide these same protections to the information submitted by other organizations.

In discussing the makeup of a Board of Directors for the Quality Institute, the Work Group members stressed the importance of limiting the size of the group in order to allow for efficient decision-making. Therefore, the Work Group recommends that the Board be appointed by the Governor and confirmed by the Senate and be comprised of no more than seven members. Members must be committed to and knowledgeable about quality improvement and represent diverse interests (geographic diversity, public/private mix, experts and consumer advocates, etc). In an effort to ensure that a full range of stakeholders are given the opportunity to participate in the work of the Quality Institute, the Board should be able to create stakeholder and technical advisory committees, with chairs of these representative groups serving as ex officio members of the Board. In addition, the group recommends that the Board appoint the Executive Director, to serve at the pleasure of the Board.

In looking at the relationships the Quality Institute would have with other initiatives working to improve quality and transparency, Work Group members attempted to differentiate a number of different approaches the Institute would take in fulfilling its roles. Members agreed that in some cases the Institute would act as a “doer”, while in others the Institute would be more likely to act as a “convener”, “facilitator” or a “funder”. The Quality Institute should act first and foremost as a convener that facilitates “safe table” opportunities for stakeholder groups to collaborate and work towards consensus on quality-related issues and should be directly involved in setting the quality and transparency policy agenda for Oregon. It is likely that the Quality Institute will often direct, support and fund other organizations in implementing specific initiatives aligned with this agenda, as well as directly carrying out these efforts.

Work Group members agreed that the Quality Institute should be a lean organization, supported by a small professional staff, but that the Institute should partner or contract with a state organization or group with a similar mission to provide human resources, office operations and other administrative support. Members suggested that the Quality Institute explore opportunities to consolidate these functions with the Oregon Patient Safety Commission, Oregon Health Care Quality Corporation or another organization with a mission closely aligned to that of the Quality Institute. However, members noted that if the Quality Institute plans to provide grants and other assistance to outside organizations it would be important for these relationships to be designed in a way that did not create a conflict of interests.

The Work Group stressed the need for state government to provide long-term and sustainable funding for a Quality Institute and to lead other stakeholders in making a robust investment in quality improvement. In addition, nothing would preclude the Quality Institute from seeking additional voluntary funding from private sources to supplement state appropriations. However, Work Group members pointed out that many private stakeholders are already supporting quality improvement organizations and that the Quality Institute should strive to partner with those organizations rather than create parallel and duplicative efforts. The Quality Institute should also be able to receive grants from state and national foundations and agencies, but the Work Group warned that grants alone cannot provide a sustainable or sufficient funding source.

The group estimated that an investment from state government of at least $2.3 million per year over a 10-year period is needed to establish a Quality Institute for Oregon. This budget should be adjusted using the consumer price index or another tool that adjusts for inflation. Appendix C provides budgets for three options for a Quality Institute, one that focuses on data collection and reporting, a second that focuses on convening stakeholders, providing grants and technical assistance and a third combines all of these functions. The Quality Institute Work Group firmly believes that only the third model will provide the infrastructure and support needed to truly drive change and improve the quality and transparency of care delivered to Oregonians.

Appendix A: Organizations and Collaborative Efforts Dedicated to Quality Improvement and Increased Transparency in Oregon

Initiative/Quality Organization Name	Lead Stakeholders/General Structure	Description of Quality Initiative(s)	Major Funding Source(s)	Target Audience(s)
Acumentra Health	Acumentra Health is a physician-led, nonprofit organization that serves as the state's Quality Improvement Organization; partners with various state agencies, research organizations, professional associations and private organizations	Provides resources and technical assistance to Oregon's Medicare providers, including nursing homes, hospitals, home health agencies, medical practices, Medicare Advantage plans, and Part D prescription drug plans to support quality improvement (QI) efforts. Initiatives include: • Doctor’s Office Quality–Information Technology (DOQ–IT) - Helps Oregon medical practices implement and optimize electronic health record systems • Culture and Medicine Project - helps providers recognize and respond to culture-based issues that affect communications with patients and their ability to follow a treatment plan • Performance improvement project training for managed mental health organizations • Rural Health Patient Safety Project	CMS Medicare contracts, state Medicaid contracts, project-base state and private funding	Providers, including nursing homes, hospitals, home health agencies, medical practices, Medicare Advantage plans, Part D Prescription drug plans
Advancing Excellence in America’s Nursing Homes	National campaign initiated by CMS. Oregon's Local Area Network for Excellence (LANE) includes Acumentra Health, The Oregon Alliance of Senior and Health Services, the Oregon Health Care Association, the Hartford Center for Geriatric Nursing Excellence at OHSU's School of Nursing, the Oregon Pain Commission, the Oregon Patient Safety Commission and Seniors and People with Disabilities; Over 23 nursing homes in the state have registered	Voluntary campaign aimed at improving quality of care in nursing homes. Oregon's LANE focusing on reducing high risk pressure ulcers, improving pain management for longer-term and post-acute nursing home residents, assessing resident and family satisfaction with quality of care and staff retention.	Support from LANE network	Providers -Nursing homes

Compare Hospital Costs Web Site	Joint effort of Department of Consumer and Business Services (DCBS) and OHPR	DCBS requires insurers in Oregon to report on payments made to Oregon hospitals. OHPR makes information on the average payments for inpatient claims for patients in Oregon acute-care hospitals available on a public website. The Website contains data on the average payments for 82 common conditions or procedures.	DCBS and OHPR agency budgets	Consumers and Researchers
Department of Human Services (DHS)	State agency made up of five divisions: Children, Adults and Families Division, Addictions and Mental Health Division, Public Health Division, Division of Medical Assistance Programs, and Seniors and People with Disabilities Division.	• Public health chronic disease department has convened plan and provider quality groups to develop a common approach to population-based guidelines including diabetes, asthma and tobacco prevention. • Heart, stroke, diabetes, asthma, and tobacco-use prevention associations and DHS all have educational and collaborative programs that encourage compliance with evidence-based guidelines. • Division of Medical Assistance Programs measures, reports and assists with quality improvement through its Quality Improvement Project • Office of Health Systems Planning and Public Health Division have a patient safety policy lead dedicated to providing leadership, information and skills, support and resources to health care providers and patients so that they can ensure patient safety	Agency budget	Providers
HB 2213 (2007) - Health Insurance Cost Transparency Bill	Department of Consumer and Business Services	Effective July 1, 2009 insurers will be required to provide a reasonable estimate (via an interactive Web site and toll-free telephone) of an enrollee's cost for a procedure before services are incurred for both in-network and out-of-network services.	Requirement of health plans to provide service to enrollees	Consumers, Health Plans, Providers

Oregon Association of Hospitals and Health Systems (OAHHS)	Oregon Association of Hospitals and Health Systems is a statewide health care trade association representing hospitals and health systems	• Posts comparative information about hospital performance on quality indicators on OAHHS website • Supports website, www.orpricepoint.org, that provides comparative charge information for Oregon hospitals • Implementing colored coded wrist band system in Oregon hospitals to improve patient safety • Convenes multi-stakeholder group to define common measures and common expectations of hospital quality ▪ Co-founder, with OMA of Oregon Quality Community	OAHHS budget largely supported through member dues	Consumers, Hospitals and Health Systems
Oregon Chapter of the American College of Surgeons (ACS)	State chapter of ACS, a professional association established to improve the care of the surgical patient by setting high standards for surgical education and practice	Championing National Surgical Quality Improvement Program (NSQIP) in Oregon hospitals • NSQIP collects data on 135 variables, including preoperative risk factors, intraoperative variables, and 30-day postoperative mortality and morbidity outcomes for patients undergoing major surgical procedures in both the inpatient and outpatient setting • ACS provides participating hospitals with tools and reports needed to compare its performance with performance of other hospitals and develop performance improvement initiatives • Started the NSQIP Consortium to identify, implement, and disseminate best practices using clinical evidence sharing aggregate data with Consortium hospitals and educating the community about NSQIP. Currently includes 5 hospitals in Portland and 1 in Eugene with hope to expand statewide	Participating hospitals (currently four in Oregon, soon expanding to 6) pay fee for participating in NSQIP; American College of Surgeons	Providers - Hospitals and Surgeons
Oregon Coalition of Health Care Purchasers (OCHCP)	Non-profit organization of private and public purchasers of group health care benefits in Oregon or Southwest Washington	Uses the joint purchasing power of the public and private membership to improve health care quality across the state and give employers the tools they need to purchase benefits for their employees based on quality. In 2007, the OCHCP started to use eValue8, an evidence-based survey tool which collects and compiles information from health plans on hundreds of process and outcome measures. In 2007, results were shared only with OCHCP members but may be released to larger audience in future.	Member dues, corporate sponsors	Purchasers, Health Plans, Providers
Oregon Community Health Information Network (OCHIN)	Not-for-profit organization that supports safety-net clinics; collaborative of 21 members serving rural and urban populations of uninsured or under-insured	• Using collaborative purchasing power to make health information technology products more affordable to safety net clinics • Offers consulting services, technical services to help staff in member clinics more effectively use health information technology to improve quality	Current funding from HRSA and AHRQ, Cisco Systems, Inc., State of Oregon, PSU and Kaiser	Providers - Clinics serving vulnerable populations

Oregon Health and Sciences University Medical Informatics	Partnership with American Medical Informatics Association, which started a 10 x 10 initiative to get 10,000 health care professionals trained in health care informatics by 2010	Offers a 10x10 certificate program which helps health care providers get training in medical informatics, the use of information technology to improve the quality, safety, and cost-effectiveness of health care	Student fees	Providers - Current and future health care providers
Oregon Health Care Quality Corporation	Multi-stakeholder non-profit organization; Collaboration of health plans, physician groups, hospitals, public sector health care representatives, public and private purchasers, health care providers, consumers and others with a commitment to improving the quality of health care in Oregon	• Aligning Forces for Quality - building community capacity to use market forces to drive and sustain quality improvement by:(1) Providing physicians with technical assistance and support to help them build their capacity to report quality measures and use data to drive quality improvement (2) Working with providers and other stakeholders to provide consumers with meaningful clinic-level comparisons of primary care quality, which includes identifying a common set of quality measures for the state(3) Educating consumers about the importance of using quality information to make health care decisions and building a consumer-friendly website to provide quality information and self-management resources • Developing private and secure health information technology systems that allow individuals and their providers to access health information when and where they are needed	Robert Wood Johnson Foundation supporting Aligning Forces grant; Health Insurers, PEBB, OCHCP also providing funding for efforts to make quality info available to customers	Consumers, Providers, Purchasers

Oregon Health Policy Commission (OHPC)	The OHPC was created by statute in 2003 to develop and oversee health policy and planning for the state. The Commission is comprised of ten voting members appointed by the Governor, representing all of the state's congressional districts and including four legislators (one representing each legislative caucus) who serve as non-voting advisory members.	OHPC has a Quality and Transparency Workgroup which is working towards making meaningful health care cost and quality information available to inform providers, purchasers and consumers.	OHPC Budget	Consumers, Providers, Purchasers, Consumers
Oregon Hospital Quality Indicators	Joint effort of Office for Oregon Health Policy and Research (OHPR) and Oregon Health Policy Commission (OHPC) with input from various stakeholders	Produces annual web-based report on death rates in hospitals for selected procedures and medical conditions	OHPR agency budget	Consumers, Purchasers
Oregon IHI 5 Million Lives Network	Joint effort of Oregon Association of Hospitals and Health Systems, Oregon Patient Safety Commission, Oregon Medical Association, Acumentra, Oregon Nurses Association, CareOregon; leading statewide expansion of Institute for Healthcare Improvement 10,000 Lives Campaign	6 statewide organizations working together to champion the use of 12 evidence-based best practices in over 40 hospitals across Oregon	Funding from six sponsor organizations	Providers – Hospitals

Oregon Patient Safety Commission	Created by the Oregon Legislature in July 2003 as a "semi-independent state agency." Board of Directors appointed by Governor and approved by Senate, to reflect the diversity of facilities, providers, insurers, purchasers and consumers that are involved in patient safety.	• Developing confidential, voluntary serious adverse event reporting systems for hospitals, nursing homes, ambulatory surgery centers, retail pharmacies, birthing centers and outpatient real dialysis facilities in Oregon with main goal of providing system level information • Using information collected through reporting to build consensus around quality improvement techniques to reduce system errors • Developing evidence-based prevention practices to improve patient outcomes information from hospitals on adverse events and reports to public	Fees on eligible hospitals, nursing homes, ambulatory surgery centers, retail pharmacies, birthing centers, outpatient renal dialysis facilities; Grants	Providers including hospitals, nursing homes, ambulatory surgery centers and retail pharmacies, Consumers
Oregon Primary Care Association	A nonprofit member association representing federally qualified health centers (FQHC)	Provides quality improvement technical assistance to its FQHC members, who also participate in Bureau of Primary Care learning collaborative	OPCA budget, funded primarily through membership fees	Providers serving vulnerable populations
Oregon Quality Community	Joint effort of Oregon Association of Hospitals and Health Systems and Oregon Medical Association; Steering Committee comprised of hospital and health system representatives	• Working with hospitals across the state to improve patient safety through improved hand hygiene. • Medication reconciliation project in planning stages.	OAHHS and OMA funding	Providers – Hospitals
Patient Safety Alliance	Partnership of Acumentra Health, Oregon Chapter of the American College of Physicians, Oregon Chapter of the American Collage of Surgeons, Northwest Physicians Insurance Company, Oregon Academy of Family Physicians and Oregon Chapter of the Society of Hospital Medicine	• Building multidisciplinary teams, including senior leadership, at Oregon hospitals to identify quality problems and build skills and models to be used for hospital-based process and quality improvement activities. Ultimate goal is to improve performance on CMS/Joint Commission medical care and surgical care measures.	Funding from six sponsor organizations	Providers – Hospitals

Public Employees Benefits Board	PEBB currently contracts with Kaiser, Regence, Samaritan and Providence to provide health care benefits to state employees	• With implementation of PEBB Vision for 2007, PEBB makes contracting decisions based on value and quality of care provided through health plans. Plans who contract with PEBB must agree to make an ongoing commitment to implement specific quality improvement initiatives, including requiring participating hospitals to report annual performance measures and national and local level quality indicators (i.e. the Leapfrog survey, Oregon Patient Safety Commission, HCAHPS survey), and developing long-term plans to implement information technology that will improve quality of care. • PEBB Council of Innovators brings the medical directors and administrative leaders from the four plans with contracts together to identify and share best practices.	State funds used to purchase employee benefits	Consumers, Health Plans, Providers
Regence Blue Cross Blue Shield	Not-for-profit health plan	Provides feedback on 40+ indicators of quality evidence based care to patients to nearly 40% of clinicians. This Clinical Performance Program includes patient specific data to allow correction and support improvement.	Regence budget	Providers
The Foundation for Medical Excellence	Public non-profit foundation, whose mission is to promote quality healthcare and sound health policy	Promoting quality healthcare through collaboration, education and leadership training opportunities for physicians	Support from individuals, foundations, health care organizations, consumer advocates and other Oregon businesses	Providers

The Health Care Acquired Infection Advisory Committee	Statutorily mandated committee comprised of seven health care providers with expertise in infection control and quality and nine other members who represent consumers, labor, academic researchers, health care purchasers, business, health insurers, the Department of Human Services, the Oregon Patient Safety Commission and the state epidemiologist.	Advising the Office for Oregon Health Policy on developing a mandatory reporting program for health care acquired infections to start in January 2009 for subsequent public reporting.	Additional appropriations made to OHPR in 2007 Legislative Session	Consumers, Providers

Other Initiatives

- The newly formed Oregon Educators Benefits Board is currently determining how to build quality improvement requirements into contracts with health plans
- Independent Practice Associations and Medical Groups are investing millions of dollars to assist their clinicians in implementing electronic health records, registries and other electronic support resources to measure and improve quality

Appendix B: Select State Quality Improvement and Transparency Efforts

This document does not provide a comprehensive description of all quality improvement across the country. Rather, it is meant to provide descriptions of some of the most innovative and influential activities in select states.

Maine

Maine Quality Forum **(MQF)** – an independent division of Dirigo Health (a broad strategy to improve Maine's health care system by expanding access to coverage, improving systems to control health care costs and ensuring the highest quality of care statewide) created by the Legislature and Governor in 2003

- Governed by a Board chaired by surgeon and includes members representing government agencies and labor, as well as an attorney. The Maine Quality Forum Advisory Council (MQF-AC) is a multi-stakeholder group consisting of consumers, providers, payers and insurers that advises the MQF.
- Consumer-focused organization established to provide reliable, unbiased information, user-friendly information to consumers. Website serves as a clearinghouse of best practices and information to improve health, and acts as an informational resource for health care providers and consumers
- Website provides data charts comparing geographical variation in chronic disease prevalence and number of surgeries performed for various conditions, as well as information about quality of hospital care reported by hospital peer groups
- Key tasks:
    - Assess medical technology needs throughout the state and inform the Certificate of Need process
    - Collect research on health care quality, evidence based medicine and patient safety
    - Promote the use of best medical practices
    - Coordinate efficient collection of health care data – data to be used to assess the health care environment and facilitate quality improvement and consumer choice
    - Promote healthy lifestyles
    - Promote safe and efficient care through use of electronic administration and data reporting

Maine Health Care Claims Data Bank – nation's first comprehensive statewide database of all medical, pharmacy and dental insurance claims, as well as estimated payments made by individuals (including co-pays, deductibles and co-insurance)

- Public-private partnership between ***Maine Health Data Organization*** and ***Maine Health Information Center*** – jointly created ***Maine Health Processing Center*** in 2001
    - Maine Health Data Organization (MHDO) - created by the state Legislature in 1996 as an independent executive agency (see below for more information)
    - Maine Health Information Center - independent, nonprofit, health data organization focused on providing healthcare data services to a wide range of clients in Maine and other states
- Beginning in January 2003, every health insurer and third party administrator that pays claims for Maine residents required to submit a copy of all paid claims to the MHDO. Maine Health Processing Center serves as technical arm and has built and maintains the data bank, collects claims information and submits a complete dataset

to MHCO. Database now includes claims from MaineCare (Medicaid) and Medicare.
- New Hampshire, Massachusetts and Vermont are all working with Maine (through contracts with either Maine Health Processing Center or Maine Health Information Center) to develop or modify claims databases so that all states collect same information, use same encryption codes, etc.

Maine Health Data Organization ***(MHDO)-*** independent executive agency created by state legislature to collect clinical and financial health care information to exercise responsible stewardship in making information available to public
- Maintains databases on: hospital discharge inpatient data, hospital outpatient data, hospital emergency department data, hospital and non-hospital ambulatory services as well as complete database of medical, dental and pharmacy claims (see above).
- Makes rules for appropriate release (for fee) of information to interested parties. Recent rule changes allows for release of information that identifies practitioners by name (except Medicare data).
- Directed by Maine Quality Forum to collect certain data sets of quality information – currently collecting information on care transition measures (CTM-3), Healthcare Associated Infections and Nursing Sensitive Indicators.
- Currently developing database of price information

Maine Health Management Coalition - coalition of employers, doctors, health plans and hospitals working to improve the safety and quality of Maine health care
- Goals: collect accurate, reliable data to measure how Maine is doing, evaluate data to assign quality ratings, present data in a way that is easy to understand and use
- Website provides individual primary care doctor quality ratings based on use of clinical information systems, results of diabetes care, and results of care for health disease. Blue ribbon distinction given to highest performers.
- Website provides hospital quality rankings based on patient satisfaction, patient safety, and quality of care for heart attack, heart failure, pneumonia, and surgical infection
- Established Pathways to Excellence programs to provide employees with comparative data about the quality of primary care and hospital care and reward providers (financially and through recognition) for quality improvement efforts. Plans to expand to specialty care.

Quality Counts – regional health care collaborative with range of stakeholder members including providers, employers and purchasers, state agencies
- Initiated as effort to educate providers about the Chronic Care Model
- Funded by membership contributions, as well as funding from Robert Wood Johnson Foundation
- Grantee of Robert Wood Johnson Aligning Forces for Quality - collaborating with other quality improvement organizations in the state on Aligning Forces goals:
    - Help providers improve their own ability to deliver quality care.
    - Help providers measure and publicly report their performance.
    - Help patients and consumers understand their vital role in recognizing and demanding high-quality care
- Contract from Maine Quality Forum to create a learning collaborative for stakeholders involved in quality improvement

Massachusetts

***Massachusetts Health Quality Partners* (MHQP)** - broad-based independent coalition of physicians, hospitals, health plans, purchasers, consumers, and government agencies working together to promote improvement in quality and health care services in MA

- Members include: Blue Cross Blue Shield of Massachusetts, Fallon Community Health Plan, Harvard Pilgrim Health Care, Health New England, Tufts Health Plan, Massachusetts Hospital Association, Massachusetts Medical Society, Massachusetts Executive Office of Health and Human Services, MHQP Physician Council, two consumer representatives, CMS Regional Office, and one employer representative.
- 5 strategic areas of focus:
    - Taking leadership role in building collaboration and consensus around a common quality agenda
    - Aggregating and disseminating comparable performance data
    - Increasing coordination and reducing inefficiencies to improve quality of care delivery
    - Developing and disseminating guidelines and quality improvement tools
    - Educating providers and consumers in the use of information to support quality improvement
- The MHQP web site compares performance of providers, reported at the group level, against state and national benchmarks on select HEDIS measures. Started with a focus on quality measurement for primary care providers and now expanded to include specialists and resource use measurements.
- MHQP website also allows the public to compare results of patient satisfaction surveys across doctors' offices.
- Convenes multi-disciplinary groups to work collaboratively to develop and endorse a single set of recommendations and quality tools for MA clinicians in order to streamline adherence to high quality, evidence-based decision making and care. Guidelines have been developed in the areas of Adult Preventative Care and Immunization, Pediatric Preventative Care and Immunization, Perinatal Care, Massachusetts Pediatric Asthma and Adult Asthma. MassHealth promotes use of guidelines for treatment of all enrollees.

Massachusetts Health Care Quality and Cost Council – a council of diverse stakeholder representatives established under recent statewide reform charged with setting statewide goals and coordinating improvement strategies.

- Established within, but not subject to the control of the Massachusetts Executive Office of Health and Human Services. Receives input and advise from an Advisory Committee that includes representation from consumers, business, labor, health care providers, and health plans.
- Charged assigned to the Council by the reform legislation include:
    - To establish statewide goals for improving health care quality, containing health care costs, and reducing racial and ethnic disparities in health care
        - Vision established by the Council: By June 30, 2012, Massachusetts will consistently rank in national measures as the state achieving the highest levels of performance in case that is safe, effective, patient-centered, timely, efficient, equitable, integrated, and affordable.

        - Specific cost and quality goals for 2008 established in areas of cost containment, patient safety and effectiveness, improved screening for chronic disease management, reducing disparities, and promoting quality improvement through transparency.
    - To demonstrate progress toward achieving those goals
        - Council mandated to report annually to the legislature on its progress in achieving the goals of improving quality and containing or reducing health care costs, and promulgates additional rules and regulations to promote its quality improvement and cost containment goals
    - To disseminate, through a consumer-friendly website and other media, comparative health care cost, quality, and related information for consumers, health care providers, health plans, employers, policy-makers, and the general public.
        - Website publishes information about cost and quality of care listed by medical topic. Depending on condition or procedure, quality information is reported by provider and/or hospital and provides information about mortality (death) rates, volume and utilization rates and whether appropriate care guidelines are followed.

Minnesota

***Buyers Health Care Action Group* (BHCAG) –** coalition of private and public employers working to redirect the health care system to focus on a collective goal of optimal health and total value

- Founding member of the **Leapfrog Group**, a national organization of private and public employers and purchasing coalitions who reinforce "big leaps" in health care safety, quality and customer value - "leaps" that can prevent avoidable medical errors. The Leapfrog Group's online reports allows consumers and purchasers of health care can track the progress hospitals are making in implementing four specific patient safety practices proven to save lives and prevent some of the most common medical mistakes
- One of eight organizations who joined together to develop the **eValue8™** Request for Information tool - a set of common quality performance expectations for health plans that purchasers can use to evaluate plans based on the value of care delivered. eValue8 collects information on plan profile, consumer engagement, disease management, prevention and health promotion, provider measurements, chronic disease management, pharmacy management and behavioral health. BHCAG, on behalf of the Smart Buy Alliance and its members, conducts a rigorous annual evaluation of major Minnesota health plans using eValue8 and makes results available to the public in an annual report (see **Minnesota Purchasers Health Plan Evaluation** below for more information)
- In 2004, introduced Bridges to Excellence (BTE), an employer directed pay-for-performance initiative that pays doctors cash bonuses for providing optimal care to patients with chronic diseases. BHCAG initiated a collaborative community plan to implement BTE, which includes 12 Minnesota private employers and public

purchasers (including Minnesota Department of Human Services) that have signed on as “Champions of Change” for a diabetes rewards program. Champions reward medical groups and clinics that provide high quality diabetes care. In 2007, BHCAG added a reward program for optimal coronary artery disease and is considering adding rewards for optimal care in depression and radiology.

Minnesota Smart Buy Alliance – voluntary health care purchasing alliance formed in 2004 by the State of Minnesota, business and labor groups to pursue common market-based purchasing principles.

- Alliance set up as a “Coalition of Coalitions” – Original members included The State of Minnesota Department of Employee Relations (purchaser of state employees benefits), Minnesota Department of Human Services (Medicaid, SCHIP, and MinnesotaCare), Buyer’s Health Care Action Group (large private and public employers) Labor/Management Health Care Coalition of the Upper Midwest (union and management groups), Minnesota Business Partnership (large employers) Minnesota Chamber of Commerce (primarily small to mid-size employers) Minnesota Association of Professional Employees, Employers Association and CEO Roundtable. Original co-chairs were the leaders of three core member groups: the Department of Human Services, BHCAG, and the Labor/Management Health Care Coalition. The Labor/Management Health Care Coalition withdrew from the Alliance in 2007.
- Together, members of the Alliance buy insurance for more than 60% of Minnesota residents (3.5 million people).
- Alliance work is guided by four main principles:
    - Adopting uniform measures of quality and results
    - Rewarding "best in class" certification
    - Empowering consumers with easy access to information
    - Requiring health care providers to use the latest information technology for purposes of greater administrative efficiency, quality improvement and protecting patient's safety

QCare – Created by the Governor of Minnesota by executive order in July 2006 to accelerate state health care spending based on provider performance and outcomes using a set of common performance measures and public reporting

- All contracts for MinnesotaCare, Medicaid and Minnesota Advantage will include incentives and requirements for reporting of costs and quality, meeting targets, attaining improvements in key areas, maintaining overall accountability
- Initial focus in four areas: diabetes, hospital stays, preventative care, cardiac care
- Private health care purchasers and providers are encouraged to adopt QCare through the Smart Buy Alliance

The Institute for Clinical Systems Improvement (ICSI) – An independent, non-profit organization that facilitates collaboration on health care quality improvement by medical groups, hospitals and health plans that provide health care services to people in Minnesota.

- 62 medical groups and hospital systems are currently members of ICSI, representing more than 7,600 physicians.
- Funding is provided by all six Minnesota health plans

- Produces evidence-based best practice guidelines, protocols, and order sets which are recognized as the standard of care in Minnesota
- Facilitates "action group" collaboratives that bring together medical groups and hospitals to share strategies and best practices to accelerate their quality improvement work.

Governor's Health Cabinet - comprised of members of Governor's Administration and representatives from business and labor groups

- Created minnesotahealthinfo.org, a clearinghouse website designed to offer a wide range of information about the cost and quality of health care in Minnesota. The site is now maintained by the Minnesota Department of Health and provides links to organizations that provide cost and quality information about Minnesota providers, as well as information about buying health care, managing health care conditions and staying healthy. The site provides links to the following state-based quality and cost public reports (links to national efforts, such as AHRQ, CMS, Leapfrog Hospital Survey Results, NCQA, are also provided):
    - **MN Community Measurement™** - a non-profit organization that publicly reports health performance at the provider group and clinic level. MN Community Measurement recently launched D5.org, a website that specifically focuses on providing information about quality of diabetes care at clinics around the state.
    - Private insurance companies, including **HealthPartners**, **Medica** and **Blue Cross and Blue Shield of Minnesota** provide members and the public with information about provider quality and costs, as well as information about costs associated with individual procedures or total cost of treating certain conditions.
    - **Patient Choice Care System Comparison Guide** –consumer guide to care system quality, cost and service published on the web by Medica that allows consumers to compare provider organizations on factors such as their management of certain conditions, patient satisfaction, cost and special programs and capabilities.
    - **Minnesota Hospital Price Check** – web site sponsored by the Minnesota Hospital Association as the result of 2005 legislation that provides hospital charges for the 50 most common inpatient hospitalizations and the 25 most common same-day procedures.
    - **Minnesota Hospital Quality Report** – web site sponsored by the Minnesota Hospital Association and Stratis Health that provides easy access to quality measures for heart attack, heart failure, and pneumonia care at Minnesota hospitals.
    - **Healthcare Facts®** - site supported by Blue Cross Blue Shield of Minnesota that provides easy-to-read information on costs, safety and quality, and service information for large hospitals in Minnesota.
    - **Health Facility Investigation Reports** – web site supported by the Minnesota Department of health that allows the public to access complaint histories and investigation reports for a variety of Minnesota health care providers. The list includes nursing homes, board and care homes, home care providers, home health agencies, hospice facilities and services, hospitals, facilities that offer housing with services, and supervised living facilities. Searches can be done

for complaint information by date, provider type, provider name, and the county or city where the provider is located.

  - **Adverse Health Events in Minnesota** – web-accessible reports, administered by the Minnesota Department of Health, on preventable adverse events in Minnesota hospitals (more information provided below).
  - **Minnesota Purchasers Health Plan Evaluation** – web-accessible report, prepared by the Buyers Health Care Action Group (BHCAG), compares health plan performance in the following areas: health information technology, consumer engagement and support, provider measurement, primary prevention and health promotion, chronic disease management, behavioral health, and pharmacy management based on eValue8 survey results.
  - **Minnesota's HMO Performance Measures** – site supported by Minnesota Department of Health's Manage Care Systems section links consumers to quality of care information reported by Minnesota HMOs on common health care services for diabetes, cancer screenings, immunizations, well-child visits, and high blood pressure.
  - **Minnesota Nursing Home Report Card** – an interactive report card from the Minnesota Department of Health and the Department of Human Services allows the public to search by geographic location and rank the importance of several measures on resident satisfaction, nursing home staff and quality of care.
  - **Minnesota RxPrice Compare** - web site displays local pharmacy prices for brand name, generic equivalent and therapeutic alternative medication options. The consumer tool compares the "usual and customary" prices of 400 commonly used prescription medications. Some of the brand name medications on this site include a list of generic medications that may be cost effective alternatives to the more expensive brand name medication. The site provides information about accessing lower-cost prescription medicine from Canada.

Adverse Health Care Events Reporting System **–** established in 2003 in response to 2003 state legislation requiring hospitals, ambulatory surgical centers and regional treatment centers to report whenever one of 27 "never events" occurs

- Website maintained by the Department of Health allows public to access annual report of adverse events and search for adverse events at specific hospitals. The report must also include an analysis of the events, the corrections implemented by facilities and recommendations for improvement.
- In September, 2007, the Governor of Minnesota announced a statewide policy, created by the Minnesota Hospital Association and Minnesota Council of Health Plans and endorsed by the Governor's Health Care Cabinet, which prohibits hospitals from billing insurance companies and others for care associated with an adverse health event.

Pennsylvania

Pennsylvania Health Care Cost Containment Council ***(PH4C)*** - independent state agency responsible for addressing the problem of escalating health costs, ensuring the quality of health care, and increasing access for all citizens regardless of ability to pay.

- Funded through the Pennsylvania state budget and sale of datasets
- Includes labor and business representatives and health care providers
- Seeks to contain costs and improve health care quality by stimulating competition in the health care market by giving comparatives information about the most efficient and effective providers to consumers and purchasers
- Hospitals and ambulatory surgery centers are mandated to provide PH4C with charge and treatment information. PH4C also collects information from HMOs on voluntary basis.
- Produces free comparative public reports on hospital quality and average charge. Reports on diagnosis include number of cases, mortality rating (ratings reported as significantly higher than expected, expected or significantly lower than expected), average length of stay, length of stay for short and long stay outliers, readmission ratings for any reason and for complication and infection, and average charge. Reports on specific procedures include number of cases, mortality rating, length of stay, readmission ratings and average charge.
- HMO quality reports also available on website. Interactive website tool allows consumers to find comparative information about plan profiles, plan ratings (based on utilization data and clinical outcomes data), plan performance on preventative measures, and member satisfaction.
- Website also provides reports on utilization by county, quality of heart bypass and hip and knee replacement reported by hospital and surgeon, and hospital financials. In addition, an interactive hospital inquired infection database can be searched by hospital, by infection, and by peer group.

Washington

Puget Sounds Health Alliance – Regional partnership involving more than 150 participating organizations, including employers, public purchasers, every health plan in the state, physicians, hospitals, community groups, and individual consumers across five counties

- Financed through county and state funding, as well as member fees - participating health plans pay a tiered fee based on their market share; providers pay according to their number of full-time employees; and purchasers and community groups pay a fee for each "covered life"—the number of employees and their families receiving employer-based health benefits. Individual consumers can join the alliance for $25 per year.
- Plans to release region's first public report on quality, value and patient experience at the end of January 2008
    - The first report will compare performance on aspects of care provided in doctors offices or clinics, using measures that reflect best-practices particularly for people with chronic conditions such as diabetes, heart disease, back pain and depression – a first draft of the report has been posted on the Alliance website for public comment

    - Future plans to expand report to include results for all doctors' offices and clinics over a certain size in the five-county region. Future reports will also compare hospital care and efficiency.
  - Convenes expert clinical improvement teams to: identify and recommend evidence-based guidelines for use by physicians and other health professionals; choose measures that will be used to rate the performance of medical practices and hospitals regarding care they provide; and identify specific strategies that will help improve the quality of care and the health and long-term wellbeing for people in the Puget Sound region
    - Clinical improvement reports have been released on heart disease, diabetes, prescription drugs, depression and low back pain. Teams currently developing asthma and prevention reports.

Wisconsin

Wisconsin Department of Employee Trust Funds - purchases health care for more state and local employees, retirees and their dependents, making it the largest purchaser of employer coverage in the state.

- Publishes "It's Your Choice" guide in print and on website intended to assist state employees in choosing health plan based on quality. The 2007 guide provides information about how many of a health plan's network hospitals have: submitted data to Leapfrog; fully implemented or made good progress on implementing patient safety measures endorsed by the National Quality Forum; provided data for prior year's error prevention measures and clinical measures reported through CheckPoint (see below); and provided data on Medication Reconciliation through CheckPoint. The guide also reports health plan quality improvement efforts, whether the plan has a 24-hour nurse line or an electronic diabetes registry, and responsiveness to enrollee calls.
- Health plans are assigned to one of three tiers, based on cost and quality and member premium contributions vary by tier. Tier designation originally based mainly on cost, but more emphasis has been put on quality by incorporating scores on patient safety, customer satisfaction, diabetes and hypertension care management, and rates of childhood immunizations and cancer screenings.
- "Quality Composite System" provides enhanced premiums to health plans displaying favorable patient safety and quality measures.

Wisconsin Hospital Association CheckPoint and Price Point **–** comparative web-based reports on hospital cost and quality based on data voluntarily reported by hospitals

- Check Point - provides comparative reports of hospital performance. Reports can be created to compare hospital performance on 14 interventions for heart attacks, heart failure, and pneumonia, 8 surgical service measures, and 5 error prevention goals.
  - Prevention measures recently expanded to include medication reconciliation measure, which indicates hospital's progress toward identifying the most complete and accurate list of medications a patient is taking when admitted to the hospital and using that list to provide correct medication for patient anywhere within the health care system.
- Price Point - allows health care consumers to receive basic, facility-specific information about services and charges associated with inpatient and outpatient services

***Wisconsin Health Information Organization* (WHIO)** - non-profit collaborative of managed care companies/insurers, employer groups, health plans, physician associations, hospitals,

- Building a statewide, centralized health repository based on voluntary reporting of private health insurance claims and pharmacy and lab data from health insurers, self-funded employers, health plans, Medicaid, and the employee trust fund
- Planning to use information to develop reports on the costs and quality of care in ambulatory settings.

***Wisconsin Collaborative for Healthcare Quality* (WCHQ) -** voluntary consortium of organizations, including physician groups, hospitals, health plans, employers and labor organizations learning and working together to improve the quality and cost-effectiveness of healthcare for the people of Wisconsin

- Governed by an assembly, comprised of CEOs, CMOs and Senior Quality Executives from each of the member institutions; Board of directors comprised of CEOs (or designees) from each member organization plus two delegates from Business Partners; receives input from workgroup of experts and business partners and business coalitions
- Web-based public Performance and Progress Reports provide comparative information on its member physician practices, hospitals, and health plans. Interactive tool allows for searches by provider types and region, clinical topic or IOM quality category (safety, timeliness, effectiveness, patient-centeredness), as well as comparison against WQHC averages and national performance.
- Set goal for providers to score above JCAHO 90 percentile performance.
- Tools designed to allow members to report data through website
- http://www.wisconsinhealthreports.org - set up as single source of quality and cost data for Wisconsin and includes links to WQHC, as well as Price Point and Check Point

Appendix C: Quality Institute Budget

Assumptions

- The following budgets assume the Quality Institute will have an unpaid voluntary Board of Directors, and voluntary advisory committees as appointed by the Board. The budgets below will have to be adjusted if the state decides the Quality Institute should have a paid Board.
- The Quality Institute will pursue all of the priority roles established in the accompanying report. The budget of the Quality Institute will determine the Institute's ability to pursue a range of other functions.
- The budget allocation for strategic investments will be used to fund projects, in partnership with other quality improvement organization, that align with the mission of the Quality Institute. A significant amount of staff and Quality Institute Board member time will have to be dedicated to developing strategic alliances with other organizations and making transparent decisions about how these dollars can be used 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 and Technical Assistance and Consumer Engagement	
Strategic Investments*	$750,000
Total	$2,305,000

The Quality Institute Work Group recommends that the state provide at least $4.6 million per biennium ($2.3 million annually) to establish and operate a Quality Institute able to significantly improve the quality and transparency of Oregon's health care system.

Reference Budgets Consulted
Population of Oregon: 3.7 million

Maine Quality Forum (See Appendix B for full description)

- Budget: MQF has an operating budget of $1 million annually, with administrative and staff salaries funded by the Dirigo Health Authority
- Population of Maine: 1.3 Million (2.4 million less than Oregon)
- Functions: MQF has convening and public reporting functions and advises state government on quality improvement issues. MQF does not directly collect data.

Utah Statewide All Claims Database (as proposed by Utah Department of Health)

- Budget: $1 million annually (includes software costs, vendor contract to clean, merge and maintain data securely and create public reports, one FTE to oversee and manage project and travel)
- Population : 2.6 Million (1.1 million less than Oregon)
- Functions: Create an all-claims database of all medical, pharmacy and dental claims processed for Utah residents and enrollment data for all health plan member. Create public cost and quality reports.

The Pennsylvania Health Care Cost Containment Council (PHC4)

- Budget: Approximately $5 million annually
- Population: 12.4 million (~3 times population of Oregon)
- Functions: Maintains a database of all hospital discharge and ambulatory/outpatient procedure records each year from hospitals and freestanding ambulatory surgery centers. Reports data about the cost and quality of health care to public. Studies quality and access issues. Advises state government on quality improvement issues.

HEALTH EQUITIES COMMITTEE FINAL REPORT

I. Executive Summary
II. Background
    a. HEC Charter
    b. Definition of Cultural Competency
    c. Topical Approach (stairway to equity)
III. Preventing disparities before they occur
    a. Population based approaches (grants)
        i. Culturally specific approaches to maximizing health and function
    b. Strengthen the relationship between providers and culturally-specific community-based organizations
        i. Renewable contracting
        ii. Direct reimbursement
    c. Offer incentives for healthy personal decision making
IV. Recommendations on reducing barriers to health care:
    a. Universal eligibility
    b. Address citizenship documentation barrier
    c. Targeted and aggressive outreach
    d. Cost-sharing
V. Recommendations on improving the quality of care
    a. Integrated Health Home (see also III-b)
    b. Benefit package
    c. Language access
    d. Workforce
        i. Adequate & diverse
        ii. Provider training in multicultural health
    e. Data collection
    f. Quality initiatives
VI. Conclusions
    a. Anything we would like to emphasize?
    b. Timeline recommendations?

- Appendix A: HEC Membership
- Appendix B: Stairway to Equity
- Appendix C: Chart of recommendations by committee
- Appendix D: Recommendations specific to Medicaid

Recommendations from the Health Equities Committee

Policy Recommendations on Benefit Design that Reduce Health Disparities

- **Promote equitable and fair sharing of health care costs.** Health insurance coverage with high deductibles and out-of-pocket costs hurts minority patients' ability to obtain needed care, as they are disproportionately low-income. Equitable cost-sharing policies take into account and attempt to minimize the uneven impact that cost-sharing arrangements may have on health care access. These include public contributions for those with low incomes to purchase health insurance, sliding fee scales for premiums, and limits on copayments and other out-of-pocket costs such that those at the lowest income levels will face only nominal charges. At a minimum, benefits should be extended to all Oregonians that protect against devastating financial losses and bankruptcy due to unforeseen catastrophic illness or injury. Utilization and quality data should be regularly accessed to determine if cost-sharing policies are contributing to health disparities.

- **Remove any financial barriers and increase reimbursement for preventive services, chronic disease management and patient education programs.** The benefit design should improve access to and utilization of appropriate services in an integrated health home and support community-based organizations that can assist in health promotion. The benefit design should also reward patients who actively participate in their own care through building in incentives for patients to follow through with the medical treatment plan they agreed upon with their health care provider. Encouraging patients to receive treatment for early disease in the less expensive outpatient setting rather than waiting until their disease process worsens and requires extensive hospitalization and surgeries will benefit both individuals and society. Patient education programs can help reduce health care disparities by providing patients with skills to effectively navigate health care systems and ensure that their needs and preferences are met. For example, patient education programs have been found to be effective in reducing racial and ethnic disparities in pain control.

- **Support direct reimbursement of community health workers for publicly sponsored health programs.** Community health workers, also known as lay health navigators or *promotoras*, are trained members of medically underserved communities who work to improve community health outcomes. Several community health worker models have proved effective in training people to teach disease prevention, to conduct simple assessments of health problems, and to help their neighbors obtain appropriate health and human resources. Oregon can stimulate these programs by recognizing community health workers as billable providers. Generally, requirements would be specific as to the education, training and certification of recognized workers and fee charts would detail allowable reimbursement rates. California secured funding for Community Health Workers and promotoras through a Section 1115 Medicaid Demonstration Program family planning waiver, allowing these services to be provided on a per-unit basis[1].

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[1] Advancing Community Health Worker Practice and Utilization: The Focus on Financing. National Fund for Medical Education, The Center for the Health Professions, University of California, San Francisco.

HEALTH EQUITIES COMMITTEE

Cultural competence refers to the process by which individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, disabilities, religions, genders, sexual orientation and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families and communities and protects and preserves the dignity of each.

Policy Recommendations on Preventing Health Disparities through Targeted and Culturally-Specific Programs of Health Promotion and Chronic Disease Prevention/ Management.

As identified by the Delivery System Committee of the Oregon Health Fund Board, there are few incentives in the current health care system to prevent disease and truly promote a healthy population. Even fully-capitated managed care organizations do not always see direct benefit from investing in prevention efforts that pay off in the long run because of movement in and out, and between, healthcare plans. The Oregon Health Fund program has the opportunity to save money with long-term prevention investments that improve the overall health of Oregonians as they move in and out, or between plans, while remaining in the overall Health Fund Program.

The Health Equities Committee recommends an on-going, substantial investment in public health activities that will prevent disease, and promote the health of Oregonians. We believe that part of this investment should be directed towards using culturally-specific approaches to disease prevention and health promotion.

- a. *Initiatives that target health disparities should be guided by members from the communities experiencing health disparities.*
    - i. *The Quality Institute and the Public Health Department would provide data to support decision-making on establishing funding and program priorities.*
    - ii. *Priorities will likely vary by region.*
- b. *Regional collaboratives consisting of social service organizations, culturally-specific organizations, healthcare organizations, and other community partners and community-based organizations would apply for grants that address targeted disparities with community-driven and implemented approaches.*
    - i. *Matching regional funds may be required.*
    - ii. *Funding should be administered in a way that supports the necessary steps to achieving targeted outcomes, and the outcomes themselves. Data & evaluation support will be provided through partnership with Public Health.*
    - iii. *Effective programs will be shared and problem-solving will be facilitated through convening regional collaborative leadership (in person or virtually) on a quarterly basis in learning collaboratives.*

Health focused community-based organizations have been very successful and providing culturally-specific programs that promote health, prevent disease, and help manage chronic diseases. These programs are overly reliant on federal grant priorities and struggle with sustainability. Providing a truly integrated healthcare home for multicultural communities requires a stronger relationship between these organizations and primary care clinics that serve vulnerable populations.

The Health Equities Committee recommends designing a contracting mechanism that will empower primary clinics who primarily serve vulnerable populations to build financial agreements with health-focused community-based organizations that provide culturally-specific health promotion and disease management services.

Renewable contracts will be awarded to health care clinics that partner with culturally-specific social service organizations (including organizations that focus on Persons with Disabilities, GLBT populations, and homeless youth or adults) to provide an integrated health care home. Clinics that have established in-house capacity for culturally-specific approaches would not be required to contract out for services already being rendered.

- *a. Partnership must include contractual financial agreements.*
    - *i. Social service organizations will provide culturally-specific approaches to health promotion, self-management for chronic diseases, and disease prevention. These approaches may include:*
        - *1. peer-to-peer health education programs*
        - *2. Community Health Workers*
- b. *Contracts will be based on a rate, adjusted to reflect the needs of the population, for serving a specified number of individuals in that population.*
    - i. *Organizations will be accountable on measures of process and outcomes that will reflect realistic timelines of:*
        - 1. *preventing chronic disease*
        - 2. *promoting population health*
        - 3. *chronic care management*
- c. *Contracts can be administered directly through the Health Fund Program or through a managed care organization.*

Recognizing that not every organization providing an integrated healthcare home is focused on serving vulnerable populations, an alternative should exist to renewable contracts that will enable a provider to purchase community-based and/or culturally-specific services.

The Health Equities Committee recommends that high-value community-based health promotion, disease prevention, and chronic disease management services, be eligible for direct reimbursement.

For organizations that want to provide an integrated healthcare home but do not wish to participate in direct contracts, accountable health plans must reimburse the following community and home-based services:

- a. *Community Health Workers*
- b. *Peer-led disease management support groups*
- c. *Culturally-specific programs to prevent or manage chronic diseases*

Community-Centered Health Initiative Proposal
Oregon Public Health Division, DHS – March 2008

- Three percent (3%) of all health care transactions in the state of Oregon will go into the Community-Centered Health Initiative (CCHI) fund.
    - All CCHI fund dollars will be used to support primary and secondary prevention activities.
    - Prevention activities will be delivered at the local level by county health departments, community-based organizations and health care delivery system entities.
    - Regional efforts will be promoted when appropriate – particularly where local resources are insufficient to assure standards will be met.
    - State government will play a role in facilitating and coordinating prevention efforts as well as providing state-level prevention activities.
    - Funds will be earmarked specifically for reducing health disparities.

- One percent (33% of CCHI funds) will be directed to county and local community prevention efforts.
    - Not less that 50% and not more that 67% will go to local health departments.
    - Not less that 33% and not more that 50% will go to community-based organizations dealing with health-related issues.
    - The local Board of Health (default is the Board of County Commissioners) will determine funding priorities for its county through a public decision-making process.
    - Regional projects will be encouraged through incentives, requirements that specific standards are met, and enhanced technical assistance for such activities.
    - At least 50% of funds to the county must be spent for 2 of the 4 state-set priority prevention activities (examples of possible activities include: tobacco prevention and education; obesity prevention/physical activity promotion; injury prevention; prenatal care)
    - Remaining funds may be spent on other evidence-based, community prevention projects.
        - At least 50% of these funds must directly address health disparities.

- One percent (33% of CCHI funds) will be directed to health care delivery system entities receiving Medicaid funding.
    - At least 50% but not more than 67% of these funds must go towards county and local level prevention activities.
        - All entities must actively participate in and support the selected state-set priority activities at the local level.

        - Entities may selectively participate in the other county and local level evidence-based prevention projects.
        - Entities may chose to become the primary sponsor of other evidence-based, community prevention projects.
    - At least 33% but not more that 50% of these funds must go towards incorporating prevention practices into health care delivery.
    - All entities must participate in community coalitions (if such exist in the community) designed to increase access to care for vulnerable populations and/or improve quality of care.
    - All entities must track and analyze the provision of both community-based and intra-system prevention activities.

- One percent (33% of CCHI funds) will be provided to state government (Department of Human Services, Public Health Division (PHD)) for standard setting, coordination, implementation assistance, and evaluation.
    - PHD will staff a state-level advisory committee (possibly the Public Health Advisory Board or Oregon Health Commission) that will determine the state-set priority activities and monitor CCHI progress.
    - PHD will provide administrative support for the programs being funded for county government, local communities, and delivery system prevention projects, including:
        - Setting standards of performance for the state-set priority activities, and when appropriate, for other evidence-based prevention projects selected by local communities.
        - Ensuring coordination of programs across jurisdiction, including the avoidance of duplicative services.
        - Providing technical assistance to counties, local communities, and delivery system entities to implement prevention projects.
        - Implementing a Prevention Projects Data System including the: development of standardized data elements; creation of data reporting mechanisms; compilation and analysis of data; and issuing an annual report detailing prevention activity performance.
    - PHD will conduct state-level, evidence-based prevention activities for all 4 of the state-set priorities.
    - PHD will develop and implement additional evidence-based prevention projects as funding allows.

Biennial Review of the Prioritized List of Health Services

In the summer of 2005, as the Health Services Commission (HSC) began to prepare for the biennial review of the list, they heard a presentation by original HSC member (1989-1993) Rick Wopat, MD. He encouraged the Commission to ask themselves whether the basic structure of the list represented what they truly considered to be the most important to the least important. Dr. Wopat suggested that a higher emphasis on preventive services and chronic disease management would ensure a benefit package that provides the services necessary to best keep a population healthy, not wait until an individual gets sick before higher cost services are offered to try to restore good health again.

The HSC believed that placing a higher value on prevention and chronic disease management was a good idea on its face and could be crucial in maintaining a sustainable program as we face an aging population. The Commission put together a workgroup that included HSC members, stakeholders, and health policy experts to study the issue further. This workgroup reviewed the principles on which the OHP was based, the values expressed in the four sets of public forums held by the HSC since 1990, and the results of the biennial public surveys on health care conducted by Oregon Health Decisions. The workgroup found evidence in all of these sources that supported such a shift in health care priorities and recommended the HSC pursue a reprioritization of the list to reflect this new emphasis.

A New Prioritization Methodology

In December 2005 the HSC embarked on the development of a new prioritization methodology for the first time since the list was initially implemented in February 1994. First the HSC developed the framework of what they thought the new list should look like by defining a rank ordered list of nine broad categories of health care (see Figure 1).

Next, each of the 710 line items on the 2006-07 Prioritized List were assigned to one of the nine health care categories. During this process, as has occurred with all biennial reviews, lines were merged or split where appropriate. For example, all superficial abscesses where combined into one line as outcomes and costs are similar regardless of where the abscess is located. In contrast, the Commission found relatively minor birth traumas lumped together with imminently life-threatening conditions and split these into two separate lines. During this process, other changes were made at the coding level to modify the composition of the lines where appropriate. As more lines were merged together than split, the new list is 680 lines long compared to the length of the list for the 2005-07 biennium at 710 lines. As most of these mergers involved previously funded condition-treatment pairs, new line 503 best equates to the benefit package represented in lines 1-530 (the funded portion) of the 2006-07 list.

Once the line items were assigned to one of the nine health care categories, a list of criteria was developed to sort the line items within the categories (see Figure 2). These measures were felt to best capture the impacts on both the individual's health and the population health that the Commission thought were essential in determining the relative importance of a condition-treatment pair. The HSC Medical Director and HSC Director worked with two HSC physician members to established ratings for the criteria for over 100 lines in order to establish a general

FIGURE 1
RANK ORDER OF HEALTH CARE CATEGORIES

1) Maternity & Newborn Care (100) - Obstetrical care for pregnancy. *Prenatal care; delivery services; postpartum care; newborn care for conditions intrinsic to the pregnancy.*

2) Primary Prevention and Secondary Prevention (95) - Effective preventive services used prior to the presence of disease and screenings for the detection of diseases at an early stage. *Immunizations; fluoride treatment in children; mammograms; pap smears; blood pressure screening; well child visits; routine dental exams.*

3) Chronic Disease Management (75) - Predominant role of treatment in the presence of an established disease is to prevent an exacerbation or a secondary illness. *Medical therapy for diabetes mellitus, asthma, and hypertension. Medical/psychotherapy for schizophrenia.*

4) Reproductive Services (70) - Excludes maternity and infertility services. *Contraceptive management; vasectomy; tubal occlusion; tubal ligation.*

5) Comfort Care (65) - Palliative therapy for conditions in which death is imminent. *Hospice care; pain management.*

6) Fatal Conditions, Where Treatment is Aimed at Disease Modification or Cure (40) - *Appendectomy for appendicitis; medical & surgical treatment for treatable cancers; dialysis for end-stage renal disease; medical therapy for stroke; medical/psychotherapy for single episode major depression.*

7) Nonfatal Conditions, Where Treatment is Aimed at Disease Modification or Cure (20) - *Treatment of closed fractures; medical/psychotherapy for obsessive-compulsive disorders; medical therapy for chronic sinusitis.*

8) Self-limiting conditions (5) - Treatment expedites recovery for conditions that will resolve on their own whether treated or not. *Medical therapy for diaper rash, acute conjunctivitis and acute pharyngitis.*

9) Inconsequential care (1) - Services that have little or no impact on health status due to the nature of the condition or the ineffectiveness of the treatment. *Repair fingertip avulsion that does not include fingernail; medical therapy for gallstones without cholecystitis, medical therapy for viral warts.*

FIGURE 2
POPULATION AND INDIVIDUAL IMPACT MEASURES

Impact on Health Life Years - to what degree will the condition impact the health of the individual if left untreated, considering the median age of onset (i.e., does the condition affect mainly children, where the impacts could potentially be experienced over a person's entire lifespan)? *Range of 0 (no impact) to 10 (high impact).*

Impact on Suffering - to what degree does the condition result in pain and suffering? Effect on family members (e.g. dealing with a loved one with Alzheimer's disease or needing to care for a person with a life-long disability) should also be factored in here. *Range of 0 (no impact) to 5 (high impact).*

Population Effects - the degree to which individuals other than the person with the illness will be affected. Examples include public health concerns due the spread of untreated tuberculosis or public safety concerns resulting from untreated severe mental illness. *Range of 0 (no effects) to 5 (widespread effects).*

Vulnerability of Population Affected - to what degree does the condition affect vulnerable populations such as those of certain racial/ethnic decent or those afflicted by certain debilitating illnesses such as HIV disease or alcohol & drug dependence? *Range of 0 (no vulnerability) to 5 (high vulnerability).*

Tertiary Prevention - in considering the ranking of services within new categories 6 and 7, to what degree does early treatment prevent complications of the disease (not including death)? *Range of 0 (doesn't prevent complications) to 5 (prevents severe complications).*

Effectiveness - to what degree does the treatment achieve its intended purpose? *Range of 0 (no effectiveness) to 5 (high effectiveness).*

Need for Medical Services - the percentage of time in which medical services would be required after the diagnosis has been established. *Percentage from 0 (services never required) to 1 (services always required).*

Net Cost - the cost of treatment for the typical case (including lifetime costs associated with chronic diseases) minus the expected costs if treatment is not provided -- including costs incurred through safety net providers (e.g., emergency departments) for urgent or emergent care related to the injury/illness or resulting complications. *Range of 0 (high net cost) to 5 (cost saving).*

scale to follow for each of the criteria. The HSC Medical Director (and in most cases HSC Director) then met with individual HSC physician members and other volunteer physicians with OHP experience. After ratings were established for all 710 lines, they were reviewed by the HSC Medical Director and HSC physician members for accuracy and consistency. A total score was then calculated for each line using the following formula to sort all line items within each of the health care categories, with the lowest net cost used to break any ties:

$$\begin{array}{l}\text{Impact on Healthy Life Years}\\ + \text{ Impact on Suffering}\\ + \text{ Population Effects}\\ + \text{ Vulnerable of Population Affected}\\ + \text{ Tertiary Prevention (categories 6 \& 7 only)}\end{array} \quad \text{X} \quad \text{Effectiveness} \quad \text{X} \quad \begin{array}{c}\text{Need for}\\ \text{Service}\end{array}$$

A workgroup of the HSC members then met to explore the best method for intermixing CT pairs across health care categories. While the nine health care categories were meant to establish the framework of the new list it was always clear that not every service in Category 1 was more important than every service in Category 2 and so on. In the methodology used to develop the initial prioritized list implemented in February 1994, approximately 75% of the line items where hand adjusted after an initial computer sort on the treatment's prevention of death and cost of the treatment. The workgroup found that applying a weight to each category that was then multiplied by the total criteria score for each condition-treatment pair achieved an appropriate adjustment in the majority of the cases. The full commission agreed with the conclusions of the workgroup and approved the weights shown in parentheses after the title for each category in Figure 1. Hand adjustments were applied where the application of this methodology did not result in a ranking that reflected the importance of the service, which was the case in fewer than 5% of the line items.

The following two examples illustrate line items that were given a very high score and a very low score as a result of this process.

Schizophrenic Disorders
(Old line: 159, New line: 27)
Impact on Healthy Life Years: 8
Impact on Suffering: 4
Effects on Population: 4
Vulnerability of Population Affected: 0
Effectiveness: 3
Need for Service: 1
Net Cost: 5
Category 3 Weight: 75
Total Score: 3600

[(8+4+4+0) x 3 x 1] x 75 = 3600

Grade I Sprains of Joints and Muscles
(Old line: 626, New line: 628)
Impact on Healthy Life Years: 1
Impact on Suffering: 1
Effects on Population: 0
Vulnerability of Population Affected: 0
Effectiveness: 2
Need for Service: 0.1
Net Cost: 4
Category 8 Weight: 5
Total Score: 2

[(1+1+0+0) x 2 x 0.1 x 5 = 2

Some of the services moving towards the top of the list as a result of this reprioritization include maternity care and newborn services, preventive services found to be effective by the US Preventive Services Task Force, and treatments for chronic diseases such as diabetes, major depression, asthma, and hypertension, where ongoing maintenance therapy can prevent exacerbations of the disease that lead to avoidable high-intensity service utilization, morbidity, and death.

Public Input

The HSC solicited public and stakeholder input throughout the process. As always, all commission meetings are open to the public and time is set aside for public testimony. When the Commission was initially considering reprioritizing the list, they sent out a survey to over 200 stakeholders. This included physicians randomly selected from the Board of Medical Examiners mailing list, specialty societies, hospitals, safety net clinics and school-based health centers. Thirty-one responses were received and, of these, thirty were supportive of a new emphasis on prevention and chronic disease management.

After the methodology had taken shape, the Commission conducted five focus groups with specialty society presidents, members of the Oregon Academy of Family Practice, representatives from service providers (hospitals, physicians, OHP managed care plans, mental health, chemical dependency, dentistry and home health), consumers, and consumer advocates. While there was no objection to the direction that the HSC was taking, there were concerns aired about things beyond the control of the Commission, including funding sources for the Oregon Health Plan, provider reimbursement and access to care. Medical directors and administrators for the contracted managed care plans were kept up to date on the HSC's work and also were supportive of the reprioritization effort.

Next Steps

A group of stakeholders brought together by the Governor's office in 2006 examined whether this new list could be used to expand coverage to a larger segment of Oregon's population living under the federal poverty level who don't meet categorical Medicaid eligibility criteria (through OHP Standard). Over the last three years, OHP Standard has seen its enrollment decrease from over 100,000 to under 24, 000 as revenues became tighter. This group, called the OHP Standard Benefit Design Workgroup, considered trade-offs in benefit coverage should additional revenues not be available for an expansion, potential issues involved in implementing such a benefit package, and whether the principles of the Oregon Health Plan would be followed under such a scenario. To note, the present cost of covering the much reduced OHP Standard population is currently higher at a per-person level due to higher chronic disease prevalence and service utilization. Therefore, after detailed analysis, the workgroup concluded that the over 200 line items that would need to be eliminated from coverage in order to increase enrollment in OHP Standard from a baseline level of 24,000 for the 2007-09 biennium to approximately 28,000 individuals was not justifiable at this time.

Health Equities Committee Final Recommendations on Policy Options that Promote Language Access

Cultural competence refers to the process by which individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, disabilities, religions, genders, sexual orientation and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families and communities and protects and preserves the dignity of each (ORS 415-056-0005).

Goal: To ensure health care services respectful of and responsive to the cultural and linguistic needs of Oregonians.

1. Take advantage of growing technological capacity in Oregon by creating a state-wide pool of qualified, certified interpreters and organizations that may be able to utilize and build on technologies being developed for telemedicine or telehealth.
    - State wide pool would include partnerships including but not limited to hospitals, clinics, language bank companies, video interpreter services, and community services, etc.
        i. As an example, partners in the pool could pay according to their percentage of services used the prior year.
    - Coordinate with statewide technology efforts, such as Telehealth, to build future infrastructure for the statewide pool, including video remote interpreting for Deaf people.
    - In planning for interpreter services, include organizations specific to ASL interpreters (such as the Oregon Registry of Interpreters for the Deaf), and disability/Deaf organizations (such as the Women with Disabilities Health Equity Coalition, and the Oregon Association of the Deaf) to ensure inclusion of video remote interpreting for ASL signers.

2. Seek federal matching funds for interpreter services through Medicaid. This targets provider organizations that serve Medicaid patients by making interpreter services affordable.
    - Promote video remote interpreting (and other telehealth technologies) as a viable option for health care providers.
    - Through a state plan amendment, make interpreter services a covered service rather than an administrative service, thereby eliminating the disincentive for providers to see non-English speaking patients.

3. Use state regulation to impose mandates with funds to off-set subsequent costs:

- Any plan that participates in the Oregon Health Fund Exchange must pay for interpreter services.

4. Create education partnerships so that more health professionals are also certified interpreters.
    - May be able to utilize existing partnerships through the Health Care Workforce Institute or other existing groups that work toward certification of interpreters.
    - As much as possible, interpretation must be included in the health professional's job description, protecting the employee's time and reflecting their dual roles.

Definitions based on the Healthcare Interpreter Oregon Administrative rules:

- "Limited English Proficient" (LEP) is a modifier used by the federal government to describe a person with limited English proficiency. "Person with limited English proficiency" means a person who, by reasons of place of birth or culture, speaks a language other than English and does not speak English with adequate ability to communicate effectively with a health care provider.
- "Health Care" means medical, surgical, or hospital care or any other remedial care recognized by state law, including mental health care.
- "Interpreter Services" is listening to a message of one language and providing an oral rendition of the same message in another language. An interpretation is to be complete and accurate and relay the meaning of the message from one language to the other, considering the context and the meaning of the whole phrase and not each word as if it were "standing alone" without context.
- "Health Care Interpreter" means a person who is employed as an interpreter working in health care who is readily able to communicate with a person with limited English proficiency and to accurately translate the written or oral statements of the person with limited English proficiency into English, and who is readily able to translate the written or oral statements of other persons into the language of the person with limited English proficiency. Health Care Interpreter further means any individual paid as an interpreter working in health services, including mental health. As used in this section, the term "employed" means anyone who performs or is utilized as a health care interpreter whether it be in an hourly or salaried position, contractor, volunteer, or intern

HEALTH EQUITIES COMMITTEE

Cultural competence refers to the process by which individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, disabilities, religions, genders, sexual orientation and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families and communities and protects and preserves the dignity of each.

Policy Recommendations on Improving the Health Care Workforce and Reducing Health Care Disparities

1. Expand educational institution capacity at health professional schools where more training opportunities are needed across the board from community college to university and postgraduate levels. Oregon's health care provider shortage is also challenged by the population's growing diversity and the need to provide culturally and linguistically competent care.

2. Increase financial aid in health professional schools for students needing more financial aid of the right kind (grants, scholarships, loan forgiveness). Ultimately, our patients pay the price when there are insufficient providers from backgrounds similar to theirs. Geographic, economic, educational, and cultural factors, with their effects on patient mortality, underscore the critical need for providers from disadvantaged backgrounds and with superior cultural sensitivity training, to improve health care for the underserved throughout Oregon. They will then be able to serve those who are now underserved, improving access to care. In addition, these individuals will function as role models for youth in their communities.

    a. Expand reduced tuition to Oregon residents pursuing careers at Oregon healthcare educational institutions with additional incentives for underrepresented populations.
    b. Offer loan forgiveness for providers who practice in underserved areas in Oregon or with underserved populations in Oregon.

3. Strengthen the pipeline to health profession schools; intervention needs to start early and focus on retention. Support mentoring program models that have been demonstrated to be effective in retaining students. We feel strongly that educational and experiential support in pre-college, college and in health professional schools will enable more applicants from disadvantaged backgrounds to apply, gain admission and graduate into the healthcare workforce.

4. Recommendation 3 must include convening all entities that are currently working on pipeline development issues so that efforts are coordinated, streamlined, and strategic in planning for the future needs of Oregon's population.

    a. The Oregon Health Care Work-Force Institute would be ideally suited for the role of convener.

   b. Entities that should be convened include, but are not limited to, Allopathic and Naturopathic providers, dentists, mid-level providers, nurses, behavioral health professionals, allied and Community-Health Workers.

5. Improve the climate for diversity at individual health professional schools by mandating cultural (including sexual and gender minorities, persons with disabilities, and other vulnerable populations) and linguistic competence throughout the institution. This in turn will mean better patient satisfaction and medical compliance, with decreases in morbidity and mortality related to chronic diseases over time. Providing culturally competent services that maximize health and functionality results in lower spending on health care, as well as increased income from a more productive workforce.

6. Utilize existing agencies to establish and report on diversity goals for health & hospital systems and healthcare training institutions to the Oregon Health Fund Board on a biennial basis.

7. Support Community Health Worker programs that recruit and train members of underserved communities to provide culturally and linguistically competent health services within that community.

8. Mandate a minimum level of educational credits for healthcare providers that must earned in coursework specifically designed to increase cultural competence and/or awareness.

   a. This can be part of initial licensure or as part of continuing education.

HEALTH EQUITIES COMMITTEE

Cultural competence refers to the process by which individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, disabilities, religions, genders, sexual orientation and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families and communities and protects and preserves the dignity of each.

Policy Recommendations on Preventing Health Disparities through Targeted and Culturally-Specific Programs of Health Promotion and Chronic Disease Prevention/ Management.

1. *1% of every health care dollar would be invested in a Population-Health Fund. This Fund would be administered by foundation-like entity, perhaps in a private-public partnership with the State of Oregon .*
    a. *Initiatives that target health disparities would be guided by a Health Equities Board in three-year grant cycles.*
        i. *The Public Health Department would provide the Health Equities Board with data to support decision-making on establishing funding and program priorities for each funding cycle.*
        ii. *Priorities may vary by region.*
    b. *Regional collaboratives consisting of social service organizations, healthcare organizations, and other community partners (schools, businesses, etc.) would apply for grants that address targeted disparities with community-driven and implemented approaches.*
        i. *Matching regional funds may be required.*
        ii. *Funding should be administered in a way that supports the necessary steps to achieving targeted outcomes, and the outcomes themselves. Data & evaluation support will be provided through partnership with Public Health.*
        iii. *Effective programs will be shared and problem-solving will be facilitated through convening regional collaborative leadership (in person or virtually) on a quarterly basis in learning collaboratives sponsored by the Population-Health Fund.*

2. *Data-driven block grants will be awarded to health care clinics that partner with culturally-specific social service organizations (including organizations that focus on Persons with Disabilities, GLBT populations, and homeless youth or adults) to provide an integrated health care home.*
    a. *Partnership must include contractual financial agreements.*
        i. *Social service organizations will provide culturally-specific approaches to health promotion, self-management for chronic diseases, and disease prevention. These approaches may include:*
            1. *peer-to-peer health education programs*
            2. *Community Health Workers*
    b. *Grants will be based on a rate, adjusted to reflect the needs of the population, for serving a specified number of individuals in that population.*
        i. *Organizations must demonstrate effectiveness at:*

    1. *preventing chronic disease*
    2. *promoting population health*
    3. *chronic care management*

c. *Block grants can be administered directly through the Health Fund Program or through a managed care organization.*

Health Equities Committee Policy Options for Linguistic and Cultural Models that Increase Health Equities.

Goal: To ensure health care services respectful of and responsive to the cultural and linguistic needs of Oregonians.

1. ***Take advantage of growing technological capacity in Oregon*** *by creating a state-wide pool of qualified and certified interpreters that may be able to utilize and build on technologies being developed for telemedicine.*
    - State wide pool would include partnerships including but not limited to hospitals, clinics, language bank companies, community services, etc.
    - Coordinate with statewide technology efforts, such as Telemedicine, to build future infrastructure for the statewide pool.
    - As an example, partners in the pool could pay according to their percentage of services used the prior year.

2. ***Seek federal matching funds for interpreter services through Medicaid*.**
    - Targets provider organizations that serve Medicaid patients by making interpreter services affordable.
    - Through a state plan amendment, make interpreter services a covered service rather than an administrative service.

3. ***Use state regulation to impose mandates with funds to off-set subsequent costs:***
    - Any plan that participates in the Oregon Health Fund Exchange must pay for interpreter services.

4. ***Create education partnerships so that more health professionals are also certified interpreters.***
    - May be able to utilize existing partnerships through the Health Care Workforce Institute or other existing groups that work toward certification of interpreters.
    - As much as possible, interpretation must be included in the health professional’s job description, protecting the employee’s time and reflecting their dual roles.

5. ***Mandate a minimum level of educational credits for healthcare providers that must earned in coursework specifically designed to increase cultural competence.***
    - This can be part of initial licensure or as part of continuing education.

Definitions based on the Healthcare Interpreter Oregon Administrative rules:

- “Limited English Proficient” (LEP) is a modifier used by the federal government to describe a person with limited English proficiency. “Person with limited English proficiency” means a person who, by reasons of place of birth or culture, speaks a language other than English and does not speak English with adequate ability to communicate effectively with a health care provider.
- “Health Care” means medical, surgical, or hospital care or any other remedial care recognized by state law, including mental health care.
- “Interpreter Services” is listening to a message of one language and providing an oral rendition of the same message in another language. An interpretation is to be complete and accurate and relay the meaning of the message from one language to the other, considering the context and the meaning of the whole phrase and not each word as if it were “standing alone” without context.
- “Health Care Interpreter” means a person who is employed as an interpreter working in health care who is readily able to communicate with a person with limited English proficiency and to accurately translate the written or oral statements of the person with limited English proficiency into English, and who is readily able to translate the written or oral statements of other persons into the language of the person with limited English proficiency. Health Care Interpreter further means any individual paid as an interpreter working in health services, including mental health. As used in this section, the term “employed” means anyone who performs or is utilized as a health care interpreter whether it be in an hourly or salaried position, contractor, volunteer, or intern

Recommendations from the Health Equities Committee

Policy Recommendations on Elements of the Medical Home and Primary Care Renewal that Reduce Health Disparities

1. Definition of Medical Home/Primary Care Home: A system of care that provides coordination of multiple, disparate elements of care for a patient. This does not assume that all care is provided within the walls of a clinic.

2. Elements of the Medical Home model that have been demonstrated to reduce health disparities and must be encouraged in any medical service organization purporting delivery of a Medical Home include:
    a. Patient Centered Care focus
        i. Extended office hours: evenings and weekends
        ii. Alternative access to providers such as telephone consultations and email exchanges.
        iii. Automatic reminders of recommended visit schedule and appointment times.
        iv. Mental Health and Chemical Dependency Integration
        v. Emphasis on chronic disease management and preventive care
        vi. Coordination with community based social organizations, peer support networks and organizations that integrate social determinants of health into care including public health as appropriate
    b. Population based care: The Medical Home should include systems to coordinate care of all patients in the practice outside of office visits.

3. For some populations, a medical home may be best provided outside of the traditional primary care service delivery system and a definition of medical home should not exclude organizations based on service-delivery type but should include coordination of care by a licensed medical provider.

4. The Medical Home needs to be integrated and viewed in the context of the social and education system, hospital and specialty care system and public health system in a community.

Interpretation Needs for the Deaf and Hard of Hearing Community

Prepared by the Women with Disabilities Health Equity Coalition (WowDHEC)
March 4, 2008

I. Introduction

The Women with Disabilities Health Equity Coalition (WowDHEC) is a Portland-based organization with a mission to improve access to and quality of health care and health promotion services for women with disabilities. WowDHEC seeks to achieve its mission by building community capacity and raising awareness about the health needs of women with disabilities among health care providers and public health professionals. WowDHEC's current health policy focus is ensuring equal opportunity and accessibility for people who are deaf and use ASL, by advocating for the implementation of Video Remote Interpreting (VRI) services in local health care settings, which is video interpreting system that provides "on-demand" access via internet-based technologies

II. Problem Statement/Need

People who are deaf and use American Sign Language (ASL), estimated to range from 100,000 to 1 million, report difficulties accessing health care.[1] These constraints stem from limited access to English language-based communication, infrequent contacts with clinicians familiar with their language and culture, the challenges of using friends and family members as interpreters, and the inadequacy or unavailability of a medically experienced certified interpreter.

In Oregon, we face a shortage of certified ASL interpreters. In recent years, there has been a decrease in the supply of freelance interpreters due to the growing popularity of video relay call centers who provide interpreting for signers calling a non-signer. . Outside of the 1-5 transportation corridor, a certified ASL interpreter for medical settings is simply not available in many areas of Oregon.

In urban areas, where there are more qualified freelance ASL interpreters, special concerns arise when there is a medical emergency situation requiring an interpreter with little or no notice. This is problematic as most interpreters are freelancers, and thus not readily available on site. Some hospitals (such as OHSU) have addressed this issue by contracting with interpreter agencies which guarantee that an interpreter will arrive within 45 minutes. However, in an emergency, a 45 minute delay can harm a patient's health.

III. Solution

There is a possible solution—video remote interpreting (VRI). This solution is already in place in several Oregon hospitals—for spoken languages, but not for ASL interpretation.

Video Remote Interpreting (VRI) helps bridge communication between deaf/hard of hearing, and hearing individuals. VRI enables virtual real-time access to interpreting services. VRI is a tool that can help eliminate communication barriers and enhance access to health care services.

How does it work? VRI can be used on-demand to obtain instant interpreting services with a simple click of button. Normally, it takes a couple of phone calls to find an interpreter who is available. The remote interpreter, usually on contract through a commercial VRI interpreting center, appears on a monitor within minutes. The monitor is positioned so that the remote interpreter, patient and health providers can communicate via the web cameras set up on both ends. The monitor can be placed on a portable cart so that it can be moved within a medical facility (as is done at OHSU and other institutions for spoken language interpretation).

In rural areas, VRI is especially critical where medically qualified interpreters are scarce. In urban areas, VRI provides a timely alternative waiting up to 45 minutes (or more), or having to schedule appointments far enough in advance in order to secure an interpreter.

IV. Benefits

Cost Effectiveness of VRI

Some hospitals have their own VRI but the language selection excludes ASL. Because of resources widely available in the area, they have a contract with a sign language interpreting agency to hire on-site interpreters. On-site interpreters are preferable for deaf and hard of hearing individuals because of in-contact interaction. However, last minute requests may not be filled; costly fees for last-minute requests may be assessed; additional fees for travel expenses may also be incurred.

Evidence-based VRI at health care settings in Maine

A recently completed evaluation of the use of VRI in Maine-based hospitals and medical centers illustrates the value of this service.

The Maine-based non profit organization Pine Tree Society's evaluation (http://www.pinetreesociety.org/interpreting_vri.asp), reports that "Nearly 40% of the Deaf and hard-of-hearing people surveyed said that without the availability of VRI, they would not have gotten help." A strong testament to the overall acceptability of Video Remote Interpreting to Deaf and hard-of-hearing patients is the 74% response rate of 'True' for the following question: 'Without VRI here, I have to go to a different hospital that has VRI.' While a major objective is to eliminate unnecessary travel for the target populations, VRI has proven itself to be valuable enough that many are willing to travel for it. Deaf and hard-of-hearing clients also remarked favorably regarding the quality of service VRI allows.

On the survey, respondents marked 'True', stating that "With VRI, I..."

- 'feel more comfortable with the hospital staff' - 90%
- 'can communicate better with hospital staff' - 81%
- 'can explain my problem better' - 95%
- 'understand better what the hospital staff told me about my problem' - 95%
- 'understand better what I need to do to feel better' - 91%
- 'will come back for my next appointment' - 88%

Health care providers attested to the high level of quality the service afforded them. Based on their comments, using VRI is seen as the same or better than using an interpreter on site for an overwhelming majority of those who have used the technology."

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[1] Steinberg AG, Barnett S, Meador HE, Wiggins EA, Zazove P. (2006). Health care system accessibility: Experiences and perceptions of deaf people. *J Gen Intern Med.* 21(3):260-6.

Changing the Focus to Outcomes

Health Equities Committee
March 4th, 2008
Mark Redding – Community Health Access Project (CHAP)
reddingz@att.net

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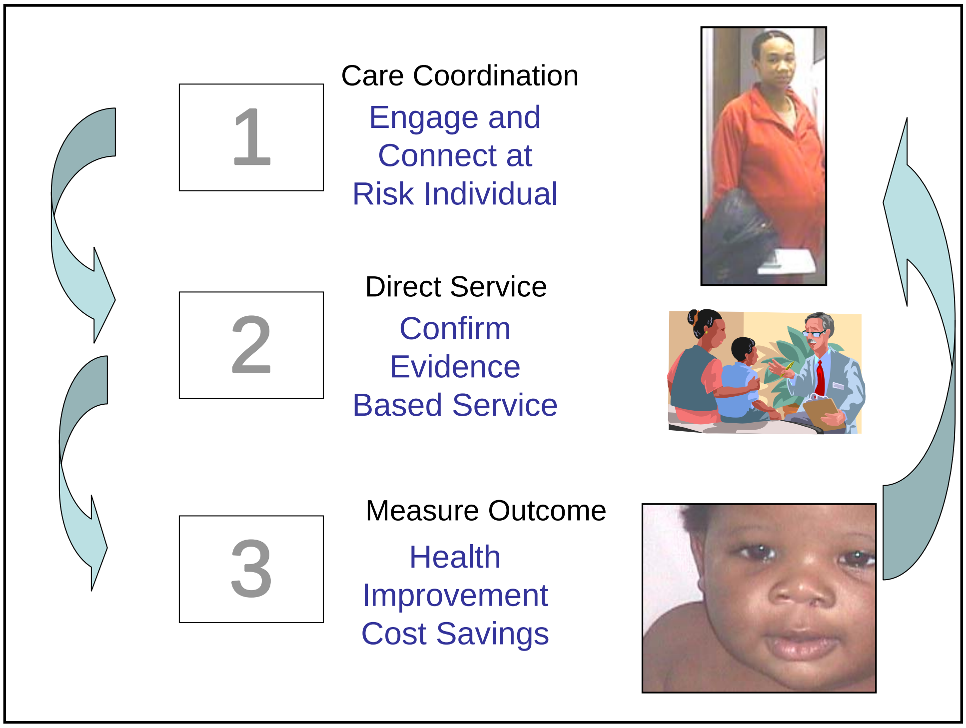
1 Find at Risk

2 Treat

3 Measure



1

Care Coordination

Engage and Connect at Risk Individual

2

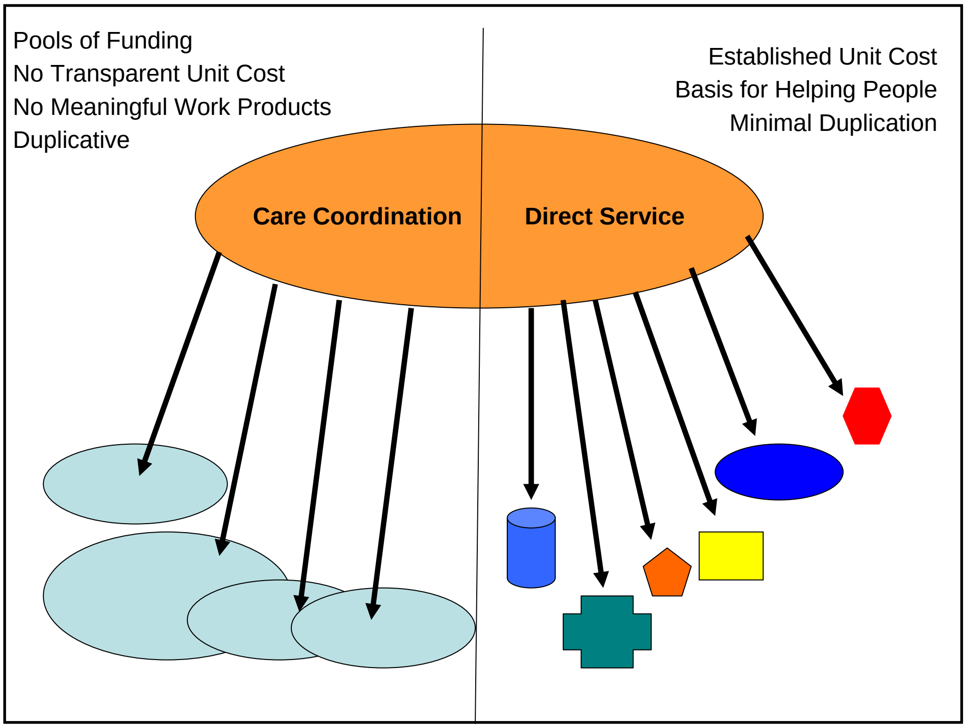
Direct Service

Confirm Evidence Based Service

3

Measure Outcome

Health Improvement Cost Savings



Pools of Funding
No Transparent Unit Cost
No Meaningful Work Products
Duplicative

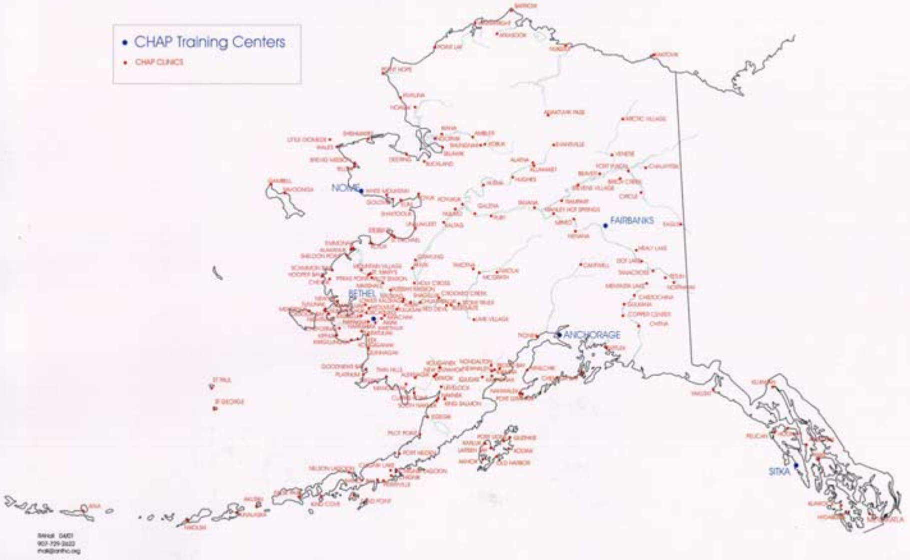
Established Unit Cost
Basis for Helping People
Minimal Duplication

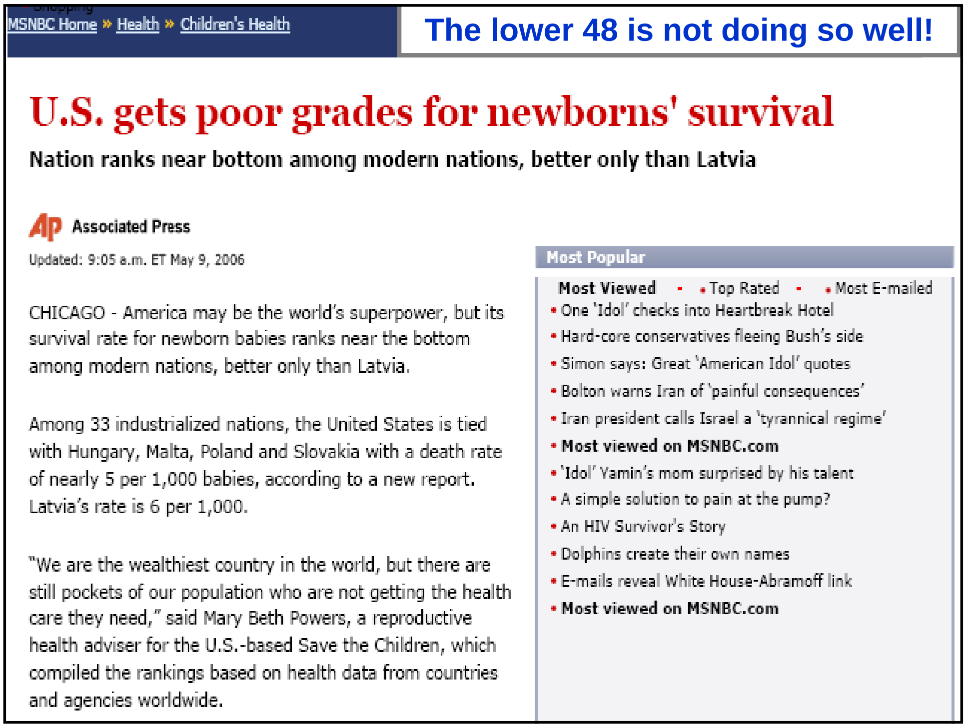
Care Coordination

Direct Service

THE ALASKA NATIVE HEALTH CARE SYSTEM

Community Health Aide/Practitioner Locations





MSNBC Home » Health » Children's Health

The lower 48 is not doing so well!

U.S. gets poor grades for newborns' survival

Nation ranks near bottom among modern nations, better only than Latvia

Associated Press

Updated: 9:05 a.m. ET May 9, 2006

CHICAGO - America may be the world's superpower, but its survival rate for newborn babies ranks near the bottom among modern nations, better only than Latvia.

Among 33 industrialized nations, the United States is tied with Hungary, Malta, Poland and Slovakia with a death rate of nearly 5 per 1,000 babies, according to a new report. Latvia's rate is 6 per 1,000.

"We are the wealthiest country in the world, but there are still pockets of our population who are not getting the health care they need," said Mary Beth Powers, a reproductive health adviser for the U.S.-based Save the Children, which compiled the rankings based on health data from countries and agencies worldwide.

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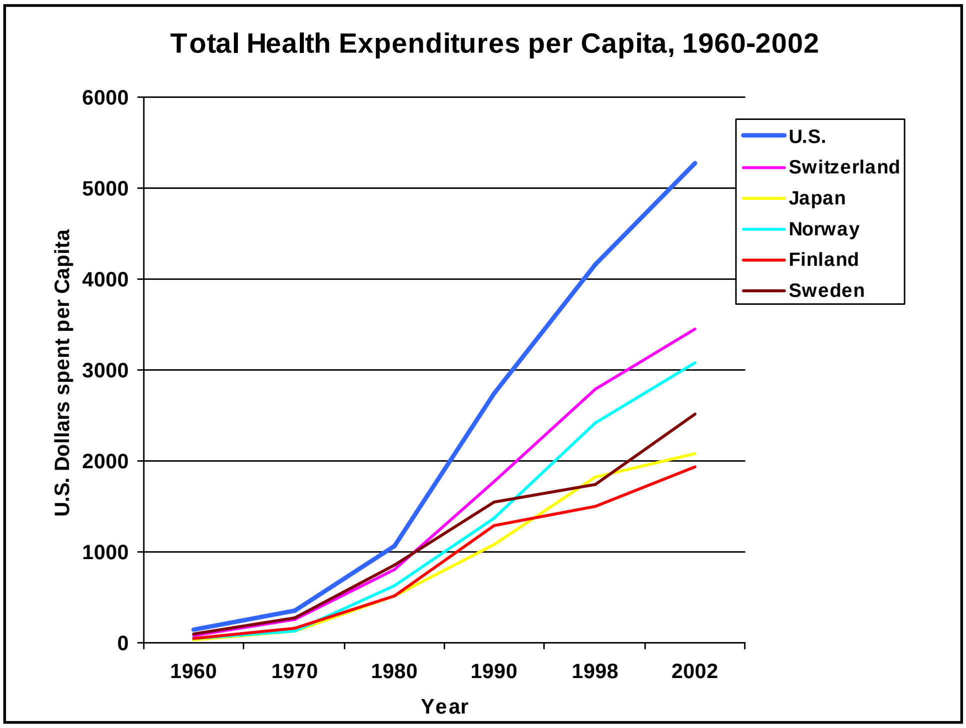
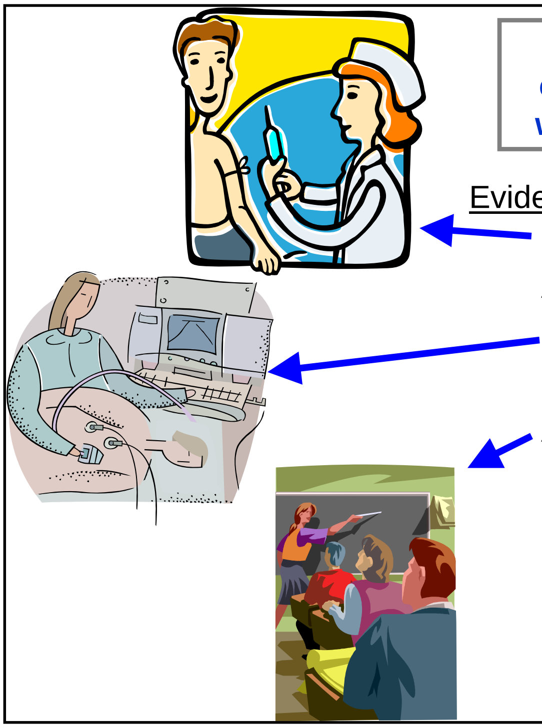


Total Health Expenditures per Capita, 1960-2002

Albert Einstein

> "We can't solve today's problems by using the same kind of thinking we used when we created them ."



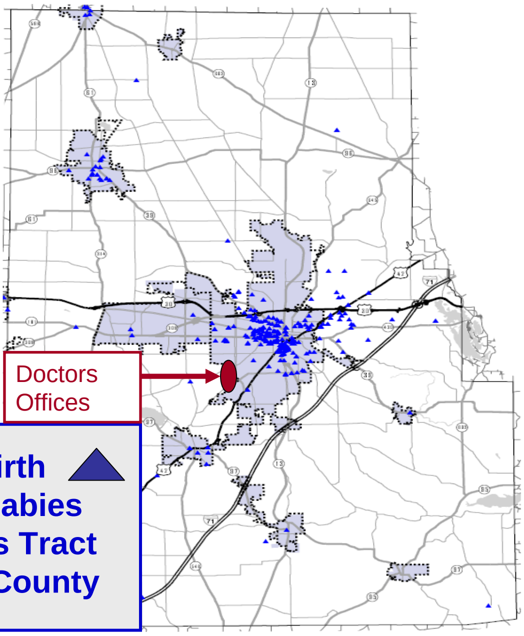
We can define the conditions and we know what works to treat them

<u>Evidence Based Interventions</u>

- Diabetes
- Asthma
- Pregnancy
- Homelessness
- Adult Education
- Unemployment

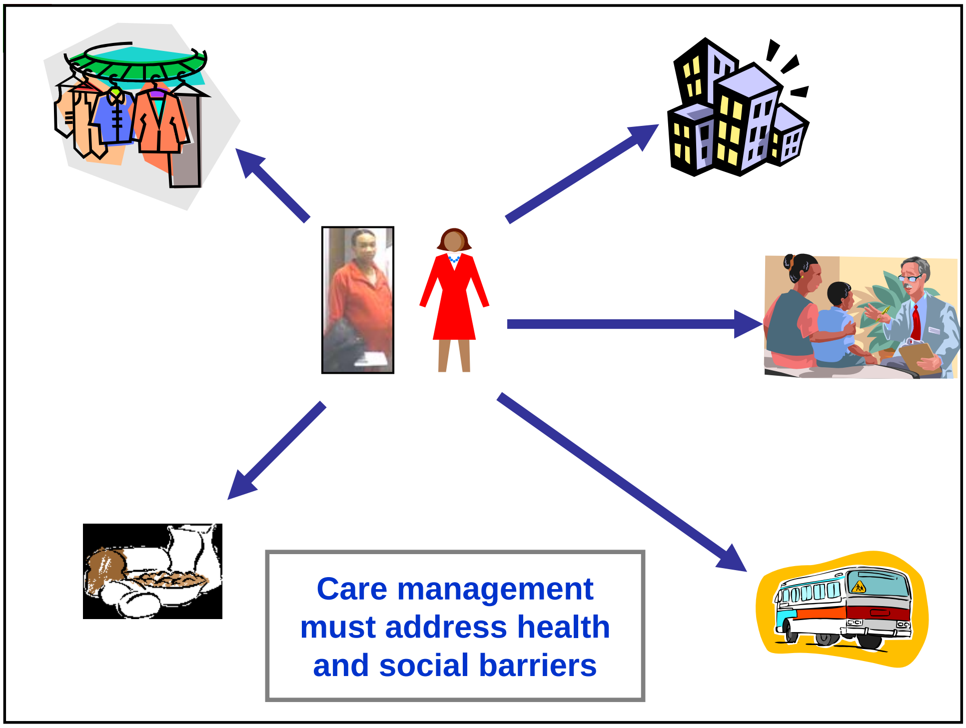
Care Coordination

Richland County Ohio



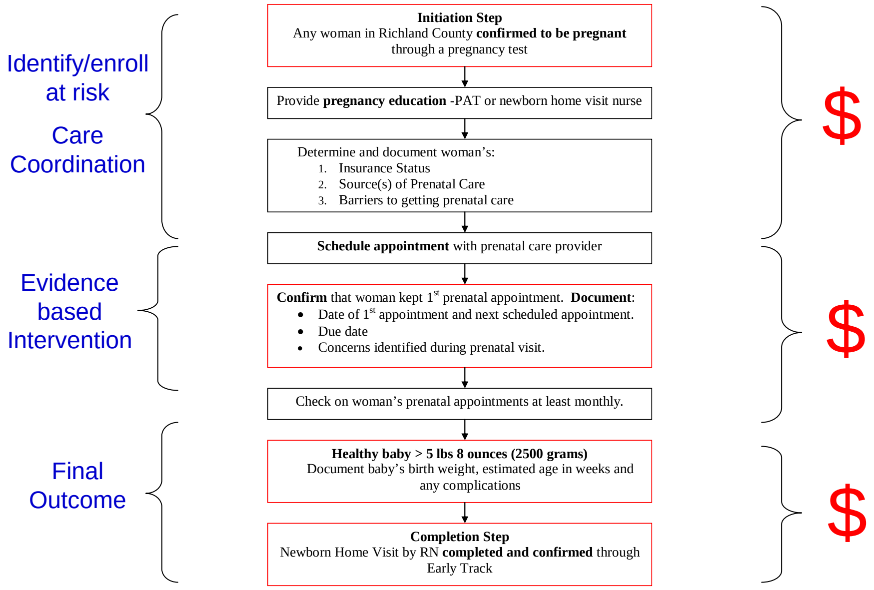
Doctors Offices

Low Birth ▲ Weight Babies by Census Tract Richland County



Care management must address health and social barriers

Pregnancy Pathway



Identify/enroll at risk

Care Coordination

Initiation Step
Any woman in Richland County **confirmed to be pregnant** through a pregnancy test

Provide **pregnancy education** -PAT or newborn home visit nurse

Determine and document woman's:
1. Insurance Status
2. Source(s) of Prenatal Care
3. Barriers to getting prenatal care

$

Evidence based Intervention

Schedule appointment with prenatal care provider

Confirm that woman kept 1st prenatal appointment. **Document**:
- Date of 1st appointment and next scheduled appointment.
- Due date
- Concerns identified during prenatal visit.

Check on woman's prenatal appointments at least monthly.

$

Final Outcome

Healthy baby > 5 lbs 8 ounces (2500 grams)
Document baby's birth weight, estimated age in weeks and any complications

Completion Step
Newborn Home Visit by RN **completed and confirmed** through Early Track

$

The Pathways Case Management Process and Definitions

CHECKLIST

Yes	No	Question
	✓	Do you need a primary medical provider?
✓		Do you need health Insurance?
	✓	Do you smoke cigarettes
✓		Do you need food or clothing?

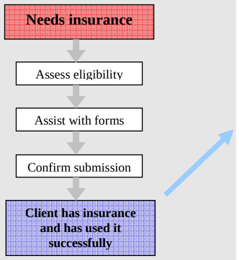
Definition:

Checklists are groups of questions designed to evaluate the client's:
- Home stability
- Mental health
- Substance abuse
- Medical home
- Insurance
- Domestic violence

A "yes" answer would indicate that there is a problem. Another way to think of this is that a "yes" answer usually triggers a Pathway (outcome production process).

Client specific checklists (pregnant client, newborn, etc.) are developed to be used at home visits.

Pathways



Needs insurance

Assess eligibility

Assist with forms

Confirm submission

Client has insurance and has used it successfully

Definition:

Each Pathway defines the problem to be addressed (Initiation Step), the evidence-based steps to address the problem, and the positive, measurable outcome (Completion Step). Pathways are not credited as complete unless the final outcome is achieved.

Pathways differ from standard protocols in being an outcome production model of accountability. If you follow a protocol and the client is 'lost to follow-up', then there are no consequences. A Pathway is only complete if the desired outcome is achieved.

Each client may have multiple Pathways - which are focused on, prioritized, and completed - one at a time.

Evaluation and Quality Assurance

Pathways/Month by Outreach Worker

Name	Immz.	Insurance	Preg.
Johnson	5	2	10
Reed	1	3	4
Pickens	9	15	18

Pathways/Month by Site

Site	Immz.	Insurance	Preg.
Johnsville	50	25	22
Elkins	64	17	35
Danville	40	32	19

Evaluation – Remove Disparities:

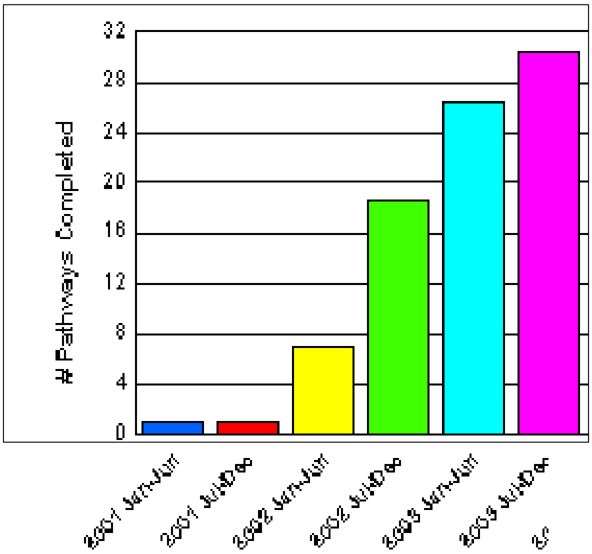
Pathway production can be evaluated from many perspectives. Focus on specific outcome production can be brought to the level of each case worker. Their results can be compared to others in similar settings. This allows strengths and weaknesses to be identified.

The focus is not to be punitive, but to try to help increase the production of positive outcomes. Barrier steps can be identified and focused on to increase production. Education and specific interventions can be deployed, and then outcome production can be reevaluated to assess the impact.

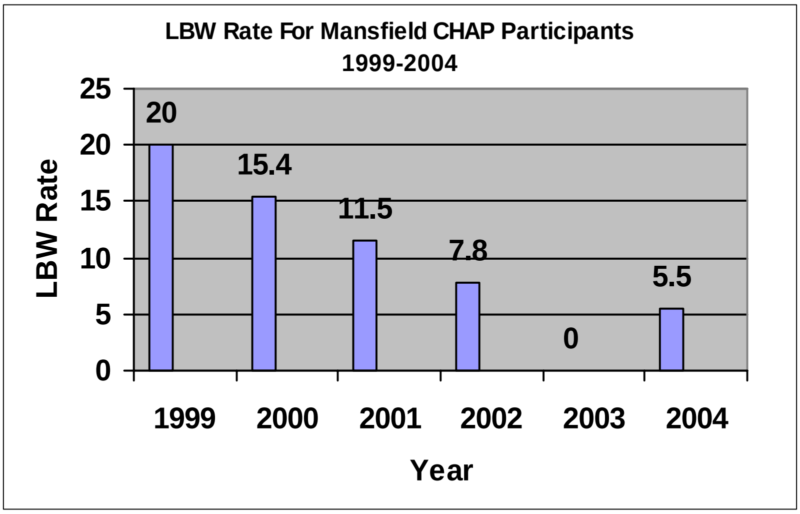
Positive outcomes are not always brought about by global changes. Placing the accountability and focus on one individual, one outcome at a time, may actually have a greater impact on health disparities.

Youngstown – Healthy Moms Healthy Babies

Health and Social Service Referral Pathways Produced Per Six Month Period Per CHW

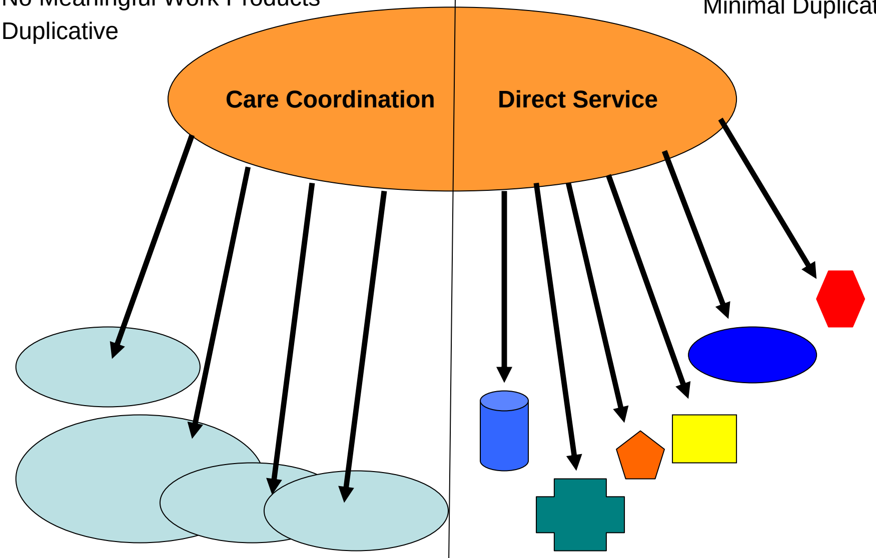


Outcome Based Accountability and Care Management Make a Difference


LBW Rate For Mansfield CHAP Participants 1999-2004

Pools of Funding
No Transparent Unit Cost
No Meaningful Work Products
Duplicative

Established Unit Cost
Basis for Helping People
Minimal Duplication



Care Coordination

Direct Service

Care Coordination

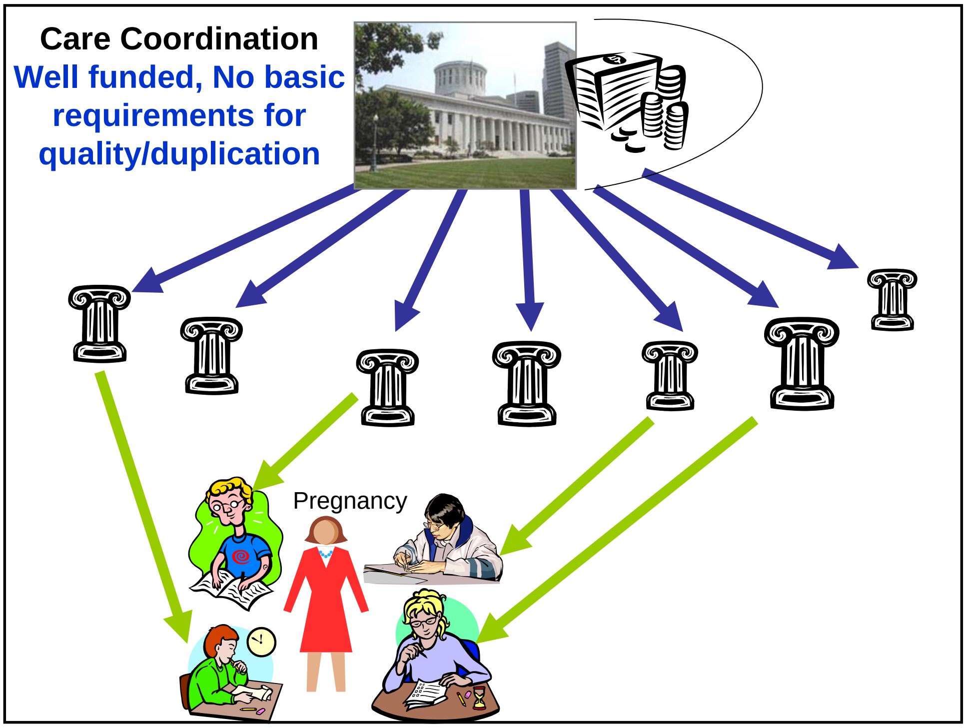
Meaningful Work Products

Not Meaningful

- On a list
- Phone call
- Hour of service
- Chart documentation

Meaningful

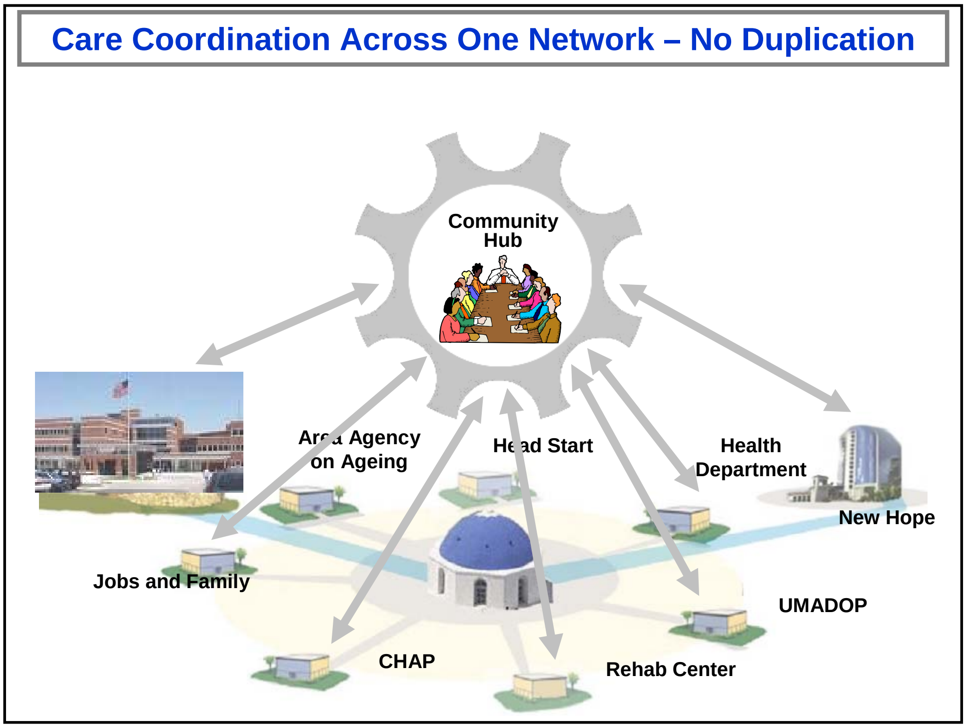
- Focus on at risk
- Evidence based intervention received
- Evidence based education received
- Housing, food clothing, education, employment received



Care Coordination

Well funded, No basic requirements for quality/duplication

Pregnancy



Care Coordination Across One Network – No Duplication

Community Hub

Area Agency on Ageing

Head Start

Health Department

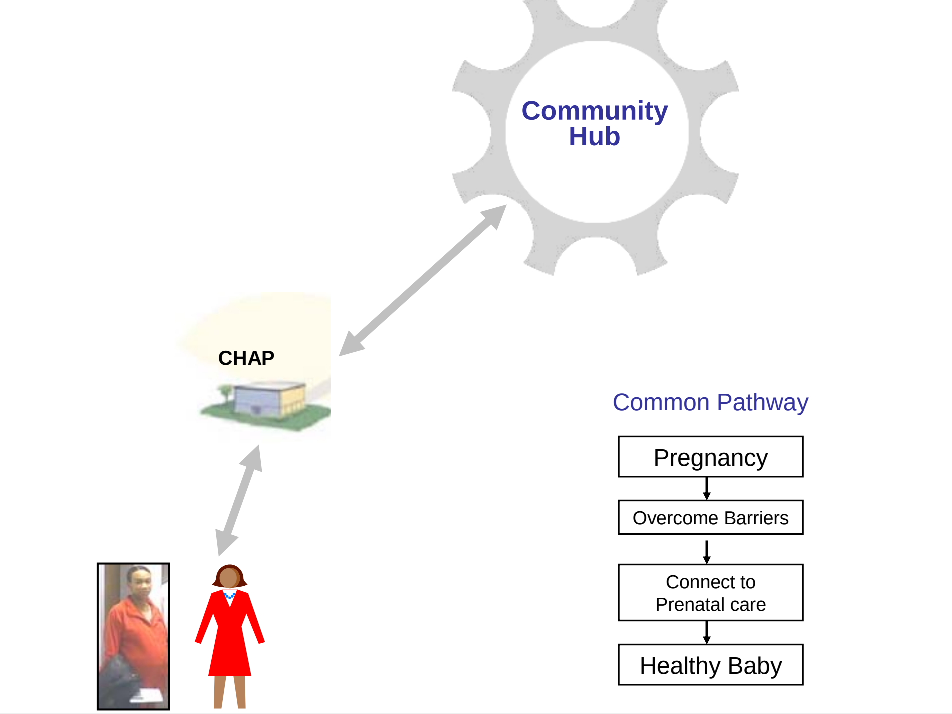
New Hope

Jobs and Family

UMADOP

CHAP

Rehab Center



Pathways Across the Community

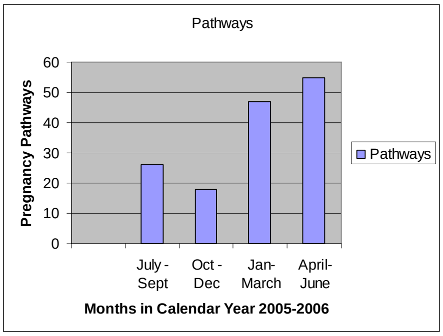
No Duplication

2004-2005

Contracting for Process

19 At Risk Served

2005-2006 –
Dollars tied to Performance
Duplication Removed
146 At Risk Served



Specific Steps to Begin

1. Establish Your Coalition
2. Define the Health and Social Conditions You Will Address
3. Define Those at Greatest Risk
4. Build your Pathways, Your Measures
5. Build your contracts, quality guidelines and measurement system
6. Throw the Switch and Measure and Improve

HEALTH EQUITIES COMMITTEE

Policy Recommendations "Straw-Person" on Improving the Health Care Workforce and Reducing Health Care Disparities

1. Expand educational institution capacity at health professional schools where more training opportunities are needed across the board from community college to university and postgraduate levels. Oregon's health care provider shortage is also challenged by the population's growing diversity and the need to provide culturally and linguistically competent care.

2. Increase financial aid in health professional schools for underrepresented in medicine (URM) students needing more financial aid of the right kind (grants, scholarships, loan forgiveness). Ultimately, our patients pay the price when there are insufficient providers from backgrounds similar to theirs. Geographic, economic, educational, and cultural factors, with their effects on patient mortality, underscore the critical need for providers from disadvantaged backgrounds and with superior cultural sensitivity training, to improve health care for the underserved throughout Oregon. As physicians, dentists, or mid-level providers, they will then be able to serve those who are now underserved, improving access to care. In addition, these individuals will function as role models for youth in their communities.

    a. Consider offering reduced tuition to Oregon residents pursuing careers at Oregon healthcare educational institutions.
    b. Consider loan forgiveness for providers who practice in underserved areas in Oregon or with underserved populations in Oregon.

3. Strengthen the pipeline to health profession schools; intervention needs to start early and focus on retention. Support mentoring program models that have been demonstrated to be effective in retaining students. We feel strongly that educational and experiential support in pre-college, college and in health professional schools (including allied health-care training programs) will enable more applicants from disadvantaged backgrounds to apply, gain admission and graduate into the healthcare workforce.

4. Recommendation 3 must include convening all entities that are currently working on pipeline development issues so that efforts are coordinated, streamlined, and strategic in planning for the future needs of Oregon's population.

    a. The Oregon Health Care Work-Force Institute would be ideally suited for the role of convener.

5. Improve the climate for diversity at individual health professional schools by mandating cultural (including sexual and gender minorities, persons with disabilities, and other vulnerable populations) and linguistic competence throughout the institution. This in turn will mean better patient satisfaction and medical

compliance, with decreases in morbidity and mortality related to chronic diseases in the long run. Economically, the decrease in disabling disease states translates into lower spending on health care, as well as increased income from a more productive workforce.

6. Establish accountability mechanisms to ensure diversity goals are reached in recommendation 4.

7. Support Community Health Worker programs that recruit and train members of underserved communities to provide culturally and linguistically competent health services within that community.

Health Equities Committee Policy Options for Linguistic and Cultural Models that Increase Health Equities.

Goal: To ensure health care services respectful of and responsive to the cultural and linguistic needs of Oregonians.

1. ***Take advantage of growing technological capacity in Oregon*** *by creating a state-wide pool of qualified and certified interpreters that may be able to utilize and build on technologies being developed for telemedicine.*
   - State wide pool would include partnerships including but not limited to hospitals, clinics, language bank companies, community services, etc.
   - Coordinate with statewide technology efforts, such as Telemedicine, to build future infrastructure for the statewide pool.
   - As an example, partners in the pool could pay according to their percentage of services used the prior year.

2. ***Seek federal matching funds for interpreter services through Medicaid*.**
   - Targets provider organizations that serve Medicaid patients by making interpreter services affordable.
   - Through a state plan amendment, make interpreter services a covered service rather than an administrative service.

3. ***Use state regulation to impose mandates with funds to off-set subsequent costs:***
   - Any plan that participates in the Oregon Health Fund Exchange must pay for interpreter services.

4. ***Create education partnerships so that more health professionals are also certified interpreters.***
   - May be able to utilize existing partnerships through the Health Care Workforce Institute or other existing groups that work toward certification of interpreters.
   - As much as possible, interpretation must be included in the health professional's job description, protecting the employee's time and reflecting their dual roles.

5. ***Mandate a minimum level of educational credits for healthcare providers that must earned in coursework specifically designed to increase cultural competence.***
   - This can be part of initial licensure or as part of continuing education.

Definitions based on the Healthcare Interpreter Oregon Administrative rules:

- "Limited English Proficient" (LEP) is a modifier used by the federal government to describe a person with limited English proficiency. "Person with limited English proficiency" means a person who, by reasons of place of birth or culture, speaks a language other than English and does not speak English with adequate ability to communicate effectively with a health care provider.
- "Health Care" means medical, surgical, or hospital care or any other remedial care recognized by state law, including mental health care.
- "Interpreter Services" is listening to a message of one language and providing an oral rendition of the same message in another language. An interpretation is to be complete and accurate and relay the meaning of the message from one language to the other, considering the context and the meaning of the whole phrase and not each word as if it were "standing alone" without context.
- "Health Care Interpreter" means a person who is employed as an interpreter working in health care who is readily able to communicate with a person with limited English proficiency and to accurately translate the written or oral statements of the person with limited English proficiency into English, and who is readily able to translate the written or oral statements of other persons into the language of the person with limited English proficiency. Health Care Interpreter further means any individual paid as an interpreter working in health services, including mental health. As used in this section, the term "employed" means anyone who performs or is utilized as a health care interpreter whether it be in an hourly or salaried position, contractor, volunteer, or intern

Recommendations from the Health Equities Committee

Policy Recommendations on Elements of the Medical Home and Primary Care Renewal that Reduce Health Disparities

1. Definition of Medical Home/Primary Care Home: A system of care that provides coordination of multiple, disparate elements of care for a patient. This does not assume that all care is provided within the walls of a clinic.

2. Elements of the Medical Home model that have been demonstrated to reduce health disparities and must be encouraged in any medical service organization purporting delivery of a Medical Home include:
    a. Patient Centered Care focus
        i. Extended office hours: evenings and weekends
        ii. Alternative access to providers such as telephone consultations and email exchanges.
        iii. Automatic reminders of recommended visit schedule and appointment times.
        iv. Mental Health and Chemical Dependency Integration
        v. Emphasis on chronic disease management and preventive care
        vi. Coordination with community based social organizations, peer support networks and organizations that integrate social determinants of health into care including public health as appropriate
    b. Population based care: The Medical Home should include systems to coordinate care of all patients in the practice outside of office visits.

3. For some populations, a medical home may be best provided outside of the traditional primary care service delivery system and a definition of medical home should not exclude organizations based on service-delivery type but should include coordination of care by a licensed medical provider.

4. The Medical Home needs to be integrated and viewed in the context of the social and education system, hospital and specialty care system and public health system in a community.

Community health workers: Integral members of the health care work force American Journal of Public Health Washington Aug 1995

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Abstract:

Community health workers can increase access to care and facilitate appropriate use of health resources by providing outreach and cultural linkages between communties and delivery systems; reduce costs by providing health education, screening, detection and basic emergency care; and improve quality by contributing to patient-provider communication.

Full Text:

Current national and state health care reform efforts have resulted in many proposals for restructuring the delivery and financing of care.(1) These efforts to rationalize and streamline the health care system have uncovered the need for a health care work force armed with the knowledge, skills, and attitudes to successfully implement change.(2) As health care delivery systems make primary and preventive care their principal organizing structures and are increasingly held accountable for health outcomes, they will be under pressure to identify and address nonfinancial barriers to care. This will require providers able to understand these barriers and to assimilate a variety of cultures, languages, and health beliefs into their practices.(3) To date, health work force reform initiatives have largely focused on the mix, training, and distribution of primary care providers.(3,4) An important but largely overlooked member of the health care work force is the community health worker.

Background

There is no single accepted definition of a community health worker or of any of the other titles commonly applied to lay health providers.(5-7) We define community health workers broadly as community members who work almost exclusively in community settings and who serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked access to adequate care. By identifying community problems, developing innovative solutions, and translating them into practice, community health workers can respond creatively to local needs.

The essential concept of community health work--empowering community members to identify their own needs and implement their own solutions--is not new in the United States.(8-12) During the 1960s, the federal government supported community health worker programs as a vehicle for expanding access to health care for underserved communities. Since 1968, the Indian Health Service has supported the only categorical community health worker program in states with large Native American populations.(11) Federal and state grants to community-based health programs continue to support community health worker programs. Legislation pending in Congress would authorize a new grant program to support community health worker programs in medically underserved areas.(13)

Limited data exist on the number, use, scope of work, and funding of community health worker programs in the United States. A variety of health promotion and medical care programs in this country have used lay or peer workers recruited from local communities. A recent national survey identified community health worker programs operating in every state (K. Clarke, written communication, August 1994). Historically, partnerships have formed with community-based care systems such as community and migrant health centers, homeless health care programs, and public health departments.(12) More recently, community health worker programs have developed partnerships with academic medical centers and managed care organizations(14-17) (S. Graham, written communication, October 1993).

The type and length of community health worker training depend on the range of services provided. Training periods vary from weeks to 6 or more months and usually combine lectures with supervised field experiences. Community health aides in Alaska, for instance, participate in a standardized curriculum to learn how to perform basic emergency care, provide patient education, and conduct prenatal and well-child checks.(11) Community health workers can be volunteers or paid workers. Typically, community health worker programs receive funding from multiple agencies, and these funds are used to support program management, instructor salaries, clerical services, and training materials.

Contributions of Community Health Workers in the United States

The contributions of community health workers to the delivery of primary and preventive care in the United States can be assessed by the impact of these individuals on health care access, quality, and cost.

Increasing Access to Health Care

As community, ethnic group, and family members, community health workers can translate health and system information into the community's language and value system.(6) Working largely in underserved areas and with high-risk populations, they can facilitate health care access through outreach, health promotion, and disease prevention services. Evaluations of maternal and child health programs have demonstrated that community health workers can successfully teach concepts of primary or secondary prevention and improve access to prenatal care.(18-23) They have been shown to effectively link mentally ill persons and those at risk for human immunodeficiency virus (HIV) infection to needed services.(24-26) At least one managed care organization has used community health workers to increase access to preventive care for its Medicaid enrollees.(14,15)

Improving the Quality of Care

Community health workers can facilitate community participation in the health system and educate providers about community health needs, cultural relevance, and outcomes of care.(6,9,11,12,16,17) With the community as their main constituency, they can also promote consumer protection and advocacy.

As part of a comprehensive team, community health workers can contribute to the continuity, coordination, and overall quality of care. Also, they can facilitate appointment keeping (14-18,21,22,27) and increase compliance with prescribed regimens.(14-18) Their role in health education and outreach can contribute significantly to increased detection of breast and cervical cancer,(28) improved childhood immunization rates,(20) decreased rates of infant mortality and low birth-weight,(18,19,21,23) hypertension control,(30) and smoking cessation.(24,29,31) In managed care settings, as mentioned earlier, community health workers have contributed to greater use of preventive and primary care services by Medicaid enrollees.(14,15)

Reducing the Costs of Care

Community health workers potentially offer a cost-effective mechanism to promote the appropriate use of health care resources. In comparison with other health care providers, they are relatively inexpensive to train, hire, and supervise.(6) Since many community health worker programs depend on volunteers, labor costs are further reduced. Most important, however, is the potential savings generated from the services community health workers can provide. As extensions of the primary care team, they can prevent unnecessary reliance on costly emergency department and specialty services.(14-16)

Broader Social Contributions

In addition to their direct role in health care, community health workers can further other social agendas by contributing to community empowerment and growth. Community health worker programs can enable low-skilled unemployed workers and welfare recipients to pursue a new occupation and career advancement. These programs could also be tied to national service programs and high school enrichment programs, allowing young people exposure to health careers. Community health worker programs can also assist health profession schools in better preparing their graduates for the realities of practice.(17)

Characteristics of Successful Community Health Worker Programs

Although no single community health worker model is applicable to all communities and circumstances, international and domestic studies have identified common characteristics of successful programs.(6,8,9,12,32-36) In these contexts, success has been measured by completion of program objectives, program sustainability, or impact on health care access, cost, and quality.

Community health worker programs should be based in, and should be reflective of, the community served. In practical terms, such programs should continually assess community health needs and demographics, hire staff from the community who reflect the linguistic and cultural diversity of the population served, and promote shared decision making among the program's governing body, staff, and community health workers. The curriculum should incorporate scientific knowledge about preventive and basic medical care, yet relate these ideas to local issues and cultural traditions. The programs should have established partnerships and referral protocols with community-based health and social service agencies. They should also provide opportunities for career mobility and professional development. Finally, sustained resources should be available to support the program.(6,8,9,12,32-36)

Barriers to the Expanded Use of Community Health Workers

The benefits of community health workers have primarily been recognized in connection with the needs of poor, underserved, minority, and high-risk populations. There are several important barriers that have contributed to the relative lack of use of such workers by the health care delivery system as a whole. First among these barriers is the lack of a standard definition and conceptualization of who community health workers are and what they do.(5) Although a single definition may not adequately capture the diversity among community health worker programs, consensus on a working definition is needed. Workers' varied scope of practice and level of training, as well as concerns about the quality of care they provide, must also be addressed.

The lack of legitimacy granted to community health workers by degreed health professionals is another barrier to the expanded use of these individuals. Concerns about the quality of care provided can stymie the development of community health worker programs. Furthermore, the media and popular culture often reinforce the dominant paradigm of professionalism in health care delivery.(37)

The lack of secure funding and dependence on multiple sources pose a continuous threat to community health worker programs and hinder their ability to conduct rigorous evaluations.(13) Until their value in other settings has been demonstrated, these programs will largely remain a province of community-based systems of care with explicit missions to serve such populations.

Recommendations for Strengthening and Expanding the Use of Community Health Workers

The current health care reform environment presents a valuable opportunity to acknowledge and capitalize on the contributions of community health workers. The following recommendations are intended to overcome barriers, build on program strengths, better integrate community health workers into the health care delivery system, and empirically document the contributions of they make.

In presenting these recommendations, we wish to warn policymakers about the potential risks inherent in building a formal infrastructure for community health worker programs. Although such support can offer financial and other securities, it can also threaten what makes community health workers unique and effective. The strength of the programs appears to be their flexibility to provide innovative solutions and adapt to changing community health needs and circumstances. Imposing rigid structures and restrictions may inhibit innovation and flexibility, thereby minimizing the effectiveness of programs.

Information Sharing and Technical Assistance

The experiences of existing programs should be disseminated to policymakers, health care delivery organizations, and developing programs. As an initial step, a national forum of community health worker programs would facilitate this exchange. A national clearinghouse would be an invaluable resource for tracking and cataloguing model programs, curricula in specific areas, potential funding sources, and program evaluations.

Program and Training Support

A community health worker/community partnerships grant program with funds from federal and/or private sources would expand and strengthen existing programs as well as create new ones. Funds could encourage innovative partnerships between communities and diverse health care delivery systems and be used to support staff, curriculum development, training, evaluation, and information dissemination. Community health worker programs could also serve as vital resources for recruiting community members into health-related careers.

Basic Research and Program Evaluation

Documenting the role that community health workers play in facilitating better access to health care, lowering health care costs, and improving health outcomes is essential to further defining the roles of these workers in a reformed health system. The federal government should fund basic research on community health workers, including randomized trials of community health worker interventions such as those currently being supported by the National Heart, Lung and Blood Institute and the National Center for Nursing Research (L. Bone, written communication, October 1993).

Continuing Education and Career Advancement

It is essential to provide community health workers with opportunities for continuing education, professional recognition, and career advancement. Access to educational scholarships and low-interest loans would help foster continuing education and career development.

Conclusion

In a health care system largely focused on acute care needs, the community-oriented approach of community health workers must not be overlooked as a strategy for expanding access, reducing costs, and improving quality. Community health workers have an important role to play as the health care system strives to function efficiently, encourage preventive and primary care, and accommodate previously underserved populations. An investment in new community health worker programs, technical and financial support to strengthen existing programs, and broad dissemination of the capabilities of community health workers are needed to expand their recognition and use as integral members of the health care workforce.

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Recognition and Support for Community Health Workers' Contributions to Meeting our Nation's Health Care Needs

The American Public Health Association,

Being aware that the formal participation of Community Health Workers (CHWs) in health and human services systems has been documented in the United States since the 1950s,[1,2] and that current estimates indicate more than 12,000 CHWs serving throughout the U.S. in a diverse array of cultural settings[3], in programs involving both volunteer and paid CHWs, utilizing many different titles, including Lay Health Advocate, *Promotor(a)*, Outreach Educator, Community Health Representative, Peer Health Promoter, and Community Health Outreach Worker; and,

Knowing that the roles of CHWs vary greatly, depending on the needs of the community being served, and that CHWs work in clinics, homes, community centers, and the streets, successfully addressing some of the most difficult health problems of our time, including the prevention of HIV/AIDS;[4] the treatment of tuberculosis;[5] helping pregnant and parenting women access early prenatal care;[6,7] promoting the timely use of immunization services;[8] increasing the utilization of cancer screening services;[9,10] aiding families in managing childhood asthma;[11] and, detecting and preventing lead poisoning;[12] and successfully building community capacity;[13,14] and

Knowing that, due in part to their status as members of the community in which they work, CHWs effectively bridge sociocultural barriers between community members and the health care system;[15,16,17] and,

Recognizing that CHWs, through the National Community Health Advisor Study, identified seven core roles of their work,[18] which are:

- Bridging cultural mediation between communities and health and social service systems
- Providing culturally appropriate health education and information
- Assuring people get services they need
- Providing informal counseling and social support
- Advocating for individual and community needs
- Providing direct service, such as basic first aid and administering health screening tests
- Building individual and community capacity; and

Understanding that while diversity and flexibility to serve unique communities' needs are a strength of CHWs, the lack of a standard definition of who CHWs are, also contributes to their lack of recognition; and,

Understanding that, while individual CHWs are doing innovative work, the lack of cohesion among CHW programs, linked to the varied settings and issues in which CHWs work, and the instability of funding for CHW programs, tends to undermine the ability of CHWs to achieve their full potential; and,

Knowing that while operating independently under various funders' mandates, CHWs have not easily shared such resources as training curricula and evaluation methods, and that CHW evaluations are frequently poorly designed and implemented due to limited funds, inadequate skills, and the lack of time needed to show results, leading to difficulty documenting the contributions CHWs make to improving health and utilization of services; therefore,

1. Urges all health and human service professionals to recognize the skills and unique attributes that both volunteer and paid CHWs bring to their work;
2. Urges CHWs and their advocates to: (a) develop a definition of the roles and functions of CHWs that clarifies the relationships to and distinctions from other professionals in health and human services; and (b) work with the Department of Labor to develop a definition of CHWs;
3. Encourages traditional and non-traditional educational institutions to develop and support effective training curricula for CHWs and their supervisors that link to defined core roles and competencies;
4. Urges federal, state, local, tribal public health and aging agencies, as well as private providers and payors to institute permanent funding streams for CHWs;
5. Urges the U.S. Congress to recognize the work of CHWs in meeting our most troubling health concerns and appropriate funds to support CHWs;
6. Urges public health professionals to include CHWs in efforts to establish a public health credentialing process;
7. Encourages national policy makers to support meaningful evaluation of CHW programs, with CHWs leading such evaluation efforts; and,
8. Urges local, state, tribal and national CHW organizations and advocacy groups to join together with CHWs at the helm, to promote visibility of CHWs and create a unified voice for the CHW field.

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Sources and Resources for the Community Health Worker/*Promotor/a* Model

Roles and Competencies of CHWs

Based on interviews and focus groups with CHWs and CHW program coordinators, the National Community Health Advisor Study identified the following roles, skills, and qualities of CHWs.

Roles of CHWs

- Cultural mediation
- Health education
- Building capacity
- Social support
- Advocacy
- Connection to resources
- Direct service
  (screenings and material aid)

Skills of CHWs

- Communication Skills
- Interpersonal Skills
- Teaching skills
- Service Coordination Skills
- Advocacy Skills
- Capacity-Building Skills
- Knowledge Base
- Organizational Skills

Qualities of CHWs

- Membership in or shared experience with the community being served
- Personal strength and courage
- Friendly, outgoing, sociable
- Patient
- Open-minded/non-judgmental
- Motivated and capable of self-directed work
- Caring, compassionate
- Empathetic
- Committed/dedicated
- Respectful
- Honest
- Open/eager to grow,/change/learn
- Dependable, responsible, reliable
- Flexible and adaptable
- Desire the help the community
- Persistent
- Creative/resourceful

A summary of the findings of the Roles and Competencies chapter of the National Community Health Advisor Study is available on video by calling Noelle Wiggins at (503) 988-3663, x26646.

See also: Love, MB, Gardner, K, Legion, V (1997). Community Health Workers: Who they are and what they do. A regional labor market study – survey of eight counties in the San Francisco Bay Area, 1996. *Health Education and Behavior* 24 (4):510-522.

Demonstrated Outcomes of Community Health Worker Programs

Despite lack of long-term funding for CHW programs and lack of adequate funding for CHW research, a substantial and growing body of literature regarding CHW outcomes does exist. Demonstrated outcomes of CHW programs include improved utilization management; increased access to preventive care; improved compliance with prescribed care; preventive health education and behavior change; successful chronic disease management; reduced costs of care; and community and individual mobilization and empowerment.

See Wiggins, N (1997). *Demonstrated Outcomes of Community Health Worker Programs* (copy provided).

Training and Capacitation[1] of Community Health Workers

Before 1990, most CHW training was provided on-the-job by the CHW's employer. Length and quality of the training varied tremendously, and most training conferred no academic credit or credential, so was not portable when CHWs moved to new jobs. For these reasons, during the last twenty years there has been a movement in the CHW field toward the development of training centers. CHWs from around a geographic area can come to the centers to participate in training, which increasingly confers academic credit and/or a credential. At the centers, CHWs also develop the networks of support that are crucial for all professionals.

Training and Capacitation Centers and Programs (very partial 2002 listing)

- Community Capacitation Center, Multnomah County Health Department, Portland, Or. (Contact: Noelle Wiggins, (503) 988-3663, x26646.)
- Community Health Education Center (CHEC), Boston City Health Dept., Boston, Mass. (Contact: (617) 534-5485.)
- Community Health Works, San Francisco, CA. (Contact: Cindy Tsai, (415) 338-3034; www.communityhealthworks.org.)
- Project Jump Start, Tucson, Arizona. (Contact: Mark Homan, Pima Community College, (520) 206-6958.)

Efforts to Promote the CHW Model and Support CHWs

- **American Public Health Association (APHA) Community Health Worker Special Primary Interest Group (SPIG)**: Its mission is to advocate for the interests of CHWs within the public health field.
- **Center for Sustainable Health Outreach (CSHO):** A partnership of The University of Southern Mississippi and the Harrison Institute for Public Law at Georgetown University Law Center. CSHO supports model community health worker programs by offering technical support and serving as a repository of information related to community health worker programs.
- **Community Health Worker Network of New York City:** "The Community Health Worker Network of NYC is a collaborative organization providing a forum for networking opportunities, the sharing of resources and the expansion of the community health worker field. The network promotes dialogue among community health workers so that we may develop a collective voice to inform policy issues relevant to our practice**."** Contact: http://www.chwnetwork.org.

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[1] The word "capacitation" comes from the Spanish word, "capacitar,"which means "to build capacity." It s use indicates that trainers seek to build on participants' existing capacity using Popular Education methodology.

- **Massachusetts Community Health Worker (MACHW) Network:** MACHW is **"**a statewide network of community health workers (CHWs) from all disciplines. We were founded in March 2000 to enable CHWs to lead the movement to organize, define and strengthen the profession of community health work." For more information, visit: http://www.mphaweb.org/MACHW.htm

<u>CHW Legislation</u> (partial listing)

- **Community Health Advisor Act of 1994 (H.R. 2245)**: Proposed in 1994 by Representative Bernie Sanders of Vermont. Would have provided funding for CHW programs in all U.S. states. The Act did not pass, but it brought together CHWs and CHW advocates from around the country.
- **Oregon Senate Bill 791:** Introduced into the Oregon Senate in 2001 by Sen. Avel Gordly. Would have created a "State Board of Community Health Workers in the Health Licensing Office" and authorized "payment for services of certified CHWs by medical assistance programs." Was introduced in a packet of related bills; was not brought forward to the Senate floor.
- **Texas Senate Bill 1051:** Enacted in May 2001, it "directed the Texas Department of Health (TDH) to develop and implement a promotor(a) or community health worker (CHW) training and certification program. This program will assure promotores(as) or CHWs meet minimum standards and have adequate guidelines to carry out their duties. The program will be voluntary for promotores(as) who do not receive compensation for their service and mandatory for promotores(as) who are financially compensated for the services they provide" (SB 1051). For more information, see: http://www.dshs.state.tx.us/chpr/chw/default.shtm
- **Community Health Workers Act of 2002:** Introduced by Sen. Jeff Bingaman of New Mexico. Would have amended the Public Health Service Act "to provide grants to promote positive health behaviors in women."
- **The Patient Navigator, Outreach, and Chronic Disease Prevention Act of 2005 (H.R. 1812):** Signed into law by Pres. Bush on June 29, 2005, the Act was designed to help eliminate health disparities by allocating $25 million in grants between 2006 and 2010. Patient navigators are described in the Act as people "who have direct knowledge of the communities they serve." Among the responsibilities assigned to patient navigators are: "assisting in the coordination of health care services and provider referrals; facilitating the involvement of community organizations in assisting individuals who are at risk; notifying individuals of clinical trials; helping patients to overcome barriers within the health care system; and conducting ongoing outreach to health disparity populations, including the uninsured, rural populations, and other medically underserved populations" (H.R. 1812).

<u>Reports, Policy Research Studies, and Policy Statements</u>

- American Public Health Association (2001). *Recognition and Support for Community Health Workers' Contributions to Meeting our Nation's Health Care Needs*. A policy statement approved at the annual conference of APHA. Copy provided.

- Rosenthal, EL, Wiggins, N, Brownstein, N, Johnson, S (1998). *The Final Report of the National Community Health Advisor Study*. Baltimore: Annie E. Casey Foundation. Brought together information and made recommendations about four areas of CHW policy and practice: roles and competencies of CHWs, evaluation of CHW programs, roles of CHWs in managed care organizations, and career advancement for CHWs.
- Koch, E, Keegan, P, Johnson, S (1997). *Community Health Workers: Meeting the needs of people in a changing health care system.* Washington, DC: The Opening Doors Program of the Robert Wood Johnson Foundation. Focuses on the potential role of CHWs within managed care organizations.
- Oregon Public Health Association (1994, revised 1999). *Community Health Worker Position Paper.*
- Centers for Disease Control and Prevention (1994). *Community Health Advisors: Models, Research and Practice (Selected Annotations – United States) Volume I.* Atlanta: U.S. Dept. of Health and Human Services.
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- Centers for Disease Control and Prevention (1998). *Community Health Advisors/Workers: Selected Annotations and Programs in the United States, Volume III.* Atlanta: U.S. Dept. of Health and Human Services.
- Pew Health Professions Commission (1993). *Community Health Workers: Essential But Often Overlooked Members of the Health Care Work Force.* A report presented to the Presidential Health Care Task Force, at the request of the Task Force.

Introduction to the Community Health Worker/Promotor/a Model

Teresa Rios and Noelle Wiggins

Objectives

By the end of the presentation, participants will know more about:

- The historical roots of the CHW model
- Roles and competencies of CHWs
- Recent developments in the CHW field
- The unique contribution can CHWs make to reducing health inequities

Agenda

■ Introduction	Noelle
■ The term “CHW”	Tere
■ Who are CHWs?	Noelle
■ History of the CHW model	Tere
■ Roles and skills of CHWs	Noelle
■ Demonstrated outcomes	Noelle
■ Recent developments	Tere

Teresa Rios

- Promotora with the El Niño Sano Project, 1988-1991
- Promotora with the La Familia Sana Project, 1991-1994
- Co-founded Oregon Public Health Association CHW Committee, 1994
- Project Coordinator for the Madres en Marcha Project, 1992-1995
- Helped to design and manage the La Comunidad Sana Project, 1995-1998
- Advisory Board of the Natl. Community Health Advisor Study, 1995-1997
- Chair of the APHA CHW Special Primary Interest Group, 2001-2003.

Noelle Wiggins

- Trained and supported CHWs in a rural, conflictive area of El Salvador, 1986-1990
- Directed the La Familia Sana Program, 1990-1995
- Assoc. Dir. of the Natl. Community Health Advisor Study, 1995-1997. Co-authored chapter on Roles and Competencies of CHWs.
- Initiated and managed the Poder es Salud/Power for Health Project, 2002-2005. This CBPR project funded by the CDC investigated whether CHWs who used popular education could successfully promote health and reduce health disparities in the African American and Latino communities.

What is one thing you know or have heard about CHWs?

Community Health Worker

(Rios and Wiggins, 1997)

- Community Health Workers are carefully chosen community members who participate in training so that they can promote health in their own communities.
- Communities can be defined by race/ethnicity, age, sexual orientation, geography, disability status, or other factors.

Community Health Worker

(APHA CHW SPIG 2005)

A frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison . . . between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.

What caught your attention in the radio play?

Qualities of Community Health Workers (Wiggins & Borbon, 1997)

- Membership in or shared experience with the community being served
- Personal strength and courage
- Friendly, outgoing, sociable
- Patient
- Open-minded/non-judgmental
- Motivated and capable of self-directed work
- Caring, compassionate
- Empathetic

Qualities of Community Health Workers

- Committed/dedicated
- Respectful
- Honest
- Open/eager to grow,/change/learn
- Dependable, responsible, reliable
- Flexible and adaptable
- Desire the help the community
- Persistent
- Creative/resourceful

Skills of Community Health Workers

- Communication Skills
- Interpersonal Skills
- Teaching skills
- Service Coordination Skills
- Advocacy Skills
- Capacity-Building Skills
- Knowledge Base
- Organizational Skills

Roles of Community Health Workers

- Cultural mediation
- Health education
- Building individual and community capacity
- Informal counseling and social support
- Advocacy
- Connection to resources
- Direct service (e.g. screenings, material aid)

Demonstrated outcomes of CHW programs

- Improved utilization management
- Increased access to preventive care
- Enhanced patient-provider communication
- Improved compliance with prescribed care
- Preventive health education and behavior change
- Chronic disease management
- Enhanced social support
- Improved understanding within the health care system about community norms and needs
- Addressing the social determinants of health

Recent developments in the CHW field

Thank you!

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American Public Health Association

135th Annual Meeting & Exposition
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Community Health Worker
Special Primary Interest Group

Meeting Program

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Scientific Sessions

Sunday, November 4, 2007

Innovative Community Health Worker Models Poster Session
4:30PM - 5:30PM. (2046.0): WCC Exhibit Halls D/E

Monday, November 5, 2007

New and Emerging Roles for CHWs, including Researchers, Patient Navigators, and Trainers
8:30AM - 10:00AM (3022.0): Marriott Metro Center Salon E

Other Issues of Importance to CHW Poster Session
10:30AM - 11:30AM (3085.0): WCC Exhibit Halls D/E

Documenting Outcomes and CHW Program Evaluation
12:30PM - 2:00PM (3210.0): Marriott Metro Center Salon C

Tuesday, November 6, 2007

New National, Local, and State Issues that Affect CHWs
8:30AM-10:00AM (4018.0): Marriott Metro Center Salon E

CHWs as Integral Members of the Health Care Delivery Team (Roundtable)
12:30PM-2:00PM (4121.0): Marriott Metro Center Salon B

Policy and Practice Issues Relevant to the Training of Community Health Workers
2:30PM-4:00PM (4208.0): WCC 152A

Politics, Policy, & Public Health
2:30PM-4:00PM (4209.0): Marriott Metro Center Salon A

Research and Policy on Community Health Workers: Making the Connection
4:30PM-6:00PM (4299.0): WCC 154A

Wednesday, November 7, 2007

What External and Internal Support Mechanisms Are in Place for CHWs
8:30AM-10:00AM (5039.0): Marriott Metro Center Salon C

Research and Policy Issues Important to CHWs
12:30PM-2:00PM (5103.0): Marriott Metro Center Montreal I

Business Meetings and Social Reception

All meetings listed below are open. Please plan on attending.

Monday, November 5, 2007
CHW Program Planning Meeting
6:30 AM-8:00AM (290.0): Marriott Metro Center Montreal I

Education Y Capacitaciốn Committee Meeting
4:00PM-6:00PM: Marriott Metro Center Lobby

Community Health Workers SPIG Social Hour
Special Event: Official Release
Report on a Proposed National Research Agenda on the CHW Field

6:30 PM-8:00 PM (330.0): Marriott Metro Center Salon E

Tuesday, November 6, 2007
CHW Policy Committee Meeting
6:30PM-8:00PM (403.0): Marriott Metro Center Executive Boardroom

Wednesday, November 7, 2007
General CHW Business Meeting
6:30 AM-8:00 AM (424.0): Marriott Metro Center Executive Boardroom

◆

Who are Community Health Workers?

The Community Health Worker Special Primary Interest Group of the American Public Health Association's (CHW SPIG of APHA) submitted the following definition to the Standard Occupational Classification Policy Committee at the Bureau of Labor Statistics in 2005. We hope that this definition will serve as a foundation for development, policy, and advocacy for the CHW field.

> A Community Health Worker (CHW) is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.

Patient Satisfaction with Different Interpreting Methods: A Randomized Controlled Trial

Francesca Gany, M.D., M.S.[1], *Jennifer Leng, M.D., M.P.H.*[1], *Ephraim Shapiro, M.B.A., M.P.A.*[1], *David Abramson, Ph.D., M.P.H.*[2], *Ivette Motola, M.D., M.P.H.*[3], *David C. Shield*[4], *and Jyotsna Changrani, M.D., M.P.H.*[1]

[1]Center for Immigrant Health, Department of Medicine, New York University School of Medicine, New York, NY, USA; [2]Columbia University Mailman School of Public Health, New York, NY, USA; [3]Jackson Memorial Medical Center, University of Miami, Coral Gables, FL, USA; [4]Yale University School of Medicine, New Haven, CT, USA.

BACKGROUND: Growth of the foreign-born population in the U.S. has led to increasing numbers of limited-English-proficient (LEP) patients. Innovative medical interpreting strategies, including remote simultaneous medical interpreting (RSMI), have arisen to address the language barrier. This study evaluates the impact of interpreting method on patient satisfaction.

METHODS: 1,276 English-, Spanish-, Mandarin-, and Cantonese-speaking patients attending the primary care clinic and emergency department of a large New York City municipal hospital were screened for enrollment in a randomized controlled trial. Language-discordant patients were randomized to RSMI or usual and customary (U&C) interpreting. Patients with language-concordant providers received usual care. Demographic and patient satisfaction questionnaires were administered to all participants.

RESULTS: 541 patients were language-concordant with their providers and not randomized; 371 were randomized to RSMI, 167 of whom were exposed to RSMI; and 364 were randomized to U&C, 198 of whom were exposed to U&C. Patients randomized to RSMI were more likely than those with U&C to think doctors treated them with respect (RSMI 71%, U&C 64%, $p<0.05$), but they did not differ in other measures of physician communication/care. In a linear regression analysis, exposure to RSMI was significantly associated with an increase in overall satisfaction with physician communication/care (β 0.10, 95% CI 0.02–0.18, scale 0–1.0). Patients randomized to RSMI were more likely to think the interpreting method protected their privacy (RSMI 51%, U&C 38%, $p<0.05$). Patients randomized to either arm of interpretation reported less comprehension and satisfaction than patients in language-concordant encounters.

CONCLUSIONS: While not a substitute for language-concordant providers, RSMI can improve patient satisfaction and privacy among LEP patients. Implementing RSMI should be considered an important component of a multipronged approach to addressing language barriers in health care.

KEY WORDS: immigrant health; satisfaction; language.
J Gen Intern Med 22(Suppl 2):312–8
DOI: 10.1007/s11606-007-0360-8

BACKGROUND

Growth of the foreign-born population in the United States has led to increasing numbers of limited-English-proficient (LEP) patients. The LEP population (defined as speaking English less than very well) increased from 14 million in 1990 to 21.4 million in 2000.[1] Language discordance between patients and their medical providers is a major factor impeding effective provision of health care.[2–10]

Communication barriers can adversely affect health services access, health outcomes, and patient satisfaction.[2,3,11,12] LEP patients are less likely to have a usual source of medical care[4] and have lower utilization of preventive services,[5,6] higher usage of unnecessary diagnostic testing,[7] and worse adherence with medical advice[9] and follow-up care.[8] Baker et al. showed that Latino patients in emergency care who were unable to get an interpreter were less satisfied with their providers.[13] Dissatisfied patients are less likely to follow their medical regimens,[11,14–16] whereas satisfaction appears to have a positive impact on clinical outcomes[17–20] and continuity of care.[21–24]

No studies have sufficiently examined how patient satisfaction varies by interpreting method. Medical interpreting can be either consecutive or simultaneous. In consecutive interpreting, the interpreting occurs after the speaker has completed speaking,[25] necessitating that the speakers pause for the interpreter. In simultaneous interpreting, the interpreter interprets at the same time as s/he is hearing the original speech.[25] Interpreting can also be proximate or remote. Proximate interpreting involves an interpreter who is physically present at the encounter. In remote interpreting, the interpreter is outside the room of the encounter. Medical interpreting is usually proximate consecutive (PCMI) or over-the-telephone consecutive [remote consecutive medical interpreting (RCMI)]; less commonly utilized is the newer method of remote simultaneous (so-called United Nations-style) medical interpreting (RSMI).

RSMI has not yet been widely utilized, as it has only recently been made commercially available. Currently, the service is being provided to three hospitals and their satellite facilities in New York City. RSMI is similar to a voice-over; the interpretation is provided within milliseconds of the original speech. The trained medical interpreters are located remotely and communicate via wireless headsets with microphones worn by the provider and the patient. The wireless headsets and microphones offer mobility to the patient and provider but are not necessary. The same interpreting method can be accomplished using two regular phone lines. The current wait time to be connected is comparable to any commercially available telephone service (RCMI), as are the per-minute rates. Privacy is potentially increased because of the remote, audio-only, nature of the interpreting method.

Regardless of the interpreting method, use of professionally trained interpreters yields higher patient satisfaction than use of nonprofessionals.[26–28] An earlier randomized controlled study of RSMI, involving families during a well-baby visit, showed high levels of satisfaction with this interpreting method.[25] Patients were randomized to either RSMI or PCMI for the initial visit and then alternated experimental and control methods in four follow-up visits. An exploratory study that compared patient satisfaction across professional interpreting services found that, generally, patients were most satisfied when the interpreting method was perceived to decrease waiting time and delay.[29] Patients indicated higher satisfaction with the increased sense of privacy conveyed by RSMI but dissatisfaction when technical glitches occurred.

As the health care system decides how to best spend its limited medical interpreting dollars, studies evaluating patient satisfaction, effectiveness, and costs of the various methods are needed. RSMI, by virtue of its simultaneous nature, has the promise to provide a more efficient form of interpreting, but there is a lack of adequate data with regard to patient satisfaction. This study, to our knowledge the first randomized controlled trial of RSMI in adult care, addresses this knowledge gap.

METHODS

This trial was conducted at the primary care clinic and the urgent care center of the emergency department (ED) at a large New York City municipal hospital. More than half of the hospital's patients prefer to communicate in languages other than English. Spanish, Mandarin, and Cantonese are the most widely spoken languages. Approval for this study was obtained from both the New York University School of Medicine Institutional Review Board and the Hospital Center Research Protocol Group.

Participants

Primary care clinic patients were recruited between November 2003 and June 2005. Eligible patients were all English-, Spanish-, Mandarin-, and Cantonese-speaking adults (over 18 years old) who presented between the hours of 9 A.M. and 5 P.M. Patients were only eligible to enroll in the study if they were new patients being seen for the first time at the clinic. ED patients were recruited between October 2003 and December 2004. Eligible ED patients were all English and Spanish speaking adults who presented between 9 A.M. and 5 P.M. with symptoms of lower back pain, urinary-tract infection, sore throat, ear pain, or musculoskeletal pain. Patients with these conditions were more likely to be treated in urgent care (rather than critical care) and therefore more likely to be able to fully participate.

Eligible patients were identified by trained bilingual research assistants prior to their encounters with the provider. Bilingual research assistants determined Spanish or Chinese concordance by asking patients if they preferred an interpreter for their medical visit that day. This question was first asked in English, then in Mandarin, Cantonese, or Spanish, to ensure the patient understood the question. If a patient stated that he/she was comfortable speaking English, the patient encounter was categorized as language-concordant, and the patient was not randomized to an interpreting method. Non-English-speaking patients who were scheduled to see providers fluent in their primary language, determined by provider self-assessment, were also deemed language-concordant and not randomized. All study participants consented to voluntary, uncompensated participation.

Study Procedure and Measures

This study investigated patient satisfaction with RSMI, the experimental method, compared with usual and customary (U&C) interpreting methods. RSMI interpreters participate in a 60 hour simultaneous medical interpreting training conducted by the Center for Immigrant Health at New York University School of Medicine. U&C methods included PCMI and RCMI. PCMI methods included both trained interpreters (e.g., hospital interpreter services) and ad hoc interpreters (i.e., family, friends, untrained hospital staff, and volunteers). The RCMI method used by study participants was a commercial language line accessed via a landline telephone.

Language-discordant encounters were randomized to RSMI or U&C interpreting, using SPSS v.12 for Windows. We selected several variables to stratify the randomization according to expected variability and strong association with our outcomes of interest. Primary Care Clinic patients were stratified by primary language (Spanish, Mandarin, or Cantonese), health insurance coverage (yes or no), and English fluency. ED patients were stratified by English fluency and insurance coverage. English fluency was determined using the question "How well do you speak English?",[30] and responses were grouped into two categories "very well"/"well" and "not well"/"not at all". Patients and providers were not aware of allocation, and research assistants were required to call the central study office to determine allocation each time a new patient was enrolled. Providers were informed of patient participation, and their consent was obtained. Research assistants gave the physician a set of RSMI headsets if the patient was randomized to RSMI. If a patient was randomized to U&C, the physician selected an interpreter, or decided not to use one, as he/she usually would. He/she called the hospital interpreter service, called the commercial over-the-telephone interpreting service, found an ad hoc interpreter, or proceeded with the encounter without an interpreter.

An 80-item demographic questionnaire was administered to all study patients prior to their encounters with the provider. After their medical encounters, participants were surveyed by a bilingual research assistant on their satisfaction with their provider, medical care, and interpreter and interpreting method (if used). Data were also collected on the actual method of interpretation received, and, if the interpreting method allocated by randomization was not used, the reasons why. All patient study interviews were conducted in the patients' primary language by bilingual interviewers using study instruments in that language.

To assess satisfaction with physician communication/care, patients were asked (yes/no) if physicians listened to them carefully, if time spent with physicians was adequate, and if they would recommend their physician to a friend. They rated on a four-point scale how well they thought their physicians understood them, understanding of physician instructions and explanations, and overall quality of medical care. They rated on a five-point scale the level of respect from the physician and overall physician care. For satisfaction with interpretation, patients were queried on a four-point scale about how well the interpreter understood them, how well the interpreter interpreted, and how well patient privacy was protected by the interpreting method. They were asked via a five-point scale about the level of respect from the interpreter. Patients were also queried (yes/no) about whether the interpreter listened to them carefully, whether they would recommend the interpreter used during the visit to a friend, and if they would recommend the method of interpretation to a friend. Where questions involved responses along a scale, a four- or five-bar graph was presented to patients with bars of different heights for each response. This enabled patients to visualize the interval between response choices.

Statistical Analysis

Analyses were performed according to the interpreting method to which the patient was randomized (intent-to-treat analysis) and according to the interpreting method the patient actually received (analysis of actual interpreting method received). The Chi-square test was used to test for sociodemographic differences between (a) the randomized groups (RSMI and U&C) to establish the validity of the randomization process, (b) the two randomized arms and the language concordant group to determine whether there were other factors that differed across groups, and (c) the five groups in the analysis of actual interpreting method received (RSMI, U&C trained interpreters only, U&C untrained interpreters, English concordant, and non-English concordant).

As in other patient satisfaction studies,[31] our results were generally skewed towards the higher end of a scale. We therefore grouped all responses other than the highest level together. The Chi-square test was used to test for statistical significance; the Fisher's exact test was used when cell sizes were less than 5.

To create multi-item satisfaction scales to efficiently test the impact of interpreting method, a factor analysis was conducted using the 16 satisfaction items. The factor analyses were run on all 16 items together and separately on those items specific to physicians (nine items) and interpreters (seven items). Two prominent factors were identified, one specific to interaction with the physician and one to interpreter interactions. The composite score for satisfaction with physician communication/care combined five items (How well did you understand your doctor's explanation of medical procedures and test results? How well did you understand your doctor's instructions about follow-up care? How would you rate your doctor in treating you with respect?

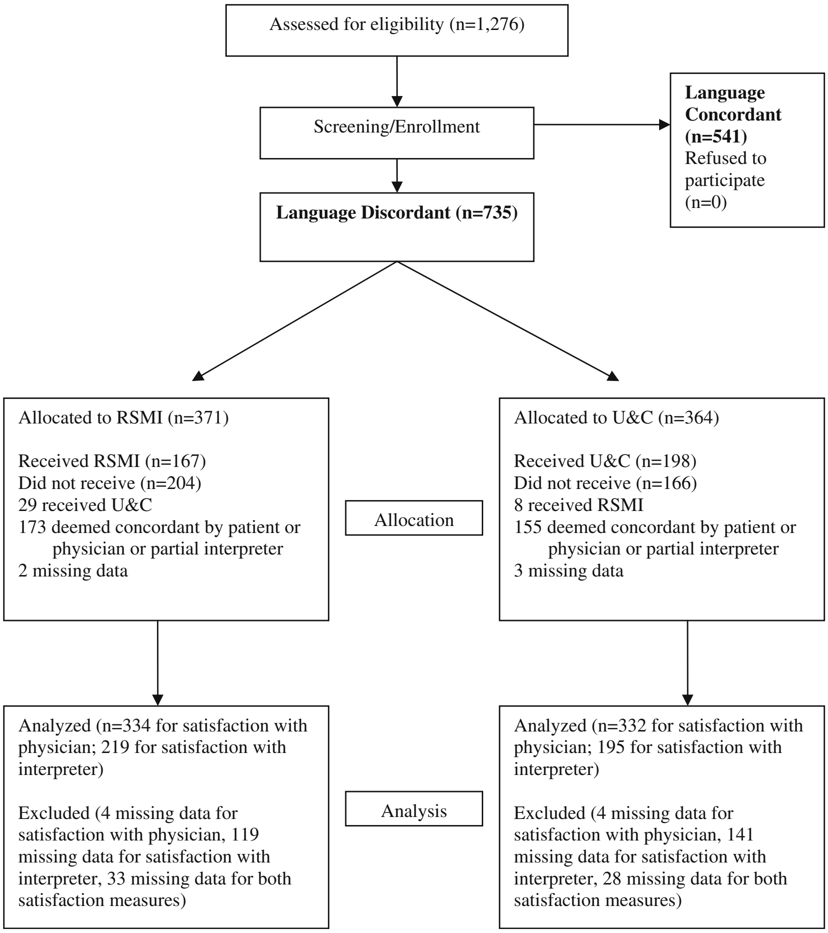

Figure 1. Flowchart: patient enrollment, randomization, and analysis

How would you rate your doctor overall? Overall how satisfied are you with the quality of your medical care today?), which had a Cronbach's alpha coefficient of 0.7692.

Similarly, the composite interpreter score combined four items (How well do you think your interpreter understood you? How would you rate your interpreter in treating you with respect? How well did the interpreter interpret your visit with the doctor? How well do you think this method of interpretation protected your privacy during this visit?), which had a Cronbach's alpha coefficient of 0.7394. Physician or interpreter composite scores were considered missing if two or more questions in the four- or five-item scale were missing. Composite scores were created as sums of individual item scores divided by the highest possible sum (range 0–1). A maximum of one item was permitted to be missing; score denominators were the sum of highest possible scores for all nonmissing items.

In the intent-to-treat analysis of satisfaction measures, RSMI was compared with U&C. In the analysis of actual interpreting method received, the three groups that were compared were RSMI, U&C (trained interpreters only), and language concordant. The U&C untrained group was excluded to avoid biasing the results towards RSMI, which was administered by trained interpreters only.

Linear regression analyses were performed on both composite satisfaction scores. If a given case was missing data for one of the covariates in the regression, it was dropped from the analysis. Regression analyses were performed using both the category of interpreting method to which the patient was randomized (intent-to-treat analysis) and as the category the patient actually received during the encounter (analysis of actual interpreting method received). The conventional $p<0.05$ significance level was used.

RESULTS

Among 1,276 patients screened for enrollment in the randomized controlled trial, 541 were deemed by our protocol to be language-concordant with their provider and, hence, were not randomized to either interpreting method (Fig. 1). Among the 371 who were randomized to RSMI, 167 (45%) actually received RSMI; among the 364 patients randomized to U&C, 198 (54%) actually received U&C. Most of those who did not receive their randomized interpreting method were deemed language-concordant by the treating physician (either the patient spoke English or the physician spoke Spanish, Mandarin, or Cantonese), and consequently proceeded without an interpreter. Interpreter satisfaction data for these patients were not collected.

Randomized patients were mostly younger than age 65, had not completed high school, had resided in the U.S. for 10 years or less, spoke primarily Spanish or English, and had "good" to "fair" self-reported health status. There were no significant differences in sociodemographic characteristics between the randomized groups (Table 1). Sociodemographic characteristics of patients by actual interpreting method received [RSMI ($n=175$), U&C trained interpreters ($n=165$), U&C untrained ($n=185$), English-concordant ($n=460$), non-English-concordant ($n=291$)] differed in that English-concordant patients were more highly educated (54% were college-educated vs. 26–39% in the other groups, $p<0.05$) and more likely to report "excellent" or "good" health status (57% vs. 29–34% in the other groups, $p<0.05$).

Table 1. Sociodemographic Characteristics of Enrolled Patients—ED and Primary Care Clinic, Randomized and Language Concordant, *n* (%)

	Randomized Patients ($n=735$)		Language-Concordant Patients ($n=541$)
	RSMI ($n=371$)	U&C ($n=364$)	
Gender			
Female	208 (56)	197 (54)	244 (45)*
Male	155 (42)	162 (45)	280 (52)
Age			
17–34	138 (37)	124 (34)	216 (40)
35–64	198 (53)	204 (56)	287 (53)
65+	16 (4)	18 (5)	15 (3)
Education			
<8th	73 (20)	65 (18)	45 (8)*
<HS	110 (30)	111 (30)	73 (13)
HS Grad	52 (14)	55 (15)	112 (21)
College	113 (30)	114 (31)	271 (50)
Years in U.S.			
<1	9 (2)	13 (4)	8 (1)*
1–5	144 (39)	113 (31)	65 (12)
6–10	68 (18)	73 (20)	69 (13)
11+	128 (35)	140 (38)	143 (26)
U.S.-born	4 (1)	4 (1)	125 (23)
Primary language			
Spanish	278 (75)	260 (71)	162 (30)*
Chinese	70 (19)	86 (24)	41 (8)
English	3 (1)	2 (1)	289 (53)
Fluency (speaks English...)			
Very well	0 (0)	1 (0)	139 (26)*
Well	10 (3)	16 (4)	120 (22)
Not well	176 (47)	180 (49)	75 (14)
Not at all	155 (42)	150 (41)	26 (5)
Enrollment site			
Clinic	271 (73)	279 (77)	255 (47)*
ER	100 (27)	85 (23)	286 (53)
Self-reported health status			
Excellent	16 (4)	23 (6)	77 (14)*
Good	104 (28)	100 (27)	209 (39)
Fair	156 (42)	156 (43)	150 (28)
Bad	51 (14)	36 (10)	50 (9)
Very bad	8 (2)	17 (5)	13 (2)

Percentages may not add up to 100% because of missing values. No significant differences found between RSMI and U&C, at a level of $p<0.05$.
**Significant differences at a level of $p<0.05$ across all three categories.*

Results by Intention to Treat

For satisfaction with physician communication/care, patients randomized to receive RSMI were more likely than those receiving U&C to rate their physicians "very well" in treating them with respect (71% RSMI vs. 64% U&C, $p<0.05$) (Table 2). Patients also rated RSMI as better than U&C at protecting their privacy (RSMI 51% vs. U&C 38%, $p<0.05$) (Table 3). The mean satisfaction with interpreter score was higher for patients in the RSMI group (RSMI 0.528 vs. U&C 0.462, $p<0.05$) as well. There were no other significant differences between the groups.

Results by Actual Interpreting Method Received

In the analysis of satisfaction with physician communication/care by actual interpreting method received, patients in the RSMI group were more likely than those in the U&C trained interpreter group to rate their physicians "very well" in treating them with respect (70% RSMI vs. 57% U&C trained, $p<0.05$)

Table 2. Satisfaction with Physician Communication/Care, by Interpreting Method

	Intent-to-treat Analysis (by randomization mode)		Actual Interpreting Method Received		
	U&C	RSMI	U&C Trained	RSMI	Language Concordant
n	364	371	165	175	751
Did your doctor listen carefully?					
Yes	324 (96)	336 (98)	145 (95)	165 (99)	697 (99)*
Did your doctor spend enough time with you?					
Yes	316 (94)	325 (96)	145 (95)	161 (98)	656 (96)
How would you rate your doctor in treating you with respect?					
Very well	213 (64)	242 (71)†	85 (57)	115 (70)‡	527 (75)*
How well do you think your doctor understood you?					
Very well	132 (39)	150 (45)	57 (37)	79 (49)‡	454 (64)*
How well did you understand your doctor's explanation of medical procedures and test results?					
Very well	125 (38)	128 (39)	52 (35)	62 (39)	404 (59)*
How well did you understand your doctor's instructions about follow-up care?					
Very well	125 (38)	134 (41)	48 (33)	60 (38)	436 (63)*
How would you rate your doctor overall?					
Very well	178 (54)	195 (59)	72 (48)	91 (56)	436 (63)*
Would your recommend your doctor to a friend?					
Yes	287 (95)	287 (95)	125 (94)	140 (97)	615 (96)
Overall, how satisfied were you with the quality of your medical care?					
Very well	155 (47)	169 (51)	72 (48)	93 (57)	396 (57)
Composite satisfaction with physician communication/care score					
Mean (SD)	0.478 (0.340)	0.514 (0.355)	0.436 (0.330)	0.518 (0.351)‡	0.628 (0.350)*

Denominators for percentages exclude missing values.

**Actual interpreting method received, significant differences between all three groups at a level of $p<0.05$.*

†Intent-to-treat analysis, significant difference between RSMI and U&C at a level of $p<0.05$.

‡Actual interpreting method received, significant differences between RSMI and U&C trained.

Table 3. Satisfaction with Interpretation, by Interpreting Method

	Intent-to-treat Analysis (by randomization mode)		Actual Interpreting Method Received	
	U&C	RSMI	U&C Trained	RSMI
n	364	371	165	175
Did your interpreter listen to you carefully?				
Yes	192 (99)	214 (98)	149 (99)	158 (99)
How would you rate your interpreter in treating you with respect?				
Very well	99 (51)	129 (58)	71 (48)	88 (54)
How well do you think your interpreter understood you?				
Very well	95 (48)	111 (50)	70 (45)	73 (45)
How well do you think your interpreter interpreted your visit with the doctor?				
Very Well	98 (50)	124 (56)	76 (50)	90 (55)
How well do you think this method of interpretation protected your privacy?				
Very Well	73 (38)	104 (51)*	52 (35)	74 (49)†
Would you recommend the interpreter to a friend?				
Yes	175 (97)	200 (97)	136 (96)	147 (99)
Would you recommend this method of interpretation to a friend?				
Yes	178 (93)	204 (96)	136 (94)	151 (97)
Composite satisfaction with interpreter score				
Mean (SD)	0.462 (0.368)	0.528 (0.393)*	0.449 (0.365)	0.502 (0.395)

Denominators for percentages exclude missing values and those for whom the response was not applicable (i.e., those who did not receive interpreter services).

**Intent-to-treat analysis, significant difference between RSMI and U&C at a level of $p<0.05$.*

†Actual interpreting method received, significant differences between RSMI and U&C trained at a level of $p<0.05$.

and to think their physicians understood them "very well" (45% RSMI vs. 35% U&C trained, $p<0.05$) (Table 2). The mean composite satisfaction with physician communication/care score was also higher for patients in the RSMI group (RSMI 0.518 vs. U&C trained 0.436, $p<0.05$). For most measures of satisfaction with physician communication/care, however, patients in the language-concordant group rated physicians more highly than patients in both the RSMI and U&C trained groups.

For interpreter satisfaction, patients felt RSMI protected their privacy better than U&C trained interpreters (49% RSMI vs. 35% U&C trained, $p<0.05$). There were no significant differences between the groups among the other measures. (Table 3)

Tables 4 and 5 show composite physician communication/care and interpreter satisfaction scores regressed on the randomized method of interpretation, and on actual interpreting method received. The intent-to-treat analysis, which included patients who did not work with any interpreter, did not illustrate a significant association between RSMI and the composite physician communication/care satisfaction score (Table 4). Actual receipt of RSMI, however, was significantly associated with increased satisfaction with physician communication/care compared to receipt of U&C trained interpretation (Table 5). Controlling for other potential explanatory factors (such as a patient's gender, primary language, self-reported health status, or enrollment site) did not significantly reduce this association (coefficient=0.100, p=0.010). The coefficient in this context means that an encounter utilizing RSMI should lead to a satisfaction score that is 10 points higher out of 100 than the average encounter utilizing PCMI or RCMI with trained interpreters. There were no significant differences between groups in satisfaction with interpreter

Table 4. Linear Regression Analysis of Satisfaction with Physician Communication/Care and Satisfaction with Interpretation Scores, Intent-to-treat Analysis

	Satisfaction with Physician Communication/Care		Satisfaction with Interpreter	
	Score (m, SD)	β (95% CI)*	Score (m, SD)	β (95% CI)*
U&C	0.478 (0.340)	Referent	0.462 (0.368)	Referent
RSMI	0.514 (0.355)	0.041 (−0.013, 0.094)	0.528 (0.393)	0.071 (−0.004, 0.145)

**Adjusted for gender, primary language, self-reported health status, enrollment site*

Table 5. Linear Regression Analysis of Satisfaction with Physician Communication/Care and Satisfaction with Interpretation Scores, by Actual Interpreting Method Received

	Satisfaction with Physician Communication/Care		Satisfaction with Interpreter	
	Score (m, SD)	β (95% CI)*	Score (m, SD)	β (95% CI)*
U&C Trained	0.436 (0.330)	Referent	0.449 (0.365)	Referent
RSMI	0.518 (0.351)	0.100 (.024, 0.176)	0.502 (0.395)	0.070 (−0.015, 0.155)
Language concordant	0.628 (0.350)	0.142 (0.076, 0.208)	N/A	N/A

Adjusted for gender, primary language, self-reported health status, enrollment site

scores in either the intent-to-treat analysis (Table 4) or in the analysis of actual interpreting method received (Table 5).

CONCLUSIONS

With the large growth of the foreign-born population in the United States, the study of interpreting strategies outcomes for language-discordant encounters is of great importance. The introduction of RSMI, with its potential for more efficient interpreting because of its simultaneity, compelled studying its impact in relation to U&C interpreting.

In this randomized controlled trial of RSMI vs. U&C interpreting, there were a few areas in which patients in the RSMI group were more satisfied than in the U&C group. Patients felt they were treated with more respect by their physicians and that their privacy was better protected. The exposure analysis revealed similar outcomes. Exposure analysis results are relevant, as patients usually did not receive the randomized method because of language concordance with their physicians, not because of interpreting method preference.

Alarmingly, all groups reported poor satisfaction with important aspects of doctor–patient communication, in particular, feeling understood by the physician, understanding physicians' explanations of procedures and results, and understanding instructions for follow-up care. However, this was much worse for patients in the interpreted medical encounter, indicating that current interpreting strategies still do not approximate a language-concordant encounter. Among language-concordant patients, dissatisfaction may have been due in part to physician "false fluency", with physicians overestimating their language abilities; to patients' overestimating their English-speaking ability; or to other shortcomings in doctor–patient communication. In a separate study, we found a significantly lower error rate with RSMI compared with U&C interpreting in Spanish–English language-discordant encounters.[32] However, comprehension was still perceived to be poor in our study, suggesting that technical accuracy alone is not sufficient. More studies are needed encompassing other languages and settings to further assess accuracy, efficiency, and patient satisfaction with the different methods of interpretation.

Patient satisfaction in cross-cultural patient–physician interactions is likely related to a constellation of factors, including socioeconomics, culture, race and ethnicity, time, and the logistics and quality of the interpreting method. In previous studies, satisfaction has been shown to have a positive impact on clinical outcomes.[17–20] The results of this study, therefore, have important implications.

RSMI may be particularly useful in clinical situations where sensitive topics are discussed and patient privacy is paramount. The mental health encounter, the discussion of sexual behavior, and the evaluation of sexually transmitted diseases, for example, require a high level of patient comfort with their providers and assurance of privacy.[33,34] The absence of a third party from the actual exam room during an RSMI (or RCMI) encounter may remove one potential barrier to patients' willingness to disclose sensitive information.

Our findings suggest that RSMI could be an important component of a multipronged approach to improving patient satisfaction in the interpreted encounter, but also that much more work needs to be done. Professional interpreters, physicians, and patients need more training and education on how best to facilitate the interpreted medical encounter. Further studies need to be conducted on interpreting modalities, and should examine errors, medical outcomes, and costs. Physician-related factors should also be assessed, including physician satisfaction and barriers to utilization. We also need qualitative data to learn more about what specifically detracts from patient satisfaction with interpreting so that appropriate interventions can be developed to address the dissatisfaction documented in this study. Future studies should include additional technology-based interpreting delivery systems, including video and computer-assisted linguistic access.

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Conflict of Interest: *Two of the authors (FG, JC) have ownership in a company that provides technology solutions for remote simultaneous medical interpreting.*

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The Impact of an Enhanced Interpreter Service Intervention on Hospital Costs and Patient Satisfaction

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BACKGROUND: Many health care providers do not provide adequate language access services for their patients who are limited English-speaking because they view the costs of these services as prohibitive. However, little is known about the costs they might bear because of unaddressed language barriers or the costs of providing language access services.

OBJECTIVE: To investigate how language barriers and the provision of enhanced interpreter services impact the costs of a hospital stay.

DESIGN: Prospective intervention study.

SETTING: Public hospital inpatient medicine service.

PARTICIPANTS: Three hundred twenty-three adult inpatients: 124 Spanish-speakers whose physicians had access to the enhanced interpreter intervention, 99 Spanish-speakers whose physicians only had access to usual interpreter services, and 100 English-speakers matched to Spanish-speaking participants on age, gender, and admission firm.

MEASUREMENTS: Patient satisfaction, hospital length of stay, number of inpatient consultations and radiology tests conducted in the hospital, adherence with follow-up appointments, use of emergency department (ED) services and hospitalizations in the 3 months after discharge, and the costs associated with provision of the intervention and any resulting change in health care utilization.

RESULTS: The enhanced interpreter service intervention did not significantly impact any of the measured outcomes or their associated costs. The cost of the enhanced interpreter service was $234 per Spanish-speaking intervention patient and represented 1.5% of the average hospital cost. Having a Spanish-speaking attending physician significantly increased Spanish-speaking patient satisfaction with physician, overall hospital experience, and reduced ED visits, thereby reducing costs by $92 per Spanish-speaking patient over the study period.

CONCLUSION: The enhanced interpreter service intervention did not significantly increase or decrease hospital costs. Physician–patient language concordance reduced return ED visit and costs. Health care providers need to examine all the cost implications of different language access services before they deem them too costly.

KEY WORDS: language barriers; interpreter services; hospital costs; patient satisfaction.
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The conversation between physician and patient has long been recognized to be of diagnostic import and therapeutic benefit. Unfortunately, many patients in the United States cannot benefit from this fundamental interaction because of language barriers. According to Census 2000, more than 46 million people in the United States do not speak English as their primary language and more than 21 million speak English less than "very well".[1] Many of these residents do not receive needed health care or the standard of care because most health care organizations provide inadequate interpreter services.[2–8] Many health care providers do not provide adequate interpretation because of the perceived financial burden.[9,10] However, they neglect to take into account the cost of the consequences of failing to provide adequate interpretation or the potential benefits of improving communication with patients. This may be due in part to the paucity of data documenting these costs and benefits.

We know of only 6 studies to date that have directly set out to measure these costs and benefits. Two studies found that the use of ad hoc interpreting by employees has an opportunity cost for institutions in the form of staff time lost to interpreting.[11,12] Another study, in a pediatric emergency department (ED), found that the presence of a language barrier between physician and parents accounted for a $38 increase in charges for testing and a 20-minute longer ED stay compared to encounters in which there were no language barriers.[13] Three additional studies have investigated the direct costs and potential cost-savings of providing professional interpreter services. They have found that the cost of these services is quite low relative to most health care costs[14] and that they can reduce the cost of care provided in the ED[15] and follow-up visit charges after ED evaluation.[16] There is still a need for investigations that compare the costs of providing adequate linguistic access services to the cost of *not* providing them, especially in the inpatient setting.

Using a conceptual model developed by the U.S. Department of Health and Human Services' Office of Minority Health to guide research efforts about the costs of language barriers in health care,[17] we undertook a study to (1) provide data on the costs of failing to provide adequate interpreter services and (2) measure the direct costs and cost-offsets of enhanced interpreter services use in the care of Spanish-speaking hospitalized patients. We define adequate interpreter services as those provided by trained and tested interpreters available on-site in a timely manner. Our overall hypothesis was that hospitalized Spanish-speaking patients who cannot readily and adequately communicate with their providers would generate higher inpatient costs compared to those who are able to communicate with their clinicians through the assistance of readily available, trained professional interpreters. Our secondary hypotheses were that Spanish-speaking patients who cannot readily and adequately communicate with their clinicians will be less satisfied with their hospital stay and physician–patient communication; will have higher rates of post discharge ED utilization and hospitalization; and will have poorer adherence with scheduled outpatient visits than patients who had the assistance of a readily available, professional interpreter.

METHODS

Setting

The study took place from January 19, 2005 to June 30, 2005 and involved the Internal Medicine service of a large public hospital in the City of Chicago, IL. The Internal Medicine service is organized into 3 firms; the firms consist of equal numbers of attending and resident physicians who work together, on a monthly rotating basis, to care for patients assigned to their firm when they are admitted to the hospital. In any given month, each firm has 4 teams of 5 physicians each (1 attending, 2 residents and 2 interns) who admit patients to the hospital every fourth night. Patients admitted to the medicine service of the hospital are assigned to be under the care of 1 of the 3 firms based on which team is next in line for an admission. This assignment is nonpurposeful and based only on the order of admission. Patients are admitted to the next available hospital bed so there are no geographical firm boundaries.

Two of the 3 firms were randomly selected to participate in the study and an enhanced interpreter intervention was randomly assigned to 1 of these 2 firms. We did not randomize patients to receive the interpreter intervention because it would have been logistically difficult for the interpreters to work across firms and we did not want the intervention to influence the physician practice for those patients not assigned to receive the intervention.

Study Participants

All patients who were admitted to the study firms during this time period and had a Hispanic surname, or were identified as needing an interpreter by hospital staff were approached by bilingual research staff. These patients were invited to participate if they were 18 years of age or older and stated that they spoke only Spanish or had difficulty communicating in a language other than Spanish. We also recruited English-speaking (ES) patients admitted to the study firms and matched them to Spanish-speaking participants on gender, age, week of admission, and firm. ES patients were used to control for firm effects not related to the enhanced interpreter services intervention. Patients were excluded from participation in the study if they were unable to consent to participation because of cognitive or mental impairments. All participants received $20 upon discharge from the hospital. The Institutional Review Board of the Cook County Bureau of Health Services approved the study.

Enhanced Interpreter Service Intervention

The enhanced interpreter service intervention consisted of 2 trained Spanish medical interpreters assigned to work with Spanish-speaking patients and their caregivers throughout their hospital stay. Both interpreters graduated from a year-long, intensive, community college interpreter training program including instruction on medical vocabulary, standards, ethics of interpreting, patient confidentiality, and triadic communication. Both completed a 120-hour internship. A single interpreter was available 7:30 A.M. to 3:30 P.M. daily during the study period. One interpreter was available Monday through Friday and the other was available during the weekend. The interpreters rounded with the intervention firm physicians each morning and were paged by the physicians, nurses, and patients when needed. The chart of each Spanish-speaking patient cared for by the intervention team had a note alerting all staff of the availability of the interpreter.

Spanish-speaking patients cared for by the nonintervention team who spoke Spanish received the usual care: no interpretation or use of ad hoc interpreters (family, friends, and untrained bilingual staff), telephonic interpreters, or the usual hospital interpreter service. The usual hospital service is not sufficiently staffed to meet the current demand for Spanish-speaking interpreters, resulting in significant delays (sometimes up to several hours) between requesting an interpreter and arrival of the interpreter at a patient's bedside. As a result, clinical staff frequently relies on ad hoc interpreters to communicate with their Spanish-speaking patients. In addition, not all hospital interpreters are trained, and those that are had more limited training than the intervention interpreters.

Measurements

Baseline patient variables included age, gender, country of birth, years lived in the United States, language ability, education, marital status, household income, and numbers of times they had seen a physician or had been hospitalized in the past year. All participants were asked in what language they usually read, thought, and spoke and chose from the following response categories; only Spanish, Spanish better than English, both equally, English better than Spanish, or English only. Education was categorized as elementary school or less, middle school, some high school, high school or GED, or greater than high school. Insurance status was categorized as private insurance, Medicare, Medicaid, no insurance, or other. Marital status was categorized as single/never married, married, not married but living with a committed partner, or separated/divorced/widowed. Household income was categorized as <$10,000, $10,000–24,999, and $25,000 or more. Diagnoses included in the patient's electronic medical record (EMR) discharge summary were used to calculate the Charlson comorbidity index (CCI) scores for each participant.[18]

The following outcome variables were abstracted from the EMR. Length of stay (LOS), number of specialty consultations and radiology tests during the hospital stay, ED visits and hospitalizations in the 3 months after hospital discharge, and adherence to follow-up outpatient visits scheduled at discharge. Patients were considered adherent if they went to at least 1 follow-up visit.

Satisfaction with the hospital stay was measured using the Hospital Consumer Assessment of Healthcare Providers and Systems (H-CAHPS), a previously-validated 24-item instrument available in English and Spanish.[19] Participants completed the survey at discharge with the help of the research assistant (RA) or, if they were discharged outside of the RA's working hours, completed it over the phone in response to RA questioning, or mailed it in. We analyzed items from the H-CAHPS that would likely be affected by communication, including satisfaction with nursing care (4 items), satisfaction with physicians (4 items), and overall satisfaction with the hospital stay (2 items).

We also collected information on attending and resident physicians' Spanish fluency. We tested the physicians who indicated that they spoke Spanish with hospitalized patients and who had not trained in or practiced in a Spanish-speaking country. Physicians deemed proficient on a test modeled on the American Council on the Teaching of Foreign Languages' oral proficiency interview,[20] and physicians who had trained in or practiced in a Spanish-speaking country were included in the "Spanish-speaking physician" category.

Costs were calculated using the average costs of care provided at the study institution in 2000, the most current year for which this information was available, and the costs of providing the interpreter service intervention during the study period. Both included overhead costs. The intervention costs include interpreter salaries, which were constant throughout the study, regardless of how many encounters were interpreted each day.

Statistical Analyses

Analyses were conducted to test our hypotheses that LOS, inpatient service utilization, and post discharge events would be lower and post discharge follow-up and satisfaction higher for Spanish-speaking patients whose physicians had access to the intervention (SS-I) compared to Spanish-speaking patients whose physicians had access only to usual care (SS-U). For each outcome, we fitted regression models with variables for Spanish-speaking patient group (SS versus ES), for firm (intervention versus usual care), and for their interaction. The interpreter services effect is given by the interaction, as it measures the difference between the effect of the firm for the SS (SS-I versus SS-U) and for ES patients, thereby isolating differences between SS-I and SS-U attributable to the enhanced interpreter services intervention. Demographic variables were included for adjustment, as was an indicator for SS patients having a Spanish-speaking attending physician. For those outcomes with a significant Spanish-speaking attending effect, a second model was fitted with the interaction between the interpreter services intervention and Spanish-speaking attending terms. These models permit investigation as to whether the attending effect is stronger or weaker in the presence or in the absence of enhanced interpreter services.

Because satisfaction variables were sums of Likert-scale responses and patients, in general, reported a high level of satisfaction, the resulting scores were not normally distributed. We modeled them with ordinal probit regression.[21] The regression coefficients comparing groups have the convenient interpretation as adjusted "effect sizes" for latent satisfaction, i.e., the mean difference between groups, divided by the within-group standard deviation. For the number of ED visits, number of hospital readmissions, LOS, and numbers of radiology tests and specialty consultations, we used Poisson regression. The regression coefficients, when exponentiated, are interpreted as adjusted relative values of the mean response (e.g., number of hours in hospital, number of tests) comparing 1 group to another. We employed robust standard errors to protect against incorrect variance assumptions.[22] For binary adherence to follow-up, we used logistic regression. Analyses were conducted using STATA, v.9.0.

RESULTS

The sample included 323 adult inpatients: 124 Spanish-speakers whose physicians had access to the intervention (of 148 eligible and approached; SS-I), 99 Spanish-speakers whose physicians only had access to usual interpreter services (of 144 eligible and approached; SS-U), and 100 English-speakers (of 212 eligible and approached; Table 1). There were no significant differences between the SS-I and SS-U groups or between intervention and control firm English-speakers in any sociodemographic characteristic, history of health care utilization, self-rated health, or Charlson cormorbidity index (Table 1). Nevertheless, in the regression models, we adjusted for variables exhibiting modest differences between firms in either the SS and/or the ES groups.

Thirty-two attending physicians cared for patients on the intervention firm and 26 on the usual care firm. Significantly, more attending physicians on the intervention firm were proficient in Spanish (n=9; 28%) than on the usual care firm (n=4; 15%, p<0.001). Forty-four residents cared for patients on the intervention firm and 44 on the usual care firm. The firms had similar numbers of residents proficient in Spanish (24 and 26, respectively).

All study participants reported high levels of satisfaction. The SS-I and SS-U groups had similar unadjusted mean nursing (18.8 [SD=3.5] vs 18.6 [SD=3.3]), physician (20.6 [SD=1.9] vs 20.2 [SD=2.5]), and overall hospital satisfaction scores (13.0 [SD=2.0] vs 13.0 [SD=2.0]). In the adjusted probit regression analyses using English-speaking patients to control for firm effects, there was no significant impact of the intervention on any of the 3 satisfaction scores (Table 2). However, having a Spanish-speaking attending physician positively and significantly impacted Spanish-speaking patients' satisfaction with the doctor and with the hospital stay (Table 2). This effect is more strongly driven by patients whose physicians did not have access to the intervention (Table 3), although the effect of Spanish-speaking attending physician on patient satisfaction was not significantly different when comparing the SS-U and SS-I groups (Table 3).

There was a significant difference in unadjusted mean patient LOS between the SS-I (5.00 days [SD=4.06]) and SS-

Table 1. Patient Characteristics

	Spanish intervention firm (*n*=124)	Spanish usual care firm (*n*=99)	English intervention firm (*n*=52)	English usual care firm (*n*=48)
Age, mean (SD)	51 (16)	47 (17)	46 (15)	47 (12)
Female (%)	50	59	42	52
Ethnicity (%)				
Mexican	80	87	7	10
Caribbean	4	3	3	2
Central/South American	16	10	1	2
Black	0	0	76	73
White/other	0	0	13	13
Years in US, mean (SD)	13 (13.3)	12 (11.3)	NA	NA
Language (%)				
Spanish only	84	83	2	2
Spanish > English	16	15	3	2
Both equally	0	2	3	6
English > Spanish	0	0	1	2
English only	0	0	91	88
Education (%)				
Elementary	52	56	6	6
Middle school	11	8	2	4
Some high school	18	17	12	26
High school or GED	10	10	29	28
Some or > college	8	9	51	36
Income (%)				
<$10,000	60	61	57	45
$10,000–24,999	24	26	28	36
$25,000 or more	4	1	15	18
Do not know	12	12	0	1
Insurance (%)				
None	89	92	69	66
Public	6	5	23	25
Private	1	0	4	7
Other	4	3	4	2
Seen physician in the last year (%)	75	68	73	75
Hospitalized in the last year (%)	46	38	66	50
Fair/poor health status (%)	76	69	69	75
Charlson comorbidity index, mean (SD)	1.7 (1.9)	1.5 (1.8)	1.7 (2.1)	1.4 (1.7)

There were no significant differences at $p<0.05$ in the sociodemographic characteristics or health care measures between Spanish-speaking patients on the intervention and usual care firms or between English-speaking patients on the intervention and usual care firms.

U groups (5.97 days [SD=5.31]; $p=0.03$). There were no other significant differences between the SS-I and SS-U groups in the unadjusted mean number of radiology tests per person (2.07 [SD=3.11] vs 2.39 [SD=2.73]; $p=0.18$) or consultations per person (0.46 [SD=0.63] vs 0.58 [SD=0.66]; $p=0.17$) while hospitalized; ED visits (0.15 [SD=0.47] vs 0.08 [SD=0.37]; $p=0.06$); or hospitalizations (0.34 [SD=0.80] vs 0.35 [SD=0.71]; $p=0.70$) per person in the 3 months after discharge; or percentage of patients adhering to follow-up (68% vs 69%; $p=0.82$). In the adjusted Poisson regression analyses, again using the English-speaking patients to control for firm effects,

Table 2. Impact of Interpreter Service Intervention and Spanish-speaking Attending Physician on Satisfaction Among Spanish-speaking Patients

	Intervention*	Spanish-speaking attending†
Satisfaction with nursing	−0.41 (−0.97, 0.15)	0.12 (−0.23, 0.48)
Satisfaction with physicians	−0.31 (−0.90, 0.29)	0.42 (0.03, 0.81)
Satisfaction with hospital stay	−0.48 (−1.1, 0.13)	0.55 (0.12, 0.99)

Three separate regression models, each including controls for gender, age, racial/ethnic identification, education, marital status, number of times seen by a physician in the past year, number of hospitalizations in the last year, self-rated health, and CCI score.

Figures are probit regression coefficients (95%CIs), which are equivalent to effect sizes for:

**The difference between SS-I and SS-U groups attributable to interpreter services intervention, in units of within-group standard deviation, controlling for Spanish-speaking attending.*

†The difference between Spanish-speaking patients with and without a Spanish-speaking attending, controlling for physician team and interpreter services intervention.

Table 3. Impact of Spanish-speaking Attending on Spanish-speaking Patients' Satisfaction in the Intervention and Usual Care Groups

	Intervention group	Usual care group
Satisfaction with nursing	0.05 (−0.59, 0.69)	0.16 (−0.27, 0.58)
Satisfaction with physicians	0.34 (−0.13, 0.80)	0.62 (−0.11, 1.4)
Satisfaction with hospital stay	0.51 (0.00, 1.02)	0.67 (−0.19, 1.5)

Three separate regression models, each including controls for gender, age, racial/ethnic identification, education, marital status, number of times seen by a physician in the past year, number of hospitalizations in the last year, self-rated health, CCI score, and physician team.

Figures are probit regression coefficients (95%CIs), which are equivalent to effect sizes for difference between Spanish-speaking patients with and without a Spanish-speaking attending, stratified by receipt of interpreter services intervention.

there was no significant impact of the intervention on mean LOS, number of ED visits or hospitalizations after discharge, radiology tests or consultations while hospitalized (Table 4). Similarly, there was no significant impact of the intervention on adherence to follow-up in the adjusted logistic regression analyses using English-speaking patients to control for firm effects (Table 4). Having a Spanish-speaking attending also showed no impact on utilization outcomes, except in the case of ED visits. Having a Spanish-speaking attending significantly reduced the number of ED visits after discharge for Spanish-speaking patients in both firms (p=0.03; Table 4). Expected adjusted ED visits per Spanish-speaking patient with a Spanish-speaking attending were 0.034 visit/patient compared to 0.166 visit/patient for those without a Spanish-speaking attending. We were unable to assess whether or not this impact was different in the SS-I versus SS-U groups because there were no ED visits for the patients in the SS-I group who had a Spanish-speaking physician.

We could not evaluate the cost-savings of the enhanced interpreter intervention, as the intervention did not significantly impact any hospital or post discharge service utilization. The cost of the enhanced interpreter intervention was $234/person in the intervention group ($34,581 for 148 eligible SS-I patients). There was a significant reduction of ED visits for Spanish-speaking patients who had a Spanish-speaking physician. Comparing the expected adjusted ED visits per Spanish-speaking patient with (0.034 visit/patient) and without (0.166 visit/patient) a Spanish-speaking attending using the model in Table 4, this represents a cost-savings of $92.02 ($700.03/visit×0.131 visit) per Spanish-speaking patient in the study. There was no additional cost of hiring or retaining Spanish-speaking attending physicians at the study institution, so these savings came without additional expenditure.

Discussion

We found no significant impact of the enhanced interpreter service intervention on any of our measured outcomes for Spanish-speaking patients. However, having a Spanish-speaking physician improved Spanish-speaking patients' satisfaction with physician care and with the hospital stay overall. This increase in satisfaction was more pronounced among patients admitted to the usual care firm, suggesting that the enhanced interpreter services intervention did have an important impact on patients' satisfaction with physician communication and hospital stay. In addition, having a Spanish-speaking attending significantly reduced the number of ED visits Spanish-speaking patients had after discharge.

Table 4. Impact of Interpreter Service Intervention and Spanish-speaking Attending Physician on Length of Stay and Health Care Utilization Outcomes among Spanish-speaking Patients

	Intervention*	Spanish-speaking attending†
Length of stay	1.00 (0.72, 1.42)	0.90 (0.75, 1.08)
Consults	1.24 (0.64, 2.41)	0.85 (0.55, 1.30)
Radiology tests	1.46 (0.90, 2.35)	0.96 (0.71,1.29)
ED visits after discharge	3.09 (0.81, 11.7)	0.21 (0.05, 0.86)
Hospitalizations after discharge	0.55 (0.15, 2.00)	0.97 (0.46, 2.02)
Adherence to follow-up appointments‡	0.99 (0.18, 4.6)	0.95 (0.43, 2.1)

Separate regression models, each including controls for gender, age, racial/ethnic identification, education, marital status, number of times seen by a physician in the past year, number of hospitalizations in the last year, self-rated health, and CCI score.

**Ratio of mean values for each outcome, measuring the difference between the SS-I and SS-U groups attributable to interpreter services intervention, controlling for Spanish-speaking attending.*

†Ratio of mean values for each outcome, comparing Spanish-speaking patients with and without a Spanish-speaking attending, controlling for physician team effects and interpreter services intervention.

‡Logistic regression controlling for variables as described above; effects are odds ratios rather than ratios of means

Whereas the study did not demonstrate that providing enhanced interpreter services results in cost-savings, it provides information on the cost of enhanced interpreter services in the context of a hospital stay. Using the mean LOS (5 days) of Spanish-speakers and mean cost of 1 day ($2,900) in the study hospital, we found that the cost of enhanced interpreter services represents 1.5% of the overall cost of patient care. This relatively small expenditure for enhanced language access services is very similar in magnitude to that found in an Office of Management and Budget report in 2002.[9] The per patient cost of this service is likely an overestimate, as cost would have been lower were the intervention not restricted to a small set of patients; in practice, the 2 study interpreters could have served many more patients. Our study also found that Spanish-speaking attending physicians reduced costs of care by lowering return ED visits without additional expenditure by the study hospital. There may be a cost to other hospitals, however, of providing Spanish-speaking providers as some institutions pay a signing bonus or provide additional salary to bilingual physicians.

There are a number of reasons why we may not have found a clear impact of the enhanced interpreter intervention on the cost and quality of hospital care. First, large firm effects may be masking the effect of the enhanced interpreter intervention. Second, this study compared enhanced interpreter services available 8 hours a day with usual care that included the hospital interpreter services available 10 hours a day. Whereas we know that our enhanced interpreter services were superior to the hospital interpreter services in interpreter training and accessibility, it may be that the enhanced services were not accessed more frequently than the usual hospital services, blunting the impact of the intervention. It is also possible that the intervention influenced nurse practice since the firms are not constrained to caring for patients on specific medicine wards, thus all nurses were exposed to the intervention. However, it is unlikely that a nurse crossover effect limited our ability to detect a difference as a result of the intervention because, anecdotally, the nurses were not frequent users of the enhanced interpreter services. Third, a large proportion of attending and resident physicians at the study institution is fluent in Spanish. It may be that the interpreters did not add to the impact of attending and resident physicians who were already providing language access in both firms. Fourth, our interpreter service intervention may not have been robust enough. Interpreters were only available 8 hours/day and their use depended on nurses, physicians, and other staff voluntarily calling for their services or patients' requesting the services verbally or through a bedside card. Greater integration of interpreter services into the care routine may have had a greater impact. Interpreters may not have as great an impact on a hospital stay where patients are closely monitored over time versus a setting like an ED where physicians have to make decisions about whether or not it is safe to release a patient. Finally, the satisfaction measure we used may not have been sensitive enough to measure the impact of the interpreter services on communication in the hospital.

In addition to these limitations, this study has several strengths. First, we included English-speakers in our study to control for firm effects and thus isolate the impact of our intervention on satisfaction and hospital service utilization. If we had not done so, we would have erroneously concluded that the enhanced interpreter service intervention reduced the LOS instead of identifying this difference as a result of firm differences. Second, whereas not a randomized controlled trial, the assignment of the patients in the study to firm was independent of patient or firm characteristics, resulting in study groups that were very similar across sociodemographic and other characteristics. Third, we measured physician Spanish language fluency. This not only allowed us to control for the impact of physician language concordance on our study outcomes, it provided us with the only data we are aware of on how Spanish language concordance between physicians and patients impacts hospital service utilization and cost.

These strengths allowed us to provide useful information on the cost of providing enhanced inpatient interpreter services relative to the total cost of a hospital stay. We consider $240 a small price to pay to ensure that hospital professional staff are able to provide the standard of care to all patients—to be able to understand and speak to them. The fact that we did not see an impact of this enhanced communication on our chosen outcome measures does not mean that interpreters are not essential to the provision of high quality care to patients with limited English proficiency. It indicates that more research needs to be done in settings where language concordant physicians and other linguistic access services are not as readily available as they were in our study setting. It also highlights the valuable contribution bilingual physicians make to the provision of health care in our increasingly diverse society, underscoring the importance of efforts to increase the ethnic and linguistic diversity of the medical profession.

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Errors in Medical Interpretation and Their Potential Clinical Consequences in Pediatric Encounters

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ABSTRACT. ***Background.*** **About 19 million people in the United States are limited in English proficiency, but little is known about the frequency and potential clinical consequences of errors in medical interpretation.**

Objectives. **To determine the frequency, categories, and potential clinical consequences of errors in medical interpretation.**

Methods. **During a 7-month period, we audiotaped and transcribed pediatric encounters in a hospital outpatient clinic in which a Spanish interpreter was used. For each transcript, we categorized each error in medical interpretation and determined whether errors had a potential clinical consequence.**

Results. **Thirteen encounters yielded 474 pages of transcripts. Professional hospital interpreters were present for 6 encounters; ad hoc interpreters included nurses, social workers, and an 11-year-old sibling. Three hundred ninety-six interpreter errors were noted, with a mean of 31 per encounter. The most common error type was omission (52%), followed by false fluency (16%), substitution (13%), editorialization (10%), and addition (8%). Sixty-three percent of all errors had potential clinical consequences, with a mean of 19 per encounter. Errors committed by ad hoc interpreters were significantly more likely to be errors of potential clinical consequence than those committed by hospital interpreters (77% vs 53%). Errors of clinical consequence included: 1) omitting questions about drug allergies; 2) omitting instructions on the dose, frequency, and duration of antibiotics and rehydration fluids; 3) adding that hydrocortisone cream must be applied to the entire body, instead of only to facial rash; 4) instructing a mother not to answer personal questions; 5) omitting that a child was already swabbed for a stool culture; and 6) instructing a mother to put amoxicillin in both ears for treatment of otitis media.**

Conclusions. **Errors in medical interpretation are common, averaging 31 per clinical encounter, and omissions are the most frequent type. Most errors have potential clinical consequences, and those committed by ad hoc interpreters are significantly more likely to have potential clinical consequences than those committed by hospital interpreters. Because errors by ad hoc interpreters are more likely to have potential clinical consequences, third-party reimbursement for trained interpreter services should be considered for patients with limited English proficiency.**

Pediatrics 2003;111:6–14; *language, interpreters, medical errors, children, pediatrics, Hispanic Americans, quality.*

ABBREVIATIONS. LEP, limited in English proficiency; SD, standard deviation.

According to the 2000 census, ~45 million people in the United States speak a language other than English at home, and ~19 million are limited in English proficiency (LEP).[1] Five percent of school-aged US children (or ~2.4 million) are LEP, an 85% increase since 1979.[2] Language barriers affect multiple aspects of health care for the LEP patient, including access to care, health status, and use of health services.[3] Studies document that LEP patients often defer needed medical care,[4] have a higher risk of leaving the hospital against medical advice,[5] are less likely to have a regular health care provider,[6] and are more likely to miss follow-up appointments,[7] to be nonadherent with medications,[7] and to be in fair/poor health.[6]

A medical interpreter is an essential component of effective communication between the LEP patient and the health care provider. Medical interpreters may be professional hospital interpreters employed by a health care institution, or ad hoc, untrained individuals, such as family members, friends, nonclinical hospital employees, and strangers from waiting rooms. Previous work has shown that family members[8] and untrained bilingual nurses[9] who provide ad hoc interpretation can commit many errors of interpretation. Not enough is known, however, about the frequency and categories of medical interpreter errors that occur in clinical encounters, whether such errors potentially have clinical consequences, and if the use of hospital rather than ad hoc interpreters produces a higher quality of medical interpretation. The goals of this study, therefore, were to: 1) determine the frequency, categories, and potential clinical consequences of errors committed by medical interpreters; and 2) compare the quality of interpretation by professional hospital versus ad hoc interpreters.

METHODS

We audiotaped pediatric encounters in which a Spanish interpreter was used in the pediatric outpatient clinic of an urban

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Massachusetts hospital over a 7-month period. All study parents had identified themselves as LEP. A bilingual research assistant was present during the encounter only to record the interaction, and did not act as an interpreter, nor take part in subsequent production of transcripts or data analysis. A bilingual verbatim transcript was prepared from the audiotape of each encounter by a professional transcriptionist fluent in both English and Spanish. To ensure accuracy and reliability of the transcripts, each transcript was reviewed 3 times for errors, once by a bilingual physician whose first language is English (G.F.), a second time by a bilingual sociologist whose first language is English (M.B.L.), and a third time by a bilingual physician whose first language is Spanish (M.A.).

The encounters analyzed for this study represent all pediatric visits with Spanish interpreters that occurred in a larger study of patient-physician communication, which consisted of a convenience sample of 153 audiotaped visits in the pediatric outpatient clinics of an urban Massachusetts hospital. Of the 153 participants in this larger study, 110 of the children and their families were Latino. Among these 110 Latino participants, there were 74 mothers/adult caregivers who were LEP, for which 38 visits occurred in Spanish with Spanish-speaking clinicians, 13 visits included a Spanish interpreter, and 25 occurred in English without an interpreter. Although this larger study used a convenience sample, the sample was obtained to reflect a reasonable spectrum of outpatient pediatric visits experienced by Latino families, and has no obvious selection biases other than respondent refusal, which was rare (only 2 potential subjects refused to participate). Participants from the larger study were sampled to capture visits from the full range of daily office hours and all 5 clinic days (Monday-Friday) during the work week. Pediatric encounters included walk-in, sick, and routine health care maintenance visits at the pediatric primary care clinic, and initial and follow-up visits at the outpatient lead and failure-to-thrive clinics. Both pediatricians and pediatric nurse practitioners provided care to study patients, and patient care was in no way altered by the study, except for the presence of the research assistant and tape recorder. The patients and their families, clinicians, and interpreters were told only that this was a study of patient-physician communication, and they were not aware that errors of medical interpretation would be analyzed.

Personnel who provided medical interpretation were classified as: 1) hospital interpreters, professional interpreters (ie, those receiving financial compensation) employed by the study hospital's department of interpreter services; and 2) ad hoc interpreters, who could include family members, friends, nonclinical hospital employees, strangers from waiting rooms, and hospital clinical staff (including nurses and social workers) who had received no formal medical interpreter training or screening. During the period when the study was conducted, all Spanish hospital interpreters who had been hired had undergone some level of screening and evaluation for language proficiency in Spanish and English. There was, however, no ongoing training or formal performance evaluation in the hospital for interpreters. Low-intensity, voluntary formal interpreter training was sporadically available at various community sites, but it was not known what proportion of interpreters took advantage of these voluntary community opportunities.

For each audiotaped encounter, analysis consisted of identification of the frequency and categories of interpreter errors. An "interpreter error" was defined as any misinterpretation of an utterance that occurred in the clinical encounter, including those committed by the designated medical interpreter, as well as those made by health care providers (such as when a physician with limited Spanish proficiency made errors in Spanish while talking to the mother after the designated interpreter had departed). Errors by health care providers were classified as interpreter errors because the study focus was on errors of interpretation made by any staff member acting as a medical interpreter during a clinical encounter, and we found that certain providers often would attempt to interpret when the designated medical interpreter departed or was temporarily unavailable.

Five categories were used to classify interpreter errors, based on 4 categories used in previous work,[10,11] supplemented by an additional category (false fluency). These categories are as follows:

Omission: The interpreter did not interpret a word/phrase uttered by the clinician, parent, or child.

Addition: The interpreter added a word/phrase to the interpretation that was not uttered by the clinician, parent, or child.

Substitution: The interpreter substituted a word/phrase for a different word/phrase uttered by the clinician, parent, or child.

Editorialization: The interpreter provided his or her own personal views as the interpretation of a word/phrase uttered by the clinician, parent, or child.

False Fluency: The interpreter used an incorrect word/phrase, or word/phrase that does not exist in that particular language.

In addition to being classified into 1 of these 5 categories, an interpreter error was also considered to have potential clinical consequences if it altered or potentially altered 1 or more of the following: 1) the history of present illness; 2) the past medical history; 3) diagnostic or therapeutic interventions; 4) parental understanding of the child's medical condition; or 5) plans for future medical visits (including follow-up visits and specialty referrals).

Medical jargon, idiomatic expressions, and contextual clarifications may occasionally require medical interpreters to not interpret a phrase word-for-word. Thus, any deviations from word-for-word interpretation in transcripts that were attributable to jargon, idioms, or contextual clarifications were not classified as interpreter errors. Because medical interpreters may also act as a cultural broker or advocate, any utterances that could be interpreted as cultural explanations or patient or family advocacy were not classified as interpreter errors. A separate analysis of the relationship of the number of verbal exchanges, the interlocutor, and the quality of the interpretation will be reported elsewhere in a separate paper.

The validity of the analytic method for identification and classification of interpreter errors was assessed as follows: 2 transcripts (cases 26 and 153) were first subjected to preliminary error analysis using simple definitions of each error type and category. The 2 transcripts were scored by 3 observers, a bilingual physician whose first language is English (G.F.) and 2 bilingual physicians (M.A. and L.M.) whose first language is Spanish. To avoid the introduction of bias, the latter 2 observers were blinded to the study goals and hypotheses. Each of the observers was assessed as being highly fluent in their second language based on years of experience providing primary care to Spanish-speaking patients in a Pediatric Latino Clinic (G.F.), 7 years as a research associate on studies of English-speaking populations in the United States (M.A.), and years of teaching high school to English-speaking students in the Massachusetts school system (L.M.). Interobserver variability for the 3 observers was assessed using agreement matrices and by calculating the percentage of agreement in 2 separate analyses, 1 for overall interpreter errors, and the second only for errors of potential clinical consequence. The Kappa Index was also determined for errors of clinical consequence. It was not possible to derive a Kappa Index for overall errors, as transcripts could not be accurately scored for 1 of the 4 cells (cell d): when neither observer identified an error, there was no reliable way to determine whether one should count by words, phrases, transcript lines, or utterances.

The preliminary error analysis of the 2 test transcripts revealed a mean percentage of agreement (± standard deviation [SD]) among the 3 observers on the overall errors of 60% ± 19, with a range of 31% to 82%. Disagreements were primarily attributable to either overlooked errors or unintended differences in the line numbering of the transcripts analyzed by different observers. After line numbering corrections, refinements, and meeting for consensus purposes, there was complete agreement among the 3 observers on the number and type of overall interpreter errors. The mean percentage of agreement (± SD) among the 3 observers on errors of potential clinical consequence in the preliminary analysis was 83% ± 12, with a range of 72% to 97%. The mean κ (± SD) for errors of potential clinical consequence in the preliminary analysis was 0.57 ± 0.3 (considered a moderate strength of agreement by the guidelines of Landis and Koch[12]), with a range of 0.21 to 0.97 (from fair to almost perfect agreement by the Landis and Koch guidelines[12]). Because the mean percentage of agreement and κ were considered unacceptably low, the error categories and types were further refined. After refinement, there was mean agreement of 99% ± 1.7 (range: 97%–100%) and a mean κ of 0.99 ± 0.03 (range: 0.94–1.0 [almost perfect by the Landis and Koch guidelines[12] for both the mean and range]) regarding interpreter errors of potential clinical consequence on the 2 test transcripts. The remaining 11 transcripts were analyzed by the first author, using the refined error categories, types, and analytic approaches.

To analyze the statistical significance of differences between hospital and ad hoc interpreters in the proportion of errors made, the Yates-corrected χ^2 test was used, with $P < .05$ considered statistically significant.

Institutional review board approval was obtained from the participating institution to conduct this study, and written informed consent was obtained from each participating parent.

RESULTS

Thirteen clinical encounters with Spanish interpreters present were audiotaped, yielding 6 hours of audiotapes, 474 pages of transcripts, and 49 513 words that were exchanged. Hospital interpreters were present in 6 of 13 encounters; in the remaining 7 encounters, the ad hoc interpreters included a nurse for 3 encounters, a social worker for 3 encounters, and an 11-year-old sibling for 1 encounter. The number of words uttered per encounter averaged 3781, and there was no statistically significant difference in the mean number of words uttered per encounter by interpreter type (mean words uttered = 3919 when hospital interpreters were present vs 3663 when ad hoc interpreters were present, with $P > .5$ by the 2-tailed Student *t* test). The visit type, clinician present, patient age, and number of interpreter errors in each clinical encounter are summarized in Table 1.

There were 396 interpreter errors noted in the 13 clinical encounters (Table 2). The mean number (± standard error) of interpreter errors per clinical encounter was 30.5 ± 3.6, with a range of 10 to 60. There was no statistically significant difference between hospital and ad hoc interpreters in the mean number of errors committed per clinical encounter.

The proportions of interpreter errors by category were: omission, 52%; false fluency, 16%; substitution, 13%; editorialization, 10%; and addition, 8%. There were no statistically significant differences between hospital and ad hoc interpreters in the proportion of errors by specific category (Table 2), except for false fluency errors, which occurred more often during encounters with hospital than ad hoc interpreters (22% vs 9%, $P = .001$). Additional analysis of false fluency errors occurring in encounters with hospital interpreters revealed that health care providers made 76% of the false fluency errors, and 58% of these errors occurred while the interpreter was out of the room or on the phone, whereas the remaining 42% of errors were made by the provider without any correction by the interpreter. Health care providers were >11 times more likely (relative risk: 11.4; 95% confidence interval: 1.7–76.2) to make false fluency errors when a hospital interpreter was involved, committing 76% of the false fluency errors with trained interpreters, compared with only 7% of false fluency errors when untrained interpreters were in-

TABLE 1. Selected Features of Study Encounters

Case	Visit Type	Clinician Present	Patient's Age	Interpreter Type	Interpreter's Relationship to Patient, if Ad Hoc Interpreter	No. of Interpreter Errors in Encounter	No. (%) of Interpreter Errors of Potential Clinical Consequence in Encounter
13	Well-child visit at pediatric primary care clinic	Nurse practitioner	7 y	Hospital	—	45	16 (36%)
19	Sick visit at pediatric primary care clinic	Attending pediatrician	9 mo	Ad hoc	Nurse	10	9 (90%)
24	Sick visit at pediatric primary care clinic	Nurse practitioner and attending pediatrician	1 mo	Hospital	—	44	29 (66%)
26	Sick visit at pediatric primary care clinic	Pediatric resident	2 y	Ad hoc	11-year-old sibling	58	49 (84%)
77	Sick visit at pediatric primary care clinic	Attending pediatrician	2 mo	Ad hoc	Nurse	24	20 (83%)
83	Sick visit at pediatric primary care clinic	Attending pediatrician	8 mo	Ad hoc	Nurse	18	12 (66%)
84	Follow-up at failure to thrive clinic	Attending pediatrician	12 mo	Ad hoc	Social worker	21	13 (62%)
88	Walk-in for immunizations at pediatric primary care clinic	Attending pediatrician	7 y	Hospital	—	14	5 (36%)
106	Follow-up at failure to thrive clinic	Attending pediatrician	11 mo	Ad hoc	Social worker	24	16 (67%)
120	Follow-up at failure to thrive clinic	Attending pediatrician	13 mo	Ad hoc	Social worker	10	8 (80%)
153	Well-child visit at pediatric primary care clinic	Nurse practitioner	5 y	Hospital	—	45	23 (51%)
165	Well-child visit at pediatric primary care clinic	Nurse practitioner	7 y	Hospital	—	23	16 (70%)
176	Initial visit to lead clinic	Attending pediatrician	18 mo	Hospital	—	60	34 (57%)

TABLE 2. Summary of Errors of Medical Interpretation Observed in Clinical Encounters in the Study

Interpreter Type	No. (%) Errors by Error Category					No. (%) Errors of Potential Clinical Consequence	Total Errors
	Omission	Substitution	Addition	Editorialization	False Fluency		
Hospital ($N = 6$)	117 (51%)	27 (12%)	17 (7%)	20 (9%)	50 (22%*)	123 (53%†)	231
Ad hoc ($N = 7$)	90 (55%)	26 (16%)	15 (9%)	19 (12%)	15 (9%*)	127 (77%†)	165
Totals	207 (52%)	53 (13%)	32 (8%)	39 (10%)	65 (16%)	250 (63%)	396

* $P = .007$ by Yates-corrected χ^2 test for comparison between hospital versus ad hoc interpreters.

† $P < .001$ by Yates-corrected χ^2 test for comparison between hospital versus ad hoc interpreters.

volved ($P < .001$). Nevertheless, health care providers committed only ~10% of all errors observed in this study. About three quarters (73%) of the false fluency errors committed by hospital interpreters involved medical terminology, including not knowing the correct Spanish words for "level," "results," and "medicine," and using the Puerto Rican colloquialism for mumps, which could not be understood by a Central American mother.

There were 250 errors (63% of all errors) that had potential clinical consequences (Table 2). The mean number (± standard error) of errors with potential clinical consequences per encounter was 19 ± 3.2, with a range of 5 to 49. Errors made by ad hoc interpreters were significantly more likely to have potential clinical consequences than those made by hospital interpreters, at 77% vs 53% ($P < .0001$). When an 11-year-old sibling was used as an interpreter, for example, 84% of the 58 errors she committed had potential clinical consequences, and when an untrained staff nurse interpreted, 90% of his 10 errors had potential clinical consequences. Indeed, the lowest proportion of errors of potential clinical consequence committed by an ad hoc interpreter was 62%.

Interpreter errors of potential clinical consequence included: 1) omitting questions about drug allergies; 2) omitting key information about the past medical history (a mother's statement that her child had been hospitalized at birth for a renal infection); 3) omitting crucial information about the chief complaint and other important symptoms (Fig 1); 4) omitting instructions about antibiotic dose, frequency, and duration; 5) instructing a mother to give an antibiotic for 2 instead of 10 days (Fig 2); 6) erroneously adding that hydrocortisone cream must be applied to an infant's entire body, instead of solely to a facial rash (Fig 3); 7) telling a mother to give soy formula to her infant, instead of a physician's instructions to breastfeed only; 8) omitting instructions on the amount, frequency, and type of rehydration fluids for gastro-

Pediatrician: "So [he vomited] five times between 1:00 and 3:00? And after that he hasn't thrown up?

Interpreter: *"Que si desde eso él no ha vomitado?"*
"That if since that [time] he has not vomited?"

Mother: *"No. Ahora tiene como dolor de oido y eso."*
"No. Now he has like pain in the ear and so on."

Interpreter: "Yes, he havin' pain"

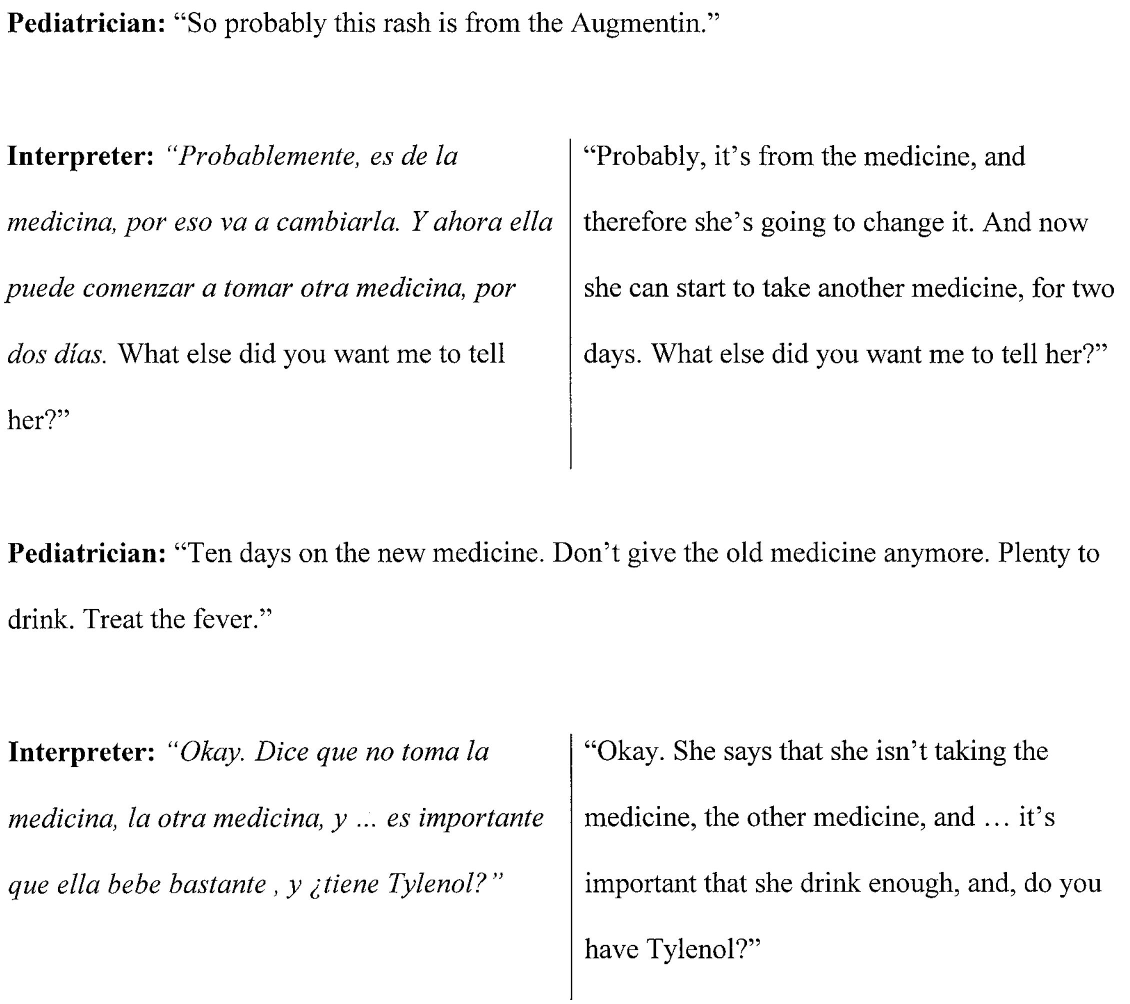
Mother: *"Dile que él tiene algo en la boca. Dile."*
"Tell her [the pediatrician] that he has something on his mouth. Tell her."

[SILENCE]

Pediatrician: "How old is he now?"

Interpreter: "Three."

Fig 1. Multiple omission errors of potential clinical consequence committed by an ad hoc interpreter (the patient's 11-year-old sister) during a sick visit to a pediatrician by a 2-year-old child for vomiting and dehydration (case 26). Note that the pediatrician never receives a response about how many times the child has vomited before the visit, and the interpreter omits the mother's statements about the child's ear pain and oral lesion.



Pediatrician: "So probably this rash is from the Augmentin."

Interpreter: *"Probablemente, es de la medicina, por eso va a cambiarla. Y ahora ella puede comenzar a tomar otra medicina, por dos días.* What else did you want me to tell her?"

"Probably, it's from the medicine, and therefore she's going to change it. And now she can start to take another medicine, for two days. What else did you want me to tell her?"

Pediatrician: "Ten days on the new medicine. Don't give the old medicine anymore. Plenty to drink. Treat the fever."

Interpreter: *"Okay. Dice que no toma la medicina, la otra medicina, y … es importante que ella bebe bastante , y ¿tiene Tylenol?"*

"Okay. She says that she isn't taking the medicine, the other medicine, and … it's important that she drink enough, and, do you have Tylenol?"

Fig 2. Substitution, addition, and omission errors of potential clinical consequence committed by an ad hoc interpreter during a sick visit to a pediatrician by a 9-month-old child for fever, vomiting, and a rash (case 19).

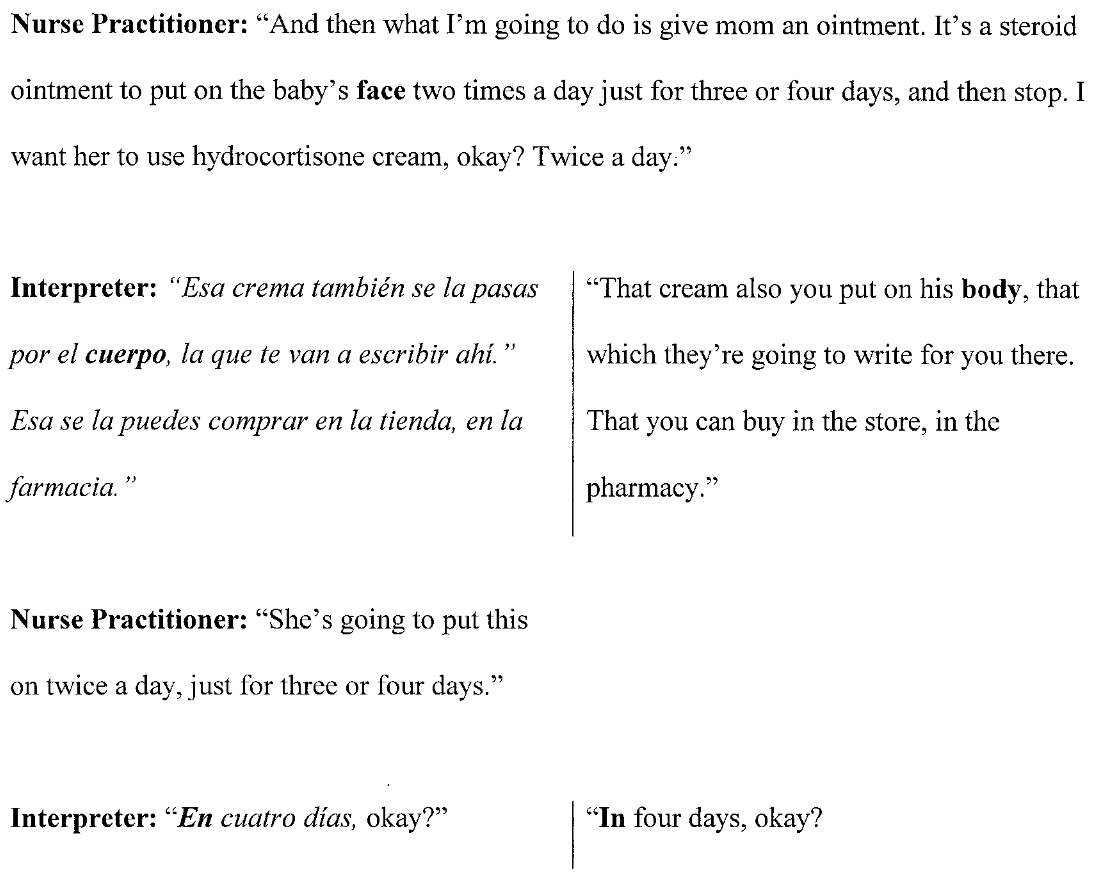
enteritis; 9) editorializing to a mother that she should not answer personal questions asked by her physician about sexually transmitted diseases and drug use; 10) explaining that an antibiotic was being prescribed for the flu; 11) omitting a mother's clear explanation that a child had already been swabbed rectally for a stool culture; 12) omitting and substituting for a mother's description of her child's abnormal behavioral symptoms (Fig 4); and 13) instructing a mother to put oral amoxicillin into her child's ears to treat otitis media (Fig 5).

DISCUSSION

Implications for Practice, Training, and Research

Errors in medical interpretation were found to be alarmingly common in this study, averaging ~31 per clinical encounter. In addition, there was no statistically significant difference between hospital and ad hoc interpreters in the mean number of errors committed per encounter. Although errors made by hospital interpreters were significantly less likely to be of potential clinical consequence than those made by ad hoc interpreters, over half of hospital interpreter errors had potential clinical consequences. These findings support the conclusion that most hospital interpreters do not receive adequate training at their institution.[13] Fewer than one fourth of hospitals nationwide provide any training for medical interpreters.[13] Only 14% of US hospitals provide training for volunteer interpreters, and in half of these hospitals, the training programs are not mandatory.[13] Even when hospitals provide training to medical interpreters, the training may be limited to short orientation sessions or shadowing more seasoned interpreters.[13] Our study findings and these national data suggest that additional research and policy work is needed to determine what type of medical interpreter training is most effective in reducing interpreter errors. Specific issues that need to be addressed include whether training of medical interpreters should be mandatory, and which training approaches are most effective in eliminating common errors of potential clinical consequence and in improving accuracy and understanding medical terminology.

The categories of interpreter errors noted in this study indicate areas where more training is needed for medical interpreters. Omissions by far were the most common type of interpreter error, accounting for more than half of all errors. This finding suggests that a principal focus of interpreter training should be the faithful transmission of each and every utterance by clinicians, patients, and patients' families.



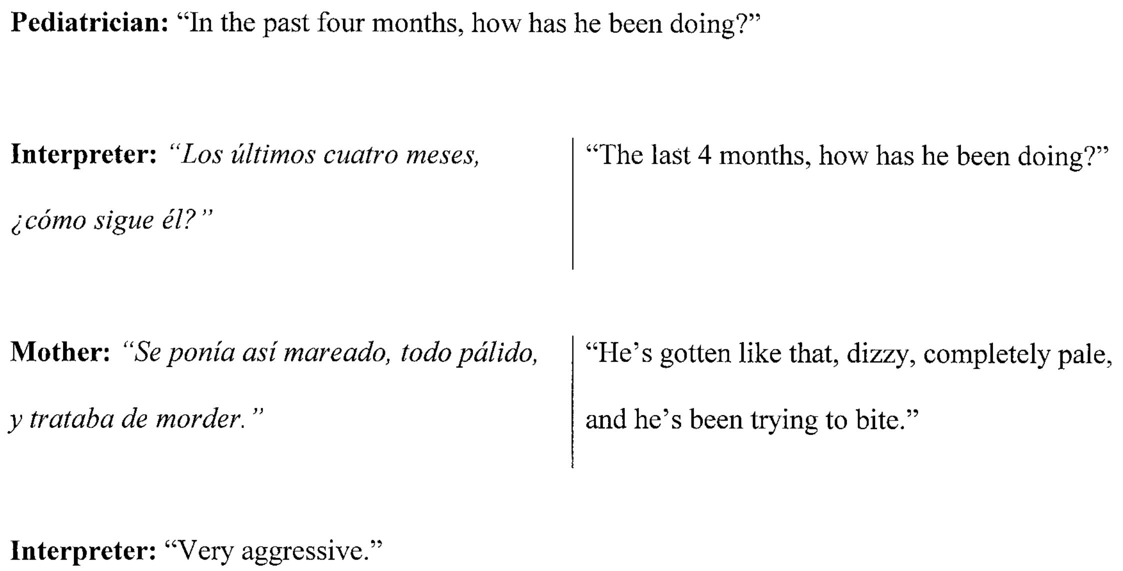
Nurse Practitioner: "And then what I'm going to do is give mom an ointment. It's a steroid ointment to put on the baby's **face** two times a day just for three or four days, and then stop. I want her to use hydrocortisone cream, okay? Twice a day."

Interpreter: *"Esa crema también se la pasas por el* ***cuerpo****, la que te van a escribir ahí." Esa se la puedes comprar en la tienda, en la farmacia."*	"That cream also you put on his **body**, that which they're going to write for you there. That you can buy in the store, in the pharmacy."

Nurse Practitioner: "She's going to put this on twice a day, just for three or four days."

Interpreter: "***En*** *cuatro días,* okay?"	"**In** four days, okay?

Fig 3. Multiple errors of omission and substitution of potential clinical consequence committed by a hospital interpreter during a sick visit to a pediatric nurse practitioner by a 1-month-old male infant for seborrhea and an upper respiratory illness.



Pediatrician: "In the past four months, how has he been doing?"

Interpreter: *"Los últimos cuatro meses, ¿cómo sigue él?"*	"The last 4 months, how has he been doing?"
Mother: *"Se ponía así mareado, todo pálido, y trataba de morder."*	"He's gotten like that, dizzy, completely pale, and he's been trying to bite."

Interpreter: "Very aggressive."

Fig 4. Omission and substitution errors of clinical consequence committed by an ad hoc interpreter during an 18-month-old boy's visit to a pediatrician in the lead clinic (case 176).

Simultaneous remote or on-site interpretation (as is done in the United Nations) has the potential to increase the number of utterances and reduce the number of errors,[11] but concerns can be raised about the costs of training and implementation, and difficulties with acceptance by interpreters. Most false fluency errors committed by hospital interpreters (73%) involved medical terminology. This finding indicates that medical interpreter training should include a detailed review of medical terms, with attention to linguistic issues such as variation among cultural subsets of a single linguistic group. In addition, periodic performance evaluation, including monitoring of false fluency errors, may be an important

Nurse Practitioner: "And she's going to have 1 teaspoon 3 times a day for 10 days."

Interpreter: *"Entonces para la amoxicilina- por los oídos…entonces le vas a dar una cucharadita tres veces al día."*	"So for the amoxicillin– **in the ears**…so you are going to give her 1 teaspoonful 3 times a day."

Fig 5. Addition and omission errors of clinical consequence made by an ad hoc interpreter during a visit to a pediatric nurse practitioner by a 7-year-old-girl diagnosed with otitis media (case 165).

means of quality improvement for medical interpreter services, indicating when additional training in medical terminology is needed.

The categories of interpreter errors noted in this study also indicate that more training is needed for clinicians in the use of medical interpreters. Clinicians commit most false fluency errors when the interpreter leaves the room or is taking a telephone call, and clinicians are 11 times more likely to make false fluency errors when hospital interpreters participate in the clinical encounter. These findings are consistent with studies that show that most hospital staff receive no training on working with interpreters,[13] and most medical schools do not provide adequate instruction on linguistic and cultural issues in clinical care.[14] For example, only 23% of US hospitals provide any training for their staff on the use of medical interpreters, and such training may consist of nothing more than policies and procedures for requesting interpreters.[13] These studies and our results suggest that clinicians should receive skills training on the proper technique for working with medical interpreters, especially the risk of false fluency errors associated with clinicians with limited foreign language fluency. It is recommended that interchanges between such clinicians and patients (and their families) in a foreign language should be limited to when the medical interpreter is present and not distracted; if such interchanges occur without an interpreter, the clinician should consider repeating the interchange when the interpreter is available once again. The limited foreign language skills of a clinician can prove to be an asset, however, in that they can provide a means of verifying the quality of medical interpretation. For example, if the clinician hears a patient utter a word or phrase that was not translated by the interpreter, the clinician could bring this to the interpreter's attention, and reemphasize the importance of faithful message transmission of each and every utterance. Conversely, because 42% of false fluency errors committed by clinicians occurred in the presence of an interpreter and went uncorrected, medical interpreters probably should be taught that it is reasonable and appropriate to correct clinician false fluency errors.

Medical Errors and Quality of Care

The study findings suggest that interpreter errors of potential clinical consequence could be a previously unrecognized possible root cause of medical errors. Although a recent Institute of Medicine report[15] has drawn much attention to medical errors, errors of medical interpretation have not generally been included in the discussion of sources of medical errors. In this study, several documented common mechanisms for medical errors[16,17] were observed among the interpreter errors of clinical consequence, including being told to use the wrong dose, frequency, duration or mode of administration of drugs and other therapeutic interventions, and omitting relevant clinical information on drug allergies and the past medical history. These findings suggest that for LEP patients, providing qualified, trained medical interpreters may be an important means of reducing medical errors and improving the quality of medical care. It also seems reasonable that as part of ongoing quality improvement efforts, medical institutions might consider periodically audiotaping or videotaping a representative subsample of clinical encounters where medical interpreters are used, to identify and monitor the overall number and categories of interpreter errors, the number of interpreter errors of potential clinical consequence, and medical errors that result from interpreter errors.

Study Limitations

Several limitations of this study should be noted, along with their implications for future research. Our sample size was relatively small; studies of errors of medical interpretation on a larger scale are needed. Only 1 observer analyzed 11 of the transcripts, so interpreter errors potentially may have been missed that could have been identified had multiple observers analyzed these transcripts. Single-observer transcript analysis was performed, however, only after refinements of the analytic technique were instituted as a result of multiple-observer testing and validation. It also seems unlikely that identification and inclusion of potentially overlooked errors would have substantially altered the principal study findings, but additional study of this interpreter error analytic tool is warranted. This study was limited to pediatric encounters; similar studies of adult LEP populations need to be conducted, particularly given that interpreter errors may have an even greater effect on adults because of their generally greater morbidity, comorbidity, and mortality. Similarly, we examined only outpatient encounters with Spanish interpreters, and studies are needed of interpreter errors and their clinical consequences in other languages and in the emergency department and inpatient settings. The hospital interpreters in this study had little to no training (although the study institution has subsequently initiated extensive training of their hospital interpreters). Replication of this study with hospital interpreters who have received extensive, consistent training compared with ad hoc interpreters may reveal more substantial differences in the number and categories of errors. Because LEP patients who need interpreters sometimes obtain medical care without interpreters, more research is needed comparing health care quality and satisfaction with care when LEP patients have trained hospital versus ad hoc versus no interpreters.

Policy Implications

The study finding that errors made by ad hoc interpreters are significantly more likely to have potential clinical consequences—coupled with a fairly extensive literature documenting that LEP patients tend to receive poorer quality medical care—would seem to constitute a strong argument for third-party reimbursement for trained medical interpreter services. Studies demonstrate a wide range of adverse effects that limited English proficiency can have on health and use of health services, including impaired health status,[6,18] a lower likelihood of having a usual source of medical care,[6,18,19] lower rates of mammograms, pap smears, and other preventive services,[20,21] nonadherence with medications,[7] a greater likelihood of a diagnosis of more severe psychopathology and leaving the hospital against medical advice among psychiatric patients,[5,22] a lower likelihood of being given a follow-up appointment after an emergency department visit,[23] an increased risk of intubation among children with asthma,[24] a greater risk of hospital admissions among adults,[25] an increased risk of drug complications,[26] longer medical visits,[27,28] higher resource utilization for diagnostic testing,[28] lower patient satisfaction,[18,29,30] and impaired patient understanding of diagnoses, medications, and follow-up.[31,32] Latino parents consider the lack of interpreters and Spanish-speaking staff to be the greatest barriers to health care for their children, and 1 out of every 17 parents in one study reported not bringing their child in for needed medical care because of these language issues.[4] On the other hand, recent studies indicate that trained professional medical interpreter services are associated with improvements in the delivery of health care services to LEP patients,[33] but do not increase the mean duration of medical visits.[34]

The lack of trained hospital interpreters is not uncommon for the millions of LEP patients in the United States: one study found that no interpreter was used for 46% of LEP patients, and when an interpreter was used, 39% had no training.[31] In a guidance memorandum, the Office of Civil Rights stated that the denial or delay of medical care for LEP patients because of language barriers constitutes a form of discrimination, and requires that any recipient of Medicaid or Medicare must provide adequate language assistance to LEP patients.[35] A Presidential Executive Order also has been issued on improving access to services for persons with Limited English Proficiency.[36] Concerns have been raised by medical associations about physicians having to cover the costs of complying with the Office of Civil Rights guidance memorandum,[37] but the issue could be resolved by having third-party reimbursement for interpreter services. Although additional research on the cost effectiveness of third-party reimbursement for interpreter services would be helpful, mounting evidence suggests that additional studies of the issue may not be needed, including a successful $71 million lawsuit over a misinterpreted word in the emergency department,[38] a report of a prolonged hospitalization for perforated appendicitis that might have been avoided if an interpreter had been called,[39] and a report of children placed in state custody for mistaken child abuse because of a misinterpreted word and failure to initially call an interpreter.[39] Legal liability and medical errors may be important factors in considering whether investment in third-party reimbursement of interpreter services is a reasonable strategy for assuring that LEP patients receive high-quality, equitable care.

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COLLEGE STUDENTS AND THE INTERNET

"The report, *'The Internet Goes to College: How Students Are Living in the Future With Today's Technology,'* was produced by the Pew Internet and American Life Project in Washington, and provides a snapshot of an emerging young digital class.

One fifth of today's college students began using computers from the ages of 5 to 8, the authors state, and an overwhelming 86% of them had gone online compared with 59% of the general population; 72% check e-mail messages at least once a day. . . Nearly 75% of college students say they use the Internet more than they use the library to look for information; just 9% said they used the library more."

Schwartz J. *New York Times.* September 16, 2002

Noted by JFL, MD

Errors in Medical Interpretation and Their Potential Clinical Consequences in Pediatric Encounters

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HOW CAN STATES GET FEDERAL FUNDS TO HELP PAY FOR LANGUAGE SERVICES FOR MEDICAID AND SCHIP ENROLLEES?

Federal funding to help states and health care providers pay for language services is primarily available through Medicaid and the State Children's Health Insurance Program (SCHIP).[1] This federal funding offers states a valuable opportunity to help providers ensure language access. However, the programs have technical requirements and vary from state to state. This document provides a brief overview to assist you in evaluating the best way for your state to offer language services reimbursement. For specific information on your state, *see* http://www.statehealthfacts.kff.org/.

What are Medicaid and SCHIP?

Medicaid and the State Children's Health Insurance Program (SCHIP) are health insurance programs for certain low-income individuals operated jointly by the federal and state governments.[2] Both programs operate as federal-state partnerships – they are jointly administered and jointly funded. Medicaid provides health insurance to over 44 million individuals, SCHIP to over 3 million.

To be eligible for Medicaid or SCHIP, you must be low-income and fit within an eligible group. Medicaid primarily serves four groups of low-income Americans: the elderly, people with disabilities, parents and children. Medicaid is an "entitlement" program – everyone who meets the eligibility requirements must be provided health care and has the right to obtain needed services in a timely manner. SCHIP primarily covers children and sometimes others. such as parents and pregnant women. SCHIP is not an entitlement – its funding is limited to pre-set amounts determined by Congress.

How does the federal government pay its share of Medicaid and SCHIP costs to the states?

The federal government pays states in three ways for their Medicaid and SCHIP expenses:

- ***Covered Service*** – States get federal reimbursement for "covered services" provided to enrollees, such as a visit to a doctor or in-patient hospital stay. States must cover certain "mandatory" services, but they also have the option of covering certain additional services, such as language services.
- ***Administrative Costs* –** States also get federal funds to assist with the administrative costs of the program (e.g. costs of staff to determine eligibility and oversee contracts, and computer costs).
- ***Disproportionate Share Hospitals* –** States also get federal funding for payments made to "disproportionate share hospitals" – hospitals that serve a disproportionate share of Medicaid and uninsured patients.[3]

Why can states get (draw down) federal reimbursement for language services?

In 2000, the Centers for Medicare & Medicaid Services (CMS), a part of the federal Department of Health and Human Services and the agency overseeing Medicaid and SCHIP, reminded states that they could obtain federal "matching" funds for language services provided to Medicaid and SCHIP enrollees. In a letter to state health officials, CMS reminded states that

> Federal matching funds are available for states' expenditures related to the provision of oral and written translation administrative activities and services provided for SCHIP or Medicaid recipients. Federal financial participation is available in State expenditures for such activities or services whether provided by staff interpreters, contract interpreters, or through a telephone service. [4]

Why don't all states cover language services for Medicaid/SCHIP enrollees?

While each healthcare *provider* who receives federal funds must provide meaningful language access, *states* do not have to reimburse providers for these expenses. Each state determines if and how it will provide reimbursement for interpreters. Individual providers cannot seek reimbursement unless their state has set up a mechanism to do so. Only twelve states and the District of Columbia directly reimburse providers for language services.[5] States have an obligation, however, to ensure language access at Medicaid and SCHIP eligibility offices.

The reasons states do not offer direct reimbursement vary, and you may need to take different steps to educate policymakers depending on the reason in your state. For example, some state officials do not know that federal funding is available. Informing them may be sufficient to build their interest in offering reimbursement. Faced with tight budgets, some states may not designate state funds to pay their share of the Medicaid/SCHIP match. In these states, you may want to educate policy makers about the costs of non-compliance with federal requirements (such as Title VI), and the indirect costs of not providing language assistance to LEP patients (such as more medical errors, reduced quality of care, and unnecessary diagnostic testing). Finally, some states view language services as part of providers' costs of doing business, and bundle the cost of language services into the providers' general reimbursement rates, regardless of providers' actual costs. In these states, changing state policies may require providing information about the utilization of language services, the actual costs of interpreters, and why a bundled payment rate is insufficient to cover these costs.

How much would my state get from the federal government for language services?

This depends on the state, the program, and how the state chooses to be reimbursed.

Covered Services -- For covered services, the state pays part of the costs and the federal government pays the remainder. Each state has a different federal "matching" rate – that is, the percentage of the provider reimbursement for which the federal government is responsible. The federal contribution varies from 50% to 83%, depending upon a state's per capita income (states with higher per capita income receive less federal funding). States also have different matching rates for Medicaid and SCHIP; SCHIP services are reimbursed at a higher rate. For example, Iowa receives a 63.50% federal match for Medicaid services and 74.45% for SCHIP services. For information on your state, *see* Kaiser Family Foundation's State Health Facts Online, http://www.statehealthfacts.kff.org/.

Administrative Costs -- Some states may choose to cover the costs of language services as an administrative expense, rather than as a covered service. For administrative expenses, all states receive a 50% federal match for both Medicaid and SCHIP.[6] In SCHIP, however, states can only spend 10% of their total federal allotment on administrative expenses. For states that are at or near their 10% administrative cap, it may thus be preferable to consider language services as a "covered service" rather than as an administration expense.

How does my state start drawing down federal reimbursement for language services?

Covered Services -- States that wish to get federal funding as a "covered service" must add language services to their Medicaid "state plan." The state plan is the document that outlines how each state's Medicaid program works, including what services it covers. The state must submit this request – a "state plan amendment" or "SPA" – to CMS. Until a service is added to the "state plan" and approved by CMS, the state cannot receive federal reimbursement. In many states, because of the financial costs of covering a new service, the state legislature must approve the SPA prior to submission to CMS.

Administrative Costs -- States that seek reimbursement for language services as an administrative expense do not need prior CMS approval. Thus, while the federal matching rate for administrative expenses may not be as high as the rate for covered services (e.g. 50% as opposed to 63.5% for Medicaid covered services in Iowa), a state may choose this option because it is easier to implement. However, this decision is also affected by the differing matching rates for Medicaid and SCHIP. In some states, the federal matching rate for Medicaid covered services is 50%, the same as for administrative expenses. In these cases, the state does not have a financial incentive to add a covered service to its Medicaid state plan. But while a state's Medicaid matching rate might be 50%, its SCHIP rate is always higher, at least 65%. In addition, states are not allowed to spend more than 10% of their SCHIP allotment on administrative expenses. So deciding to cover language services as an administrative expense in SCHIP may produce fewer federal dollars, and also create conflicts with other administrative priorities.

Disproportionate Share Hospital Costs -- States can also use federal funding available for "disproportionate share hospitals" (DSH) – that is, hospitals that serve a disproportionate share of Medicaid and uninsured patients – to help pay for language services. States determine which hospitals are considered DSH and how much funding to distribute to them. States could consider a hospital's language services expenses in determining the allocations of DSH money.

Which providers can get reimbursed for language services?

Each state determines which Medicaid and SCHIP providers can obtain reimbursement. States may choose to reimburse all providers or only some —for example, only "fee-for-service"[7] providers, or hospitals, or managed care organizations. Most states that provide reimbursement do so for fee-for-service providers. Two states reimburse hospitals. One state has added money to the "capitation rate" it pays to managed care organizations for each enrolled patient to cover the costs of providing interpreter services.[8]

The decision of which providers to reimburse will vary state by state. Factors to consider include whether a provider uses a staff member or contract interpreter, whether staff interpreters interpret full-time or have other job responsibilities, and whether bilingual providers are competent to provide services in a non-English language and should be compensated for their language skills.

How can my state reimburse providers who receive pre-set rates for services?

Some states set payment rates that "bundle" all of the costs of providing services to a patient into a single fee; the fee includes the costs of medical tests or procedures, as well as of other services and items – for example, consultation, medical supplies and medications. The payment rate also includes reimbursement for a share of the facility's overhead costs – salaries, utilities, maintenance of physical plant, etc. Such bundling is particularly common for inpatient hospital services. The federal Medicare program bundles fees into "diagnosis related groups," or DRGs. Some states pay for inpatient hospital stays based on DRGs, while others pay on a per-case or per-diem basis. The cost of language services is implicitly included in whatever bundling method a state employs. For other health care providers, such as doctors operating small group practices, many states include all administrative and overhead costs – including language services – in the provider's payment rate. Federally qualified health centers receive bundled payments through a "prospective payment system," an advance payment that estimates the health centers' costs.

Since states set the Medicaid/SCHIP payment rates for each service, states can modify the rates to add on direct reimbursement for interpreters when they are used.[9] States can have a separate "billing code" with a payment rate specifically for interpreters – each time a provider uses an interpreter, the provider receives both the payment rates for the covered service and for the interpreter. States can also add a "modifier" for an existing rate – each time a provider uses an interpreter, the modifier increases the payment rate by either a percentage or a specific amount. The rates or modifiers can vary by language (frequently encountered versus less frequently encountered), type of interpreter (staff interpreter, contract interpreter, bilingual provider, telephone language line), or other factors.

Many states include requirements to provide access to language services in their contracts with managed care organizations. If a state chooses to directly pay managed care organizations for the costs of these language services, they have two options – pay for language services separately from the managed care capitation rate[10] (i.e. "carve out" language services from the set of services the managed care organization must provide) or increase the capitation rate to include language services.

How much should the state pay for interpreters?

When a state decides to reimburse providers for language services, it determines the payment rate. Those currently in use vary from $12 to $190 per hour. The rates should reflect labor costs in the state and consider training or certification requirements. When setting the payment rate, the state should also consider travel time, waiting time, and other activities associated with providing interpretation; these circumstances vary by state, and often by region. For example, in rural areas where travel times can be lengthy, a state should evaluate whether the interpreter can receive reimbursement for travel time. (A state also needs to determine if and what to pay in a variety of circumstances: for example, what happens if the interpreter arrives but the provider or patient cancels the appointment.) To encourage the use of interpreters, it is important that states set a rate that will cover at least the interpreter's actual costs. The state should also set an adequate reimbursement rate to ensure that a sufficient number of interpreters to meet the needs of its LEP population are willing to participate in the program.

How can states offer reimbursement?

Currently, states that provide reimbursement for language services use four payment models:

- require providers to hire interpreters and submit for reimbursement
- pay interpreters directly
- use "brokers" or language agencies – providers can call these designated organizations to schedule an interpreter; the state reimburses the broker/agency which in turn pays the interpreter
- provide access to a telephone language line for providers.

For more information on these models, see *Medicaid and SCHIP Reimbursement Models for Language Services* in this Action Kit.

What about language services for individuals <u>not</u> enrolled in Medicaid/SCHIP?

Federal funding is only available for language services for Medicaid and SCHIP enrollees (or to parents of Medicaid/SCHIP enrolled children). It is also available for patients who receive Medicaid-covered emergency services.

Health care providers who receive federal funds, however, must ensure language access for *all* of their patients, not just Medicaid and SCHIP enrollees. Thus, a gap exists between existing federal funding and the need for services. States could use state funds to provide language services for other individuals. Once a state has established a language assistance program for its Medicaid and SCHIP beneficiaries and invested the initial resources necessary to implement it, the additional costs to expand the program to other LEP patients would probably be minimal.

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[1] The Community Health Centers Reauthorization Act includes language services demonstration programs but funding has not yet been provided.

[2] For more information on these programs, *see* www.healthlaw.org, http://www.kff.org/content/2001/2248/2248.pdf (*Medicaid: A Primer*) or http://cms.hhs.gov/medicaid/mover.asp (*Medicaid: An Overview).*

[3] Currently, hospitals that serve a "disproportionate share" of Medicaid and uninsured patients are eligible to receive supplemental Medicaid payments through the Disproportionate Share Hospital (DSH) program. In many states the DSH program represents one of the most significant sources of federal funding to support health care for the uninsured and Medicaid beneficiaries. More than 10% of all Medicaid funding is through DSH, amounting to more than $15.8 billion combined federal and state spending in 2001.

[4] This letter is available at http://www.cms.hhs.gov/smdl/downloads/smd083100.pdf.

[5] These twelve are the District of Columbia, Hawaii, Idaho, Kansas, Maine, Minnesota, Montana, New Hampshire, Utah, Vermont, Virginia, Washington and Wyoming. For more information on the models these states are using, *see Medicaid/SCHIP Reimbursement Models for Language Services: 2007 Update*, available at www.healthlaw.org.

[6] Limited exceptions exist to the administrative matching rate. For example, states can receive 90% federal funding for upgrading computer systems or providing family planning services and supplies; 75% federal funding to cover the costs of medical and utilization review; and 100% for expenses in implementing and operating an immigration status verification system.

[7] "Fee-for-service" generally refers to services not provided through a hospital, managed care organization, or community health center. Providers agree to accept a state-set fee for the specific service provided to a Medicaid/SCHIP enrollee.

[8] For more information on the models these states are using, *see Medicaid/SCHIP Reimbursement Models for Language Services: 2007 Update*, available at www.healthlaw.org..

[9] States cannot, however, increase their Medicaid/SCHIP reimbursement rates above Medicare reimbursement rates.

[10] The "capitation rate" is the amount a state pays the managed care organization for each enrollee per month, which compensates the managed care organization for all the services covered by the contract. It is a set amount that does not vary depending on how many or few services the enrollee utilizes.

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MEDICAID AND SCHIP REIMBURSEMENT MODELS FOR LANGUAGE SERVICES

2007 UPDATE

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MEDICAID/SCHIP REIMBURSEMENT MODELS FOR LANGUAGE SERVICES

2007 UPDATE

In 2000, the Centers for Medicare & Medicaid Services (CMS) reminded states that they could include language services as an administrative or optional covered service in their Medicaid and State Children's Health Insurance Programs, and thus directly reimburse providers for the costs of these services for program enrollees. Yet only a handful of states are directly reimbursing providers for language services. Currently, the District of Columbia and 12 states (Hawaii, Idaho, Kansas, Maine, Minnesota, Montana, New Hampshire, Utah, Vermont, Virginia, Washington, and Wyoming) are providing reimbursement. Three states have initiated discussions about reimbursement. Connecticut and Texas enacted legislation requiring reimbursement but they have not yet been implemented. North Carolina expects to provide reimbursement after establishing interpreter credentialing. And California has a Task Force established by the Department of Health Services that is identifying methods of initiating reimbursement.

The remainder of this issue brief outlines existing state mechanisms for directly reimbursing providers for language services for Medicaid and SCHIP enrollees.[1] (For more information on funding for Medicaid and SCHIP services, see *How Can States Get Federal Funds to Help Pay for Language Services for Medicaid and SCHIP Enrollees?*[2]). While only some states currently provide reimbursement, the examples below can help you identify promising ways to evaluate and establish reimbursement mechanisms to meet your state's needs and goals.

STATES CURRENTLY PROVIDING REIMBURSEMENT

State	For which Medicaid and SCHIP enrollees?	Which Medicaid and SCHIP providers can submit for reimbursement?	Who does the State reimburse?	How much does the state pay for language services provided to Medicaid/SCHIP enrollees?	How does the state claim its federal share – as a service or administrative expense[3]?	What percentage of the state's costs does the federal government pay (FY 2006)[4]?
DC	Fee-for-service[5] (FFS)	FFS practice < 15 employees	language agencies[6]	$135-$190/hour (in-person) $1.60/min (telephonic)	Admin	50%
HI	Fee-for-service (FFS)	FFS	language agencies	$36/hour (in 15 min. increments)	Service	Medicaid (MA) – 57.55% SCHIP – 70.29%
ID	FFS	FFS	providers	$12.16/hour	Service	MA – 70.36% SCHIP – 79.25%
KS	Managed care	not applicable (state pays for language line)	EDS (fiscal agent)	Spanish – $1.10/minute; other languages – $2.04/minute	Admin	50%
ME	FFS	FFS	providers	reasonable costs reimbursed	Service	MA – 63.27% SCHIP – 74.29%
MN	FFS	FFS	providers	lesser of $12.50/15 min or usual and customary fee	Admin	50%
MT	all Medicaid	all[7]	interpreters	lesser of $6.25/15 minutes or usual and customary fee	Admin	50%
NH	FFS	FFS	interpreters (who are Medicaid providers)	$15/hour $2.25/15 min after first hour	Admin	50%
UT	FFS	FFS	language agencies	$28-35/hour (in-person) $1.10/minute (telephonic)	Service	MA – 70.14% SCHIP – 79.10%
VA	FFS	FFS	Area Health Education Center & 3 public health departments	reasonable costs reimbursed	Admin	50%
VT	All	All	language agency	$15/15 min. increments	Admin	50%
WA	All	public entities	public entities	50% allowable expenses	Admin	50%
WA	All	non-public entities	brokers; language agencies	brokers receive administrative fee language agencies receive $33/hour ($34 as of 7/1/07)	Admin	50%
WY	FFS	FFS	interpreters	$11.25/15 min	Admin	50%

District of Columbia

Beginning in March 2006, the District of Columbia's Medical Assistance Administration (MAA) began providing access to a telephone language line that fee-for-service Medicaid/SCHIP providers could use – at MAA expense – to obtain an interpreter. Only fee-for-service primary care providers who employ less than fifteen (15) persons are eligible to use this language line. All FFS providers with fifteen (15) or more employees must provide and pay for interpreter services themselves.

According to the MAA transmittal sent to all Medicaid providers, eligible providers must request interpreter services at least seven (7) business days prior to the date of service or appointment. The provider sends the request to MAA's designated language agency. MAA approves or disapproves each request and the language agency then confirms the availability of an interpreter and notifies the requesting provider and Medicaid beneficiary. If emergency interpreter services are required, the provider can contact the language agency directly.

Managed care organizations have a separate obligation to provide language services under both federal law and the terms of DC's Medicaid managed care contract. Health care providers serving Medicaid managed care enrollees must request an interpreter directly from the MCO. The MCO notifies the requesting provider and Medicaid beneficiary of the availability of an interpreter within three (3) business days of the request.

MAA contracts with one language agency and pays between $130-$190 per hour. The rate varies based on the language needed and how much advance notice is provided. For example, Spanish interpreters cost MAA $135./hour if 3-5 business days notice is provided and $160/hour if less notice is provided; the rates are $160 and $190 respectively for Amharic, Chinese, Korean, and Vietnamese interpreters. After the first hour, charges range from $3-$5 per minute. All encounters are subject to a $25. administrative charge. MAA pays $1.60/minute for telephonic interpretation.

In the first six months the program was operational, MAA spent $895. on interpreters and $2723.09 for translation of written materials.

Hawaii[i]

The state contracts with two language service organizations to provide interpreters. The eligible enrollees are Medicaid fee-for-service patients or SCHIP-enrolled children with disabilities. The state pays the language service agency a rate of $9 per 15 minutes. If an interpreter is needed for more than 1½ hours, a report must be submitted stating the reason for the extended time. Interpreters who are staff or bilingual providers are not reimbursed.

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[i] The information from Hawaii is from 2002. The author made repeated attempts to contact Hawaii agency staff to update this information but received no response.

Interpreters are allowed to charge for travel, waiting time, and parking. The state has guidelines on billing procedures and utilization, and language service organizations are expected to monitor quality and assess the qualifications of the interpreters they hire. The state spends approximately $144,000 per year on interpreter services for approximately 2570 visits (approximately $56 per visit). Hawaii receives reimbursement for the interpreter services as a “covered service” (similar to an office visit or other service covered by the state’s Medicaid plan). The state receives federal reimbursement of approximately 57% for Medicaid patients and 70% for SCHIP patients.

The costs of providing interpreters for in-patient hospital stays are included in hospitals’ existing payment rates; separate reimbursement is not allowed. QUEST, the state’s Medicaid managed care program, includes specific funding in its capitated rates for enabling/translation services (based on volume and claims submission data).

Idaho

Idaho began reimbursing providers for the costs of interpreters prior to 1990. The state reimburses for interpreters provided to fee-for-service enrollees and those participating in the Primary Care Case Management program. Providers must hire interpreters and then submit claims for reimbursement. Providers must use independent interpreters; providers can only submit claims for reimbursement for services provided by members of their staff if they can document that the staff are not receiving any other form of wages or salary during the period of time when they are interpreting. No training or certification requirements for interpreters currently exist.

Hospitals may not submit claims for reimbursement for language services provided during in-patient hospital stays. The costs of language services are considered part of the facilities’ overhead and administrative costs.

Idaho reimburses the costs of language interpretation at a rate of $12.16 per hour (this is the same rate for sign language interpreters). In 2006, the state spent $87,913. on 7,438 units of interpretive services. These services were for 768 unduplicated clients. In FY 2004[8], the state spent $37,621 on language services for 4137 encounters.

Kansas

In 2003, Kansas began offering Medicaid managed care healthcare providers access to a telephone interpreter/language line. The service is provided to primary care providers (for example, individual doctors and group practices, rural health centers, federally qualified health centers, Indian health centers, advanced registered nurse practitioners, and Nurse Mid-wives) and specialists.

The state began providing this service in part because of federal Medicaid managed care regulations and in response to results from a provider survey. The survey results – collected from 87 providers – identified that Spanish is the most frequently spoken language requiring interpretation services. Other languages are less frequently encountered. Nineteen providers reported that they never needed access to an interpreter. Twenty-five providers reported needing an interpreter 1-10 times per month and seven providers responded they needed an interpreter over 100 times per month.

The state's Medicaid fiscal agent, EDS, administers the language line. The provider calls into the Managed Care Enrollment Center (MCEC) and provides a password to the customer service rep (CSR). The CSR then connects to the language line and the provider uses their services. The bill is returned to the MCEC who then passes it on to the state Medicaid agency for reimbursement. The state utilizes two language lines – Propio Language Services for Spanish interpretation (charging $1.10/minute) and Certified Languages International for other languages ($2.04/minute).

From January through December 2006, Kansas spent $46,479.74. Total minutes for calendar year 2006 was 41,193 – 39,951 was Spanish and 1,242 was all other languages.

Maine

According to the National Conference of State Legislatures, interest in adding sign language as a reimbursable service under Medicaid paved the way for adding foreign language interpreters. In January 2001, after public hearings and public comment, Maine revised its Medicaid program manual to add interpreters for sign language and foreign language as covered services.[9]

The state reimburses providers for the costs of interpreters provided to Medicaid and SCHIP enrollees. The selection of the interpreter is left up to the provider. Providers are encouraged to use local and more cost-effective resources first, and telephone interpretation services only as a last resort. Providers then bill the state for the service, in the same way they would bill for a medical visit, but using a state-established interpreter billing code. When using telephone interpretation services, providers use a separate billing code and must submit the invoice with the claim for reimbursement.

The provider must include a statement of verification in the patient's record documenting the date and time of interpretation, its duration, and the cost of providing the service. The state reimburses the provider for 15-minute increments. The reimbursement does not include an interpreter's wait time; travel time is not specifically addressed although its policy states that it will not reimburse an interpreter who is transporting an enrollee. The state no longer has an established reimbursement rate but reimburses "reasonable costs". The provider must ensure that interpreters protect patient confidentiality and have read and signed a code of ethics. The state provides a sample code of ethics as an appendix to its Medical Assistance Manual.

The state is explicit that family members and friends should not be used as paid interpreters. A family member or friend may only be used as an interpreter if: 1) the patient requests it; 2) the use of that person will not jeopardize provider-patient communication or patient confidentiality; and 3) the patient is informed that an interpreter is available at no charge.

Hospitals (for language services provided during an in-patient stay), private non-medical institutions, nursing facilities, and intermediate care facilities for the mentally retarded may not bill separately for interpreter costs. Rather, costs for interpreters for these providers are included in providers' payment rates. *(MaineCare Benefits Manual,* formerly *Medical Assistance Manual,* Chapter 101, 1.06-3.)

Minnesota

In 2001, Minnesota began drawing down federal matching funds for language interpreter services for Medicaid and SCHIP fee-for-service and managed care enrollees. All fee-for-service providers can submit for reimbursement for out-patient services. The state's managed care capitation rate includes the costs of language services.

Under Minnesota's provisions, providers must both arrange and pay for interpretation services and then submit for reimbursement. The state established a new billing code and pays either $12.50 or the "usual and customary charge" per 15-minute interval, whichever is less.

Providers may only bill for interpreter services offered in conjunction with an otherwise covered service. For example, a physician may bill for interpreter services for the entire time a patient spends with the physician or nurse, and when undergoing tests, but not for appointment scheduling or interpreting printed materials. Providers serving managed care enrollees must bill the managed care plan. The managed care plan has the responsibility, pursuant to its contract with the state, to ensure language access; these costs are included in its payment rate.

Hospitals may obtain reimbursement for interpreter costs provided for out-patient care. The costs of language services in in-patient settings are bundled in the hospital payment rate. This payment rate, called the DRG (Diagnosis Related Group), does include a differential to address the costs of language services. When the DRG rates are set by the state, it considers historical data and makes rate adjustments. Although there are not specific adjustments for language services; these costs are generally assumed to be included in the hospital's overhead costs. But because the state bases the DRG on each hospital's own expenses (rather than peer groups or one DRG for the entire state), if a particular hospital has high language services costs, these should be included in the hospital's overall expenses, resulting in a higher DRG rate to compensate.

In FY 2005[10], the state spent $1,644,400 on language services for fee-for-service enrollees. Approximately 15,000 distinct recipients received interpreter services for a total of approximately 42,400 encounters. In FY 2004, the numbers were $1,637,900 for 15,000 distinct recipients and 43,000 encounters.

Website: http://www.dhs.state.mn.us

Montana

Montana began reimbursing interpreters in 1999 following an investigation by the federal HHS Office for Civil Rights. Montana pays for interpreter services provided to eligible Medicaid recipients (both fee-for-service and those participating in the Primary Care Case Management program) if the medical service is medically necessary and a covered service. The interpretation must be face-to-face; no reimbursement is available for telephone interpretation services. The interpreter must submit an Invoice/Verification form signed by the interpreter and provider for each service provided; Montana then reimburses the interpreter directly. Reimbursement is not available if the interpreter is a paid employee of the provider who provides interpretation services in the employer's place of business, or is a member of the patient's family. In addition, the interpreter and provider must attest that the interpreter is qualified to provide medical interpretation.[11]

The reimbursement rate is the lesser of $6.25 per 15-minute increment or the interpreter's usual and customary charge. Interpreters may not bill for travel or waiting time, expenses, or for "no-show" appointments. The interpreter can bill for up to one 15-minute increment of interpreter time outside the Medicaid provider's office (i.e., at the Medicaid client's home or pharmacy) for each separate interpreter service performed per day. This time is specifically used for the interpreter to exchange information and give instructions to the Medicaid client regarding medication use.

The state does not have any interpreter certification requirements. Thus it is the responsibility of the provider to determine the interpreter's competency. While a state referral service operates for sign language interpreters, no equivalent exists for foreign language interpreters. The state spent less than $2000. on interpreters in FY 2006.[12]

New Hampshire

New Hampshire has had policies to reimburse sign language and foreign language interpreters since the 1980's. While the state initially reimbursed for interpreters as a covered service, it currently reimburses interpreters as an administrative expense.[13]

Currently, interpreters are required to enroll as Medicaid providers, although through an abbreviated process since they do not provide medical services. Each interpreter has a provider identification number and can bill the state directly for services provided. The state contracts with EDS – a company that oversees all provider enrollment and billing – which also oversees interpreter enrollment. The state reimburses interpreters $15. for the first hour, and $2.25 for each subsequent quarter hour ($25/hour for sign language interpreters).

Interpreters can bill directly or can work for an organization that coordinates interpreter services. Each interpreter, however, must individually enroll as a Medicaid provider regardless of who bills for reimbursement. Currently, interpreters (or language services organizations) can submit claims for reimbursement for language services only for clients of fee-for-service providers; interpreters cannot submit claims for hospital (in- or out-patient services) and community health center clients. At the present time, the state has 76 interpreters enrolled as Medicaid providers; training programs funded in part by the state have helped increase this number. The state is also examining ways to lessen the administrative burdens on interpreters and increase the availability of Medicaid interpreters.

In FY 2006[14], the state spent $17,809.75 on interpreters (both foreign language and sign language) for 1,763 encounters serving 331 distinct Medicaid recipients. In FY 2005, the numbers were $15,334.50, 1,116 encounters, and 233 Medicaid recipients. In FY 2004, the state spent $9,017 on 157 Medicaid recipients for 605 encounters. In FY 2003, the state spent $5,870 on interpreters. Eighty-two Medicaid recipients received interpreter services for a total of 310 encounters.

Utah

Utah covers medical interpreter services as a covered service; in FY 2007, the state will receive a 72% federal matching rate for Medicaid interpretations and 80% for SCHIP expenditures. The state pays for interpreters when three criteria are met: 1) the client is eligible for a federal or state medical assistance program (including Medicaid and SCHIP); 2) the client receives services from a fee-for-service provider; and 3) the health care service needed is covered by the medical program for which the client is eligible.

The state contracts with four language service organizations – two provide both in-person and telephonic and two only provide telephonic interpreter services to fee-for-service Medicaid, SCHIP, and medically indigent program patients. The health care provider must call the language service organization to arrange for the service. The language service organizations are reimbursed by the state between $28-$35 (with a one-hour minimum). The rates vary by company, time of day (higher rates are paid for after hours services) and less frequently encountered languages. If an in-person interpreter is not available, the provider may use a telephone interpretation service for which the state pays $1.10/minute.

Providers cannot bill Medicaid directly, and they do not receive any rate enhancements for being bilingual or having interpreters on staff. Rather, interpreters bill the Medicaid agency. Hospitals can utilize Medicaid-funded interpreters for fee-for-service Medicaid enrollees for all services covered by Medicaid, both in- and out-patient. Hospitals may not use the Medicaid language services for Medicaid managed care enrollees. For enrollees in managed care, Utah requires health plans to provide interpretation services for their patients as part of the contract agreements. For services covered by Medicaid but not the health plan,[15] the state will pay for interpreters.

Utah does not have training or certification for interpreters but does require the contracting language assistance service organizations to provide information on quality assurance measures, including ethics standards, confidentiality, cultural competence and training in medical terminology.[16]

In FY 2003, Utah spent $46,700 for interpretation although the amount nearly doubled in FY 2004 to $87,500. (Utah's costs for sign language interpretation were approximately $8,000 in FY 2003 and $13,000 for FY 2004 although these figures include non-Medicaid expenses as well). In calendar year 2006, the state spent approximately $263,000 on interpreting of which $180,000 was for foreign language interpreters and $83,000 for sign language interpreters.

Website: http://health.utah.gov/medicaid/html/interpreter.html,
http://health.utah.gov/medicaid/pdfs/InterpretGuide10-06.pdf

Vermont

Vermont began reimbursing for interpreters provided to Medicaid clients a few years ago. Medicaid providers hire interpreters and can submit the costs of interpreters along with the medical claim. Reimbursement is limited to $15. for each 15-minute increment. The state does not reimburse for travel or waiting time. Further, reimbursement is not allowed for bilingual staff that serves as interpreters.

While providers may hire any interpreter, services are primarily provided by one language agency. The state Agency for Health Services has a contract with the language agency to meet its interpretation needs and informs providers of this agency. However, providers must make their own arrangements with the agency. The agency also has a statewide telephonic interpretation contract to provide interpreters in rural areas but providers who use telephonic interpretation cannot currently submit for Medicaid reimbursement.

Virginia

Virginia began a pilot project for reimbursement in 2006. Senate Joint Resolution 122 (2004) directed the Department of Medical Assistance Services (DMAS) to seek reimbursement for translation and interpreter services from the Centers for Medicare & Medicaid Services. The state will submit claims to CMS as part of its administrative expenses. The project began in Northern Virginia.[17] Other areas may join as the project proceeds and DMAS intends to eventually expand the program statewide.

The state has a contract with Virginia Commonwealth University (VCU) to facilitate DMAS payment for these services. VCU is the contracting entity for the Virginia statewide area health education centers program, one of which (Northern Virginia AHEC, hereinafter AHEC) is participating in the pilot project. In addition to AHEC, three health departments (Alexandria City, Arlington County, and Fairfax County) will provide language services. The three health departments currently offer language services through the use of salaried staff, contracted staff, telephonic resources, and administration of services. AHEC will both provide language services and act as a broker to receive calls from recipients requesting language services; confirm that a covered medical service is involved; and schedule the language services. AHEC will aggregate the claims from itself and the health departments and submit them to DMAS through VCU. AHEC and the three health departments will contribute the state's share of costs and obtain 50% federal reimbursement. This agreement is similar to Washington state's Intergovernmental Transfer (see below).

DMAS requires the participating interpreters and translators to meet proficiency standards, including a minimum 40-hour training for interpreters. The state will reimburse for the reasonable costs incurred by the providers. It anticipates that each health department will have contracts to provide telephonic and/or in-person interpreters; since the health department contracts and language agencies will differ, the state chose not to set a reimbursement rate but rather to monitor spending and evaluate whether a state-wide reimbursement rate should be implemented at a later date. There is no formal budget for the pilot project.

In FY 2006, Virginia spent $8546 for 507 hours of service.

Website: http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/SD222004/$file/SD22.pdf

Washington

Providers that are not public entities.[18] In 1998, the Department of Social and Health Services' (DSHS) Language Interpreter Services and Translation (LIST) program began contracting with language agencies through a competitive procurement process. Beginning in 2003, the state changed its system to contract with nine regional brokers for administrative scheduling of appointments. The brokers contract with language agencies. In FY 2004,[19] the Department provided interpreters for over 180,000 encounters. Interpreters are paid for a minimum of one hour; mileage is paid if an interpreter has to travel more than 10 miles.

Rather than require clients to schedule interpreters, providers – including fee-for-service providers, managed care organizations, and private hospitals – call a regional broker to arrange for an interpreter. The state requires providers to schedule interpreters to avoid interpreters independently soliciting work and/or acting as advocates rather than interpreters. Once services are provided, the language agency then bills the broker for the services rendered. For interpretation services provided in a health care setting, the claim form requires the name of the referring physician, as well as the diagnosis or nature of illness or injury.

The state pays the brokers an administrative fee; the brokers then pay the language agencies. For Medicaid and SCHIP enrollees, the state obtains federal reimbursement for these costs. Currently, payments to language agencies are $33.00 per hour, increasing to $34.00 per hour effective July 1, 2007. The state spends approximately $1 million a month on all DSHS language services; from November 2005 to October 2006, Washington provided 217,865 encounters. The Medicaid spending during this time period was $38,225.47.

Washington has a comprehensive assessment program for interpreters. Now called the "Language Testing and Certification program", the state requires medical interpreter certification for interpreters in the seven most prevalent foreign languages in Washington: Spanish, Vietnamese, Cambodian, Lao, Chinese (both Mandarin and Cantonese), Russian, and Korean. Interpreters for all other languages must be qualified rather than certified (because of limited resources available for full certification in all languages). The state has given tests for 88 languages plus major dialects and offers statewide testing at five sites, with four days of testing per month per site. Additional tests are available upon request. The state also offers emergency/ provisional certification for those who have passed the written test but await oral testing, and in other limited situations.

Website: http://www1.dshs.wa.gov/msa/LTC/index.html

Public hospitals and health departments. Washington has a separate reimbursement program for interpreter services provided at government and public facilities, such as public hospitals or local health jurisdictions. These entities can receive federal reimbursement for expenses related to language services if they enter into a contract (e.g. interlocal or intergovernmental agreement) with the state and agree to:

$ provide local match funds (locally generated private funds);
$ ensure that the local match funds are not also used as matching funds for other federal programs;
$ ensure that the local match funds meet federal funding requirements;
$ ensure that the local match funds are within the facilities' control;
$ use only certified interpreters (as certified by Washington's LIST program);
$ coordinate and deliver the interpreter services as specified by the state;
$ collect, submit and retain client data as required; and
$ accept all disallowances that may occur.

These facilities receive reimbursement for both direct (e.g. interpreter services provided as part of the delivery of medical/covered services) and indirect (e.g. time spent coordinating or developing interpreter programs, billing, equipment purchasing) interpreter expenses. The facilities receive reimbursement for 50% of their costs – the federal administrative share. Because these entities act as the state for the purposes of reimbursement, the 50% state "match" is paid by the facility.

There are currently 20 public hospitals with interlocal agreements. Thus far, 12 have been reimbursed $393,414.09 for the last calendar year (the remaining 8 are not current on their billing).

Website: http://fortress.wa.gov/dshs/maa/InterpreterServices/FFP.htm

Wyoming

Beginning in July 2006, Wyoming began paying for language services for its Medicaid enrollees. The interpretation may be provided in-person or via telephone language line.

To access interpreter services, a provider must: 1. determine a need for interpreter services; 2. utilize an agency-approved interpretation provider; 3. provide a medical service for which the interpretation is used. Interpreter services are not provided for in- and out-patient hospital services; intermediate care facilities for persons with mental retardation (ICF-MR); nursing facilities; ambulance services by public providers; residential treatment facilities; comprehensive in- or out-patient rehabilitation facilities; and other agencies/organizations receiving direct federal funding. Further, the state will not pay for interpretation provided by family members, friends or by volunteers.

Interpreters must abide by the national standards developed by the National Council on Interpreting in Health Care (www.ncihc.org). They can bill only for time spent with the client and are not reimbursed for travel.

Interpreters are paid in 15 minute increments (but interpreters can bill for the unit only after 10 minutes into the unit). Interpreters are reimbursed at $11.25/15 min. and are limited to billing no more than six units per date of service for any individual Medicaid recipient.

STATES DEVELOPING REIMBURSEMENT

California

The Department of Health Services (DHS) has convened the Medi-Cal Language Access Taskforce. The Taskforce is charged with forming recommendations to DHS on "a model for the economical and effective delivery and reimbursement of language services in Medi-Cal." The Taskforce includes 22 representatives from the following categories: Office of Multicultural Health Council, Government Agencies, Providers and Practitioners, and Consumers and Advocates.

Website:
http://www.dhs.ca.gov/director/omh/html/MC_Language_Access_Services_Taskforce.htm

Connecticut

On June 19, 2007, Public Act No. 07-185 became law, requiring the Commissioner of Social Services to amend the Medicaid state plan to include foreign language interpreter services provided to any beneficiary with limited English proficiency as a covered service under the Medicaid program. This program has not yet been implemented.

North Carolina

In 2002, the federal Department of Health and Human Services' Office for Civil Rights entered into a Voluntary Compliance Agreement (VCA) with the North Carolina Department of Health and Human Services (DHHS) to identify and meet language needs at the state and county levels. In part because of the VCA and in part from suggestions from the DHHS Compliance Attorney and the Department's Title VI Advisory Committee[20], North Carolina has embarked on plans to initiate reimbursement. The impetus for these discussions is to ensure competent interpreters are available to provide much-needed resources to healthcare providers.

The process is twofold – development of interpreter credentialing and establishment of reimbursement.

Credentialing

Two organizations have been training interpreters in North Carolina since the '90's. Originally, the NC Area Health Educational Center (AHEC) launched a Spanish language interpreter training project. Recognizing the additional needs for interpreter brought on by newly arrived refugees, the Center for New North Carolinians (CNNC) contracted with NCDHHS/DSS to train interpreters in languages other than Spanish. This contract lasted from the spring of 1999 through July of 2003. Following this contract, CNNC continued interpreter training on a fee for service basis. In 2004, AHEC partnered with CNNC statewide to provide interpreter training through the AHEC network. Last year, given CNNC's long history of providing interpreter training, DHHS requested CNNC develop an interpreter credentialing program for interpreters providing language services to DHHS and the healthcare providers it funds.[21]

The current CNNC training program, using a model developed by AHEC, has three levels: Level I is a two day introductory level; Level II is a one day practicum to reinforce the Level I; and Level III is an advanced two day training, currently focused on Spanish medical vocabulary. The new curriculum will continue to include levels I and II but will incorporate recently released National Standards of Practice and Code of Ethics from the National Council on Interpreting in Health Care. It will start with an assessment of an individual's language competency and require a demonstration of interpreter competency. A basic credentialing process will be developed first, followed by specialized credentialing (level III) in advanced areas such as social service, public health, and mental health, using the AHEC Level III construct. DHHS would only reimburse interpreters who are credentialed in the areas for which they interpret.

Reimbursement

After the certification curriculum is approved by the agency, DHHS expects to submit a State Plan Amendment to include language services as a "covered service" in Medicaid. It is expected that reimbursement will include an array of Medicaid services and support the adequate provision of medically necessary care. DHHS will establish procedure codes and anticipates providing reimbursement for both in-person and telephonic interpreters. If an agency providing telephonic interpretation is used, it will be the responsibility of the agency to assure that training is at least equivalent to the requirements of the DHHS approved curriculum.

It is expected that reimbursement will include all types of Medicaid services -- in- and out-patient as well as fee-for-service and managed care. Depending on the development, testing and implementation of certification, reimbursement may begin in early 2008.

Texas

In 2005, Texas enacted legislation establishing a Medicaid pilot project for reimbursement for language services in five hospital districts.[22] The Health and Human Services Commission (HSSC) is tasked with developing the project. HSSC is working to identify the most appropriate model for the pilot. There has been some delay because the majority of

Medicaid enrollees in the designated hospital districts are in managed care. Since the managed care organizations' costs of language services are already included in their capitated rate, the pilot project does not cover them.

Thus, HSSC is working with the hospitals to identify the best methods to track language services provided to fee-for-service and emergency Medicaid recipients. Originally, HSSC offered two cost allocation methodologies – 1) a direct charge allocation method, meaning that the contractor must document that the entire cost is completely related to the performance of an allowable activity, or 2) a Medicaid Eligibility Ratio (MER) allocation method. Since the hospitals assert that both these approaches are administratively cumbersome, they requested consideration of a third approach – a documentation method called a random moment time study (RMTS) approach. HHSC is in the process of seeking approval for this approach with the federal Centers for Medicare and Medicaid Services (CMS).

HHSC is consulting CMS on the possibility of utilizing an RMTS for the pilot. Once CMS guidance is received, HHSC will proceed with the contract development process. The estimated date of program implementation is dependent on CMS direction and contract negotiation.

The state is using the administrative cost mechanism and thus will receive 50% reimbursement from CMS (since TX's covered service FMAP rate is also 50% for Medicaid, it would not gain financially from having language services added to its state plan). The pilot project will likely be financed through "fund certifications" from the participating hospital districts. A fund certification requires the hospital to certify that it has spent a certain amount on language services but, unlike intergovernmental transfers, does not involve the actual transfer of dollars. Because the hospital districts act as the state for the purposes of reimbursement, the 50% state "match" is paid by the facility that will receive reimbursement for 50% of its costs. The program expires on September 1, 2009, if no further action is taken.

Under Texas' two managed care models, the state pays for interpreter services. The state's contracted Medicaid and Children's Health Insurance Program (CHIP) HMOs, as well as the PCCM administrator, are contractually required to provide interpreter services. The state includes the costs of these services into rates paid by the state to these contractors.

A status report on the pilot project was submitted to the State Legislature in January 2007: *Medicaid Interpreter Services Pilot: Report on Program Effectiveness and Feasibility of Statewide Expansion* is available at http://www.hhsc.state.tx.us/reports/RPCMemo121906LangInterpretPilotRept.pdf.

STATES PREVIOUSLY PROVIDING REIMBURSEMENT

Massachusetts

From FY 2002-2005, Massachusetts provided direct reimbursement for language services in Medicaid for hospital emergency rooms and in-patient psychiatric institutions The legislature did not include an appropriation in FY 2006, possibly because the state raised general hospital payment rates. Massachusetts now bundles payment for interpreter services into its payment rates. Massachusetts does not make discrete provider payments for interpreter services because such costs are incorporated in the fee-for-service payment and the agency considers interpreter services to be part of the cost of doing business for hospitals as well as other providers. The following describes the program as it had operated.

In April 2000, the legislature passed Chapter 66 of the Acts of 2000, "An Act Requiring Competent Interpreter Services in the Delivery of Certain Acute Health Care Services." This law, effective July 2001, mandates that "every acute care hospital . . . shall provide competent interpreter services in connection with all emergency room services provided to every non-English-speaker who is a patient or who seeks appropriate emergency care or treatment." The law also applies to hospitals providing acute psychiatric services. The state attorney general is authorized to enforce the law, and individuals who are denied emergency services because of the lack of interpreters are also given legal standing to enforce their rights.

In 2003, Massachusetts received approval of three State Plan Amendments (one each for psychiatric hospitals, and in-patient and out-patient acute-care hospital care) to obtain federal reimbursement. In FY2005, the last year the program operated, the state budget included an appropriation of $1.1 million to reimburse hospitals and acute psychiatric facilities for the costs of language services. The state's Medicaid agency made "supplemental payments" to "qualifying" hospitals for interpreter services provided at hospital emergency departments, acute psychiatric facilities located within acute hospitals, and private psychiatric hospitals. The distribution was based on an "equity formula" comparing expenses submitted by each qualifying hospital to the total expenses submitted by all qualifying hospitals.

In addition, the state's Medicaid agency previously considered interpreter costs in its DSH (Disproportionate Share Hospital) distribution formula. Medical interpreter costs were identified by the hospitals on their cost reports, which were used to determine unreimbursed costs for DSH purposes. Distribution of DSH funds was then based on these unreimbursed costs.

As part of its comprehensive Health Care Reform plan, passed in April 2006 and approved by the federal government in July 2006, Massachusetts technically no longer has a DSH program. MA has transitioned its federal DSH dollars, as well as other federal 1115 waiver-related dollars, into a new pool of money called the Safety Net Care Pool. Safety Net Care Pool funds are used to provide subsidies to low-income individuals to purchase private coverage through the Commonwealth Care program (which was implemented on October 1, 2006) and to fund a residual uncompensated care pool. For purposes of its Uncompensated Care Pool (UCP), Massachusetts allows hospitals to include the costs of language services in the base costs used to develop Medicaid rates and the UCP cost-to-charge ratio.

CONCLUSION

Given the requirements of Title VI of the Civil Rights Act of 1964 that health care providers who receive federal funds ensure access to services for people with limited English proficiency, more states should access available federal funds to ensure that their agencies – and the providers with whom they contract – have the means to hire competent medical interpreters. The use of competent interpreters can improve the quality of care, decrease health care costs by eliminating unnecessary diagnostic testing and medical errors, and enhance patients' understanding of and compliance with treatments.

ENDNOTES

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[1] This document outlines information gathered as of March 15, 2007.

[2] This document is available in the *Language Services Action Kit* from NHeLP and The Access Project at http://www.healthlaw.org/library.cfm?fa=detail&id=71337&appView=folder.

[3] States can draw down Medicaid/SCHIP funding in two ways – as a "covered service" (paying for the cost of a service, such as a doctor's office visit or a hospital stay) or as an "administrative expense" (paying for the costs of administering the program). For information *see How Can States Get Federal Funds to Help Pay for Language Services for Medicaid and SCHIP Enrollees?* in NHeLP's *Language Services Action Kit, available at* http://www.healthlaw.org/langaccess/resources.html#nhelp.

[4] For "covered services", the federal reimbursement rate varies from 50-83%, based on the state's per capita income. For "administrative" expenses, every state receives 50% of its costs from the federal government.

[5] "Fee-for-service" generally refers to services *no*t provided through a managed care organization, community health center or in-patient hospital settings. Providers agree to accept a state-set "fee" for the specific "service" provided.

[6] Language agencies are organizations that contract with and schedule interpreters. They may also oversee assessment and/or training.

[7] Providers who have staff interpreters cannot submit for reimbursement.

[8] FY 2004 ran from July 1, 2003 through June 30, 2004.

[9] Language Access: Giving Immigrants a Hand in Navigating the Health Care System, NCSL's *State Health Notes*, volume 23, number 381, October 7, 2002).

[10] FY 2005 ran from July 1, 2004 through June 30, 2005.

[11] Interpreter Services, Medicaid Services Bureau, 11/27/02, *available from* National Health Law Program.

[12] FY 2006 ran from July 1, 2005 through June 30, 2006.

[13] NH switched from a covered service to an administrative reimbursement due to a change in CMS policy; subsequently CMS clarified that states can get reimbursed at the covered service rate. Since New Hampshire's FMAP for medical services, 50%, is the same as for administrative expenses, no practical difference exists in New Hampshire. For SCHIP, considering language services as a covered service would increase the federal share of costs.

[14] The state's fiscal year runs from July 1 through June 30.

[15] For example, pharmacy, dental and chiropractic services.

[16] Bau I, Chen A. Improving access to health care for limited English proficient health care consumers: Options for federal funding for language assistance services. The California Endowment *Health in Brief* April 2003.

[17] The project will initially include Arlington County, Fairfax County, Falls Church and Alexandria City.

[18] Washington has two reimbursement mechanisms. The first is for non-public entities – this includes most fee-for-service providers, managed care providers, and non-public hospitals.

[19] The fiscal year runs from July 1, 2003 through June 30, 2004.

[20] The Title VI Advisory Committee composed of representatives from all divisions within the Department, including public health, social services, mental health, vocational rehabilitation, and Medicaid, and volunteers from the North Carolina Institute of Medicine, the Justice Center (legal aid) and several statewide advocacy groups. Its 25 members have a wide range of skills and hold various positions in and out of state government.

[21] In 1999, NCDHHSDSS contracted with CNNC to train health and human service interpreters in languages other than Spanish (the state contracted with NC Area Health Education Centers (AHEC) to train Spanish interpreters) and provide refugee interpreter services in the state. Beginning three years ago, AHEC began contracting with CNNC for the bulk of its interpreter training services. CNNC also maintains an interpreter bank from which health care providers can contract trained interpreters.

[22] S.B. No. 376 passed the Senate on March 17 and the House on May 9, 2005. A separate bill, H.B. No. 3235, was also enacted requiring provision of interpreter services to deaf and hard of hearing Medicaid patients subject to the availability of funds. The five hospital districts given preference are Harris County Hospital District; Bexar County Hospital District; El Paso County Hospital District; Tarrant County Hospital District; and Parkland Health and Hospital System.

Final Recommendations to the Oregon Health Fund Board (OHFB) and the Eligibility & Enrollment Committee of the OHFB

Health Equities Committee Policy Recommendations on Eligibility

- *It is a long held Oregon value that all Oregon residents have equal opportunity to support their families, pay taxes, and contribute to the State's economy. To maintain the health of that workforce, it is fair, wise and in the State's economic interest that the Oregon Health Fund program shall be available to all Oregon residents.*

- *As consistent with current practices in the private marketplace, no citizenship documentation requirements will be in place to participate in the Oregon Health Fund program.*

In order for these two recommendations to be realized, the Committee felt that policy implementation options should be considered by the Oregon Health Fund Board.

For example, a preferred option from the Committee would be: *to establish an 'Oregon Primary Care Benefit Plan', or alternatively a health care pool, within the Oregon Health Fund Program for non-qualified [legal immigrants who have been in the U.S. under 5 years, and individuals without documentation] Oregon residents who are unable to afford purchasing health care without a subsidy. Financing for this portion of the program could be structured so that industries employing non-qualified Oregon residents are directed to contribute through the "play or pay" requirement of the employer mandate.*

The Committee recognizes that this option faces the following challenges:
- If revenue comes solely from businesses rather than community support—it may still prove to be economically infeasible;
- The administration of such a program may require limited state funds for implementation;
- Creating two entirely different programs based on eligibility creates equity issues;
- This program could be construed as implicit support for individuals who are not authorized U.S. residents; and,
- Businesses may oblige the "play or pay" requirement for "recognized" workforce and avoid "unrecognized" workforce unless the state actively identified individuals in the latter group.

However, the Committee also maintains this recommendation for the following reasons:
- The Oregon Health Fund Program would be "universal" in that all Oregon residents included;
- No specific federal waiver would be needed if federal funds are not being utilized;
- Addresses both "cost-shift" from uncompensated care as well as public health concerns created by exclusion;
- Businesses that heavily rely on a largely immigrant workforce will be included in the employer mandate and would also directly benefit from participation;

- If the Oregon Primary Care Benefit Plan is within the Oregon Health Fund Program it would combine all value-based purchasing advantages; and,
- Is less voluntary in design for employers and would therefore possibly prove to be more economically sustainable.
- The state would continue to benefit from federal dollars that support the CAWEM program, providing reimbursement for emergency hospitalization costs, including childbirth.

The alternative policy options the Committee considered:

Non-qualified Oregon residents may purchase their own health coverage either through the private market or through the exchange and are ineligible for direct state contributions.

Challenges:
- Oregon Health Fund Program would not be "universal" in that low-income non-qualified Oregon residents excluded;
- This option doesn't address the "cost-shift" from uncompensated care as well as public health concerns created by exclusion; and,
- The "play or pay" amount from businesses employing non-qualified workers not provided to those workers.

Advantages:
- No specific federal waiver would be needed;
- Option takes 'hot button' issue of immigration off the table as something that may stymie or present a roadblock to bipartisan agreement for comprehensive plan; and,
- This option would be consistent with current public programs such as the Oregon Health Plan and the Family Health Insurance Assistance Program (which requires citizenship documentation).

All Oregon residents are to be eligible regardless of federal qualifications for state contributions to low-income individuals through the Oregon Health Fund Program.

Challenges:
- No federal match would be available for these individuals and the program would be reliant on state contribution only;
- Inserts 'hot button' issue of immigration into the comprehensive plan that may stymie or present a roadblock to bipartisan agreement; and,
- Inconsistent with the Oregon Health Plan that requires citizenship documentation.

Advantages:
- Oregon Health Fund Program would be "universal" in that all Oregon residents included;
- Addresses both the "cost-shift" from uncompensated care as well as public health concerns created by exclusion; and,

Final Recommendations to the Oregon Health Fund Board (OHFB) and the Eligibility & Enrollment Committee of the OHFB

- The “play or pay” amount from all businesses going to all workers regardless of federal qualification.

Final Recommendations to the Oregon Health Fund Board (OHFB) and the Eligibility & Enrollment Committee of the OHFB

Establish an 'Oregon Primary Care Benefit Plan' within the health insurance exchange alongside the Oregon Health Fund Program whereby foundations, providers, managed care groups, targeted employers, counties, cities and others may continually contribute funds, on a voluntary basis, that will be appropriated to provide subsidies to individuals that do not qualify for state contributions but are unable to afford purchasing health care without them.

Challenges:

- Not a guarantee of shared responsibility "play or pay" payment by businesses that employ non-qualified individuals;
- Voluntary basis of revenue source may provide an inadequate long-term economic feasibility, particularly if large industries such as hospitality and/or agricultural choose not to participate;
- If not financially viable, fewer people will be covered, violating universality due to enrollment caps;
- Creating two entirely different programs based on eligibility creates equity issues;
- State resources would be necessary for administrative costs due to eligibility determinations; and,
- Could be construed as implicit support for individuals who are not authorized U.S. residents.

Advantages:

- Comprehensive plan would be "universal" in that all Oregon residents eligible;
- No specific federal waiver would be needed and no foreseeable problems with federal match;
- This option avoids contentious immigration debate that could weigh down the comprehensive plan because new state dollars will not be appropriated for non-qualified individuals;
- This option would be consistent with the Oregon Health Plan (which requires citizenship documentation) for state contributions;
- Addresses both "cost-shift" from uncompensated care as well as public health concerns created by exclusion; and,
- This option allows a myriad of interested parties the opportunity to contribute to reduce the number of uninsured Oregonians

Policy Recommendations "Straw-Person" on Improving the Health Care Workforce and Reducing Health Care Disparities

1. Expand educational institution capacity at health professional schools where more training opportunities are needed across the board from community college to university and postgraduate levels. Oregon's health care provider shortage is exacerbated by the population's growing diversity

2. Increase financial aid in health professional schools for underrepresented in medicine (URM)[*] students needing more financial aid of the right kind (grants, scholarships, loan forgiveness). Ultimately, our patients pay the price when there are insufficient providers from backgrounds similar to theirs. Geographic, economic, educational, and cultural factors, with their effects on patient mortality, underscore the critical need for providers from disadvantaged backgrounds and with superior cultural sensitivity training, to improve health care for the underserved throughout Oregon. As physicians, dentists, or physician assistants, they will then be able to serve those who are now underserved, improving access to care. In addition, these individuals will function as role models for youth in their communities.

3. Strengthen the pipeline to health profession schools intervention needs to start early and focus on retention. We expect that educational and experiential support in the pre-college, college and medical and dental school years will enable more applicants from these backgrounds to apply to medical and dental school, gain admission and graduate. This should include convening all entities that are currently working on pipeline development issues so that efforts are streamlined.

4. Improve climate for diversity at individual health professional schools where cultural and linguistic competence must be mandated throughout the institution. This in turn will mean better patient satisfaction and medical compliance, with decreases in morbidity and mortality related to chronic diseases in the long run. Economically, the decrease in disabling disease states translates into lower spending on health care, as well as increased income from a more productive workforce.

5. Establish accountability mechanisms to ensure diversity goals are reached in recommendation 4.

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[*] "'Underrepresented in medicine' means those racial and ethnic populations that are underrepresented in the medical profession relative to their numbers in the general population." For example: African Americans, Hispanic or Latino, American Indian or Alaskan Native, Native Hawaiian or Other Pacific Islander. Hence, most Asians, Chinese, Filipino, Japanese, Korean, Asian Indian or Thai are not considered underrepresented in medicine.

DRAFT – FOR DISCUSSION ONLY

Policy Recommendations "Straw-Person" on Elements of the Medical Home and Primary Care Renewal that Reduce Health Disparities

1. Definition of Medical Home: A system of care that provides coordination of multiple, disparate elements of care for a patient. This does not assume that all care is provided within the walls of the medical home.

2. Elements of the Medical Home model that have been demonstrated to reduce health disparities and must be encouraged in any medical service organization purporting delivery of a Medical Home include:
   a. Extended office hours: evenings and weekends
   b. Alternative access to providers such as telephone consultations and email exchanges.
   c. Automatic reminders of recommended visit schedule and appointment times.
   d. Mental Health and Chemical Dependency Integration
   e. Emphasis on chronic disease management and preventive care

3. For some populations, a medical home may be best provided outside of the traditional primary care service delivery system and a definition of medical home should not exclude organizations based on service-delivery type.
   a. Examples include a community based social organization, a peer support network and organizations that integrate social determinants of health into care including public health.

DRAFT – Final Recommendations

Recommendation from the Health Equities Committee Concerning Outreach

A media-only approach to outreach for the Oregon Health Fund Board is not an adequate response to reducing health disparities in health insurance status in Oregon.

1. A sustainable funding mechanism, with additional Medicaid matching funds, must support community-based organizations in delivering culturally-specific and targeted outreach with direct application assistance to members of racial/ethnic/language minority communities, individuals living in geographic isolation, and populations that encounter additional barriers such as individuals having cognitive, mental health, deafness or sensory disorders, physical disabilities, chemical dependency or mental health condition, and individuals in homelessness.
2. These community-based approaches should be collaborative rather than competitive among agencies that serve vulnerable populations.
3. The Office of Multicultural Health and Oregon’s county health departments should have a key role in ensuring that barriers to outreach and enrollment are addressed at both the community and system level and that those efforts are continuous and coordinated between the Oregon Health Fund Program, Department of Medical Assistance Programs, and community-based organizations.
4. The Office for Oregon Health Policy & Research should evaluate the effectiveness of the county-based organizations in their efforts to enroll vulnerable populations.

100% enrollment of individuals who are eligible to participate in the Oregon Health Fund Board is the object and resources and interventions must be targeted towards this goal.

DRAFT Final Recommendations

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http://www.hhs.gov/valuedriven/fourcornerstones/index.html

The Executive Order is intended to ensure that health care programs administered or sponsored by the federal government build on collaborative efforts to promote four cornerstones for health care improvement:

1. **Interoperable Health Information Technology (Health IT Standards):** Interoperable health information technology has the potential to create greater efficiency in health care delivery. Significant progress has been made to develop standards that enable health information systems to communicate and exchange data quickly and securely to protect patient privacy. Additional standards must be developed and all health care systems and products should meet these standards as they are acquired or upgraded.
2. **Measure and Publish Quality Information (Quality Standards):** To make confident decisions about their health care providers and treatment options, consumers need quality of care information. Similarly, this information is important to providers who are interested in improving the quality of care they deliver. Quality measurement should be based on measures that are developed through consensus-based processes involving all stakeholders, such as the processes used by the AQA (multi-stakeholder group focused on physician quality measurement) and the Hospital Quality Alliance.
3. **Measure and Publish Price Information (Price Standards):** To make confident decisions about their health care providers and treatment options, consumers also need price information. Efforts are underway to develop uniform approaches to measuring and reporting price information for the benefit of consumers. In addition, strategies are being developed to measure the overall cost of services for common episodes of care and the treatment of common chronic diseases.
4. **Promote Quality and Efficiency of Care (Incentives):** All parties - providers, patients, insurance plans, and payers - should participate in arrangements that reward both those who offer and those who purchase high-quality, competitively-priced health care. Such arrangements may include implementation of pay-for-performance methods of reimbursement for providers or the offering of consumer-directed health plan products, such as account-based plans for enrollees in employer-sponsored health benefit plans.

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2. For some populations, a medical home may be best provided outside of the traditional primary care service delivery system and a definition of medical home should not exclude organizations based on service-delivery type.

3. The promotion of medical homes, including the establishment of standards, public reporting of performance, and rewards for achieving excellence, would support improvement in the delivery of health care services in all settings.

Policy and Procedures for Staff Review Panels

1. The meetings of the Board, its six committees (Finance, Delivery System, Benefits, Enrollment & Eligibility, Health Equities and Federal Law) and the formal work groups created by the committees (currently Insurance Exchange [Finance Committee] and Quality Institute [Delivery System]) are subject to public meetings requirements. This has been and will continue to be the operating policy of OHFB/OHPR.

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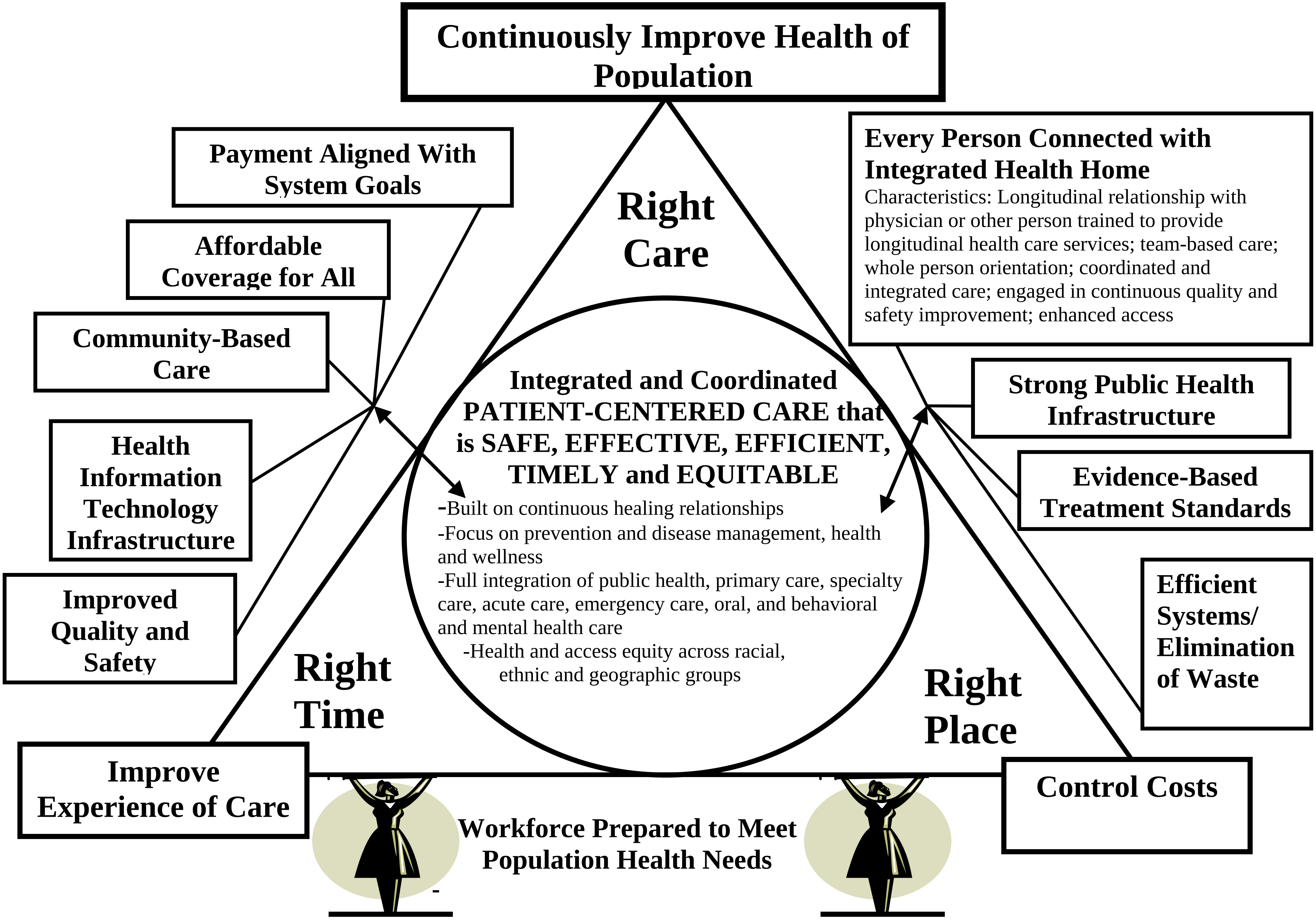
Framework for Delivery System Reform in Oregon
DRAFT 1/10/08



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

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

Strong Public Health Infrastructure

Evidence-Based Treatment Standards

Efficient Systems/ Elimination of Waste

Right Care

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

Right Time

Right Place

Improve Experience of Care

Control Costs

Workforce Prepared to Meet Population Health Needs

Excepts from Reports Consulted in Developing Framework for Delivery System Reform

Institute of Medicine (IOM)– Crossing the Quality Chasm
http://books.nap.edu/openbook.php?record_id=10027&page=R1

The committee proposes six aims for improvement to address key dimensions in which today's health care system functions at far lower levels than it can and should. Health care should be:

- Safe - avoiding injuries to patients from the care that is intended to help them.
- Effective - providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively).
- Patient-centered - providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
- Timely - reducing waits and sometimes harmful delays for both those who receive and those who give care.
- Efficient - avoiding waste, including waste of equipment, supplies, ideas, and energy.
- Equitable - providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

Institute for Healthcare Improvement (IHI) – Best Health Care Results for the Population: The Triple Aim
http://www.ihi.org/NR/rdonlyres/5FFFC58F-3236-4FB7-8C38-2F07CC332AE3/0/IHITripleAimTechnicalBriefJune2007.pdf

Transformation of health care delivery starts with a transformational aim. The Institute for Healthcare Improvement believes that one such transformational aim includes a balance or optimization of performance on three dimensions of care—which IHI calls the "Triple Aim":

1. The health of a defined population;
2. The experience of care by the people in this population; and
3. The cost per capita of providing care for this population.

These three dimensions of care pull on the health care system from different directions. Changing any one of the three has consequences for the other two, either in the same or opposite directions. For example, improving health can raise costs; reducing costs can create poor outcomes, poor experience of care, or both; and patients' experience of care can improve without improving health. With the goal of optimizing performance on all three dimensions of care, we recognize the dynamics of each dimension while seeking the intersection of best performance on all three.

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DRAFT Final Recommendations

Health Equities Committee Policy Recommendations on Citizenship Documentation Requirements for Participation in OHP-like Programs

1. *The Health Equities Committee recommends investigating the possibility of obtaining a federal waiver exempting Oregon from the citizenship documentation requirements established by administrative rule, stemming from the Deficit Reduction Act of 2007.*
2. *Oregon would request returning to previous documentation methodology employed by the Department of Medical Assistance Programs. Findings from a previous state audit demonstrated that this methodology was an effective mechanism for ensuring appropriate participation in the Oregon Health Plan.*

DRAFT – NOT FOR DISTRIBUTION

The Medical Home Model of Primary Care: Implications for the Healthy Oregon Act

December 2007

Office for Oregon Health Policy and Research

DRAFT – NOT FOR DISTRIBUTION

The Medical Home Model of Primary Care: Implications for the Healthy Oregon Act

Prepared by:

Rob Strenger, MD, MPH, Oregon Health and Science University Family Medicine, with updates from Office for Oregon Health Policy and Research staff

Received by:

The Office for Oregon Health Policy and Research

If you have any questions, or if you need this material in
an alternate format, please call (503) 378-2422

Office for Oregon Health Policy and Research
http://egov.oregon.gov/DAS/OHPPR/

December 2007

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Gretchen Morley - OHPR
Ralph Prows, M.D. – Regence BCBS
Jeanene Smith, M.D. – OHPR
Elizabeth Steiner, M.D. – Oregon Academy of Family Physicians
Jean Thorne – Public Employees’ Benefits Board
Rick Wopat, M.D. - Samaritan Health System

Contents

Executive Summary

The Healthy Oregon Act of 2007 establishes the Oregon Health Fund Board (OHFB) and charges it with developing a comprehensive health care reform plan for the state. The Act directs the Board to reform the current health care system so that it covers all Oregonians, while improving equity, efficiency, safety, effectiveness, quality and affordability of care. The bill specifically calls for a revitalization of primary care, with an increased focus on prevention, wellness, and disease management and requires that the Board explore proposals to expand access to primary care medical homes.

While there are significant problems with the entire health care system in Oregon, there are specific challenges in the primary care sector that must be addressed by any effort to improve health care delivery. A primary care workforce shortage, as well as decreasing access to primary care providers, makes it difficult for many Oregonians to seek regular primary care and receive recommended primary care and preventative services. In addition, primary care physicians are facing overwhelming workloads, but are paid substantially less than specialists. Evidence shows that an effort to overcome these challenges and strengthen the primary care core in Oregon can lead to a system that better meets the needs of the population. Research has demonstrated better health outcomes and lower per capita costs for states and countries with strong primary care systems.

Many health care organizations and professional associations see the primary care medical home as a vital component of primary care renewal. While a number of slightly different definitions have been proposed, the primary care medical home can generally be characterized as a primary care practice which provides the following to its patients: a continuous relationship with a physician; a multidisciplinary team that is collectively responsible for providing for a patient’s longitudinal health needs and making appropriate referrals to other providers; coordination and integration with other providers, as well as public health and other community services, supported by health information technology; an expanded focus on quality and safety; and enhanced access through extended hours, open scheduling, and/or email or phone visits. While there have been few large-scale demonstrations of medical homes, a growing evidence base demonstrates that these core features can lead to higher patient satisfaction, better health outcomes, and lower overall costs.

One of the major barriers to the implementation of the medical home model is the current reimbursement structure. Most physicians are currently paid on a fee-for-service basis, which rewards providers for higher volume rather than for using resources effectively to maximize health. In addition, providers are currently reimbursed only for office visits and cannot bill for email or phone communication with patients or for providing care coordination services. A number of different payment mechanisms have been proposed to encourage primary care providers to become more patient-centered and to provide the resources that practices need to transform into true medical homes. In order to more closely align reimbursement policies with the goals of the medical home, funding mechanisms must be transparent, provide services for coordination of care, improve access and care management, reward providers for improving health outcomes and quality and decreasing cost; and must support transitional and start-up costs associated with transformation, including investments in health information technology. A number of payment models have been proposed to support the medical home, including pay-for-performance and pay-for-process, comprehensive prospective payments for providing medical home services, fee-for-service reimbursement for medical home services, one-time grants and specific support for case management, and disease management services. Most organizations have agreed that effective payment reform will need to combine traditional fee-for-service payments with bundled payments for providing medical home services and a bonus based on performance.

There are a number of key systems and cultural and policy barriers that must be addressed in any effort to transform primary care practices across the state into patient-centered primary care medical homes. These challenges include inadequate funding of primary care, dilution of financial incentives across purchaser organizations, an absence of a common vision among primary care providers, premature expectations of progress, habituation to misaligned incentives, resistance to change, and a public that is accustomed to an open health system. Fortunately, there are many organizations in both the private and public health care sectors in Oregon and across the nation that have invested resources in medical home initiatives and demonstration projects to learn how the medical home model can be implemented in real world settings. Many of these efforts are described in the ***Medical Home Initiatives and Demonstration Projects*** section of the full paper. These efforts have resulted in important tools and lessons that can inform the work of the Oregon Health Fund Board.

In its efforts to encourage system changes and move towards providing a primary care medical home for all Oregonians, the Oregon Health Fund Board should consider the following steps:

#1 – *Encourage and reward efforts to inform providers of the need for primary care reform and the characteristics of a patient-centered medical home.*

#2 – *Develop a standard definition of medical home and standard measures to determine whether primary care providers meet this definition. This definition should be broad enough to allow for innovation and encompass various models that provide medical home services to their patients.*

#3 – *Coordinate lessons from current demonstrations of medical home models in Oregon and encourage more demonstrations.*

#4 – *Consider specific support for demonstration projects targeted at small practices and rural providers.*

#5 – *Consider specific support for demonstration projects targeted at high need or vulnerable populations.*

#6 – *Develop a sustainable financing model that supports medical home services.*

#7 – *Partner with other purchasers of health care to develop a uniform set of standards or common measures of clinical performance outcomes.*

#8 – *Consider how best to provide adequate funding for technical support, education, and dissemination of best practices to support patient-centered primary care practice re-design.*

Introduction

Passed in 2007, the Healthy Oregon Act establishes the Oregon Health Fund Board (OHFB) and tasks it with developing "a comprehensive plan" for health reform in Oregon.[1] The Act creates the Oregon Health Fund Program, the goal of which is to provide Oregonians with universal access to high-quality health care while containing system-wide costs. Meeting the goals outlined in the Healthy Oregon Act will require an efficient and effective system for delivering primary care. One way to accomplish this, as specified by the Act, will be to require that every participant in the new program has a "primary care medical home".

The aim of this paper is to provide the OHFB and the public with information on the current status of the primary care system in Oregon as well as an overview of the role for medical homes in this environment. It looks within Oregon, as well as to other states and coalitions, to examine the defining characteristics of primary care homes and draw lessons from efforts to integrate medical home programs into delivery systems. Medical homes will likely play a large role in the new Oregon Health Fund Program, and this report offers key opportunities for the OHFB to consider as the group develops a plan for delivery system reform.

The Primary Care System Envisioned by the Healthy Oregon Act

The ambitious goals of the Healthy Oregon Act will require significant changes in the financing and delivery of health care in Oregon. The Act lays out a series of core principles on which the Oregon Health Fund Program must be based, which include "expanding access, equity, education, efficiency, economic sustainability, aligned financial incentives, wellness, community based care, and coordination of care (Sect 3, 1-15)". The bill calls for a greater emphasis on preventative care, chronic disease management, health promotion and wellness, which are hallmark features of a strong primary care core. Furthermore, the Act specifies that all participants in the Oregon Health Fund Program should have a primary care home and that payment incentives must be restructured to reward more effective and efficient provision of care. Given these requirements, delivery system redesign must begin with a renewal of the primary care system, which includes efforts to provide more Oregonians with primary care medical homes.

Challenges Facing the Primary Care System

By many accounts, the medical system in Oregon is not sustainable. In its *Road Map for Health Care Reform*, the Oregon Health Policy Commission found that the number of uninsured Oregonians is rising; health care costs are increasing rapidly; service delivery is fragmented; and the current system fails to consistently provide high-quality, prevention-oriented health care to Oregonians.[2]

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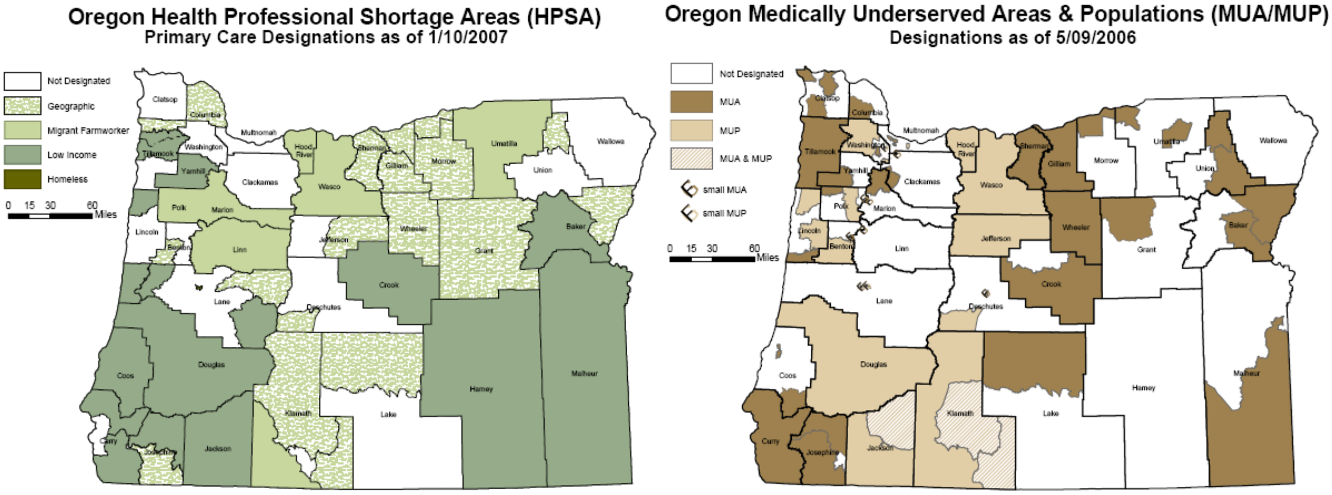
[1] Enrolled Senate Bill 329, The Healthy Oregon Act. June 2007.
[2] Oregon Health Policy Commission. Road Map for Health Care Reform. March 2007.

While the whole health care system is not performing adequately, there are many unique problems in the primary care system that prevent even those with health insurance and a regular doctor from consistently receiving high-quality, cost-effective care.

Workforce shortage in primary care – There are 63 primary care physicians for every 100,000 residents in Oregon, representing about one-third of the physician workforce.[3] If these physicians were ideally distributed and all worked a full-time clinical schedule, this would result in a panel size of about 1,600 patients per primary care physician. Proposals for primary care reform suggest a panel size of between 1,000-2,000 patients per full time provider, with smaller panel sizes when physicians provide care to many complex patients with chronic conditions.[4,5] Given the current numbers of physicians and distribution of primary care providers, an ideal panel size is unattainable in much of the state. Consequently, significant portions of the Oregon population live in a primary care Health Professional Shortage Area (defined as a local population to primary care physician ratio of greater than 3,500:1) or are "medically underserved" (Figure 1).[6]

Figure 1: Primary Care Shortage Areas and Underserved Populations in Oregon



Decreasing access to primary care providers – As the shortage of primary care physicians becomes more pronounced, patient access to primary care providers suffers. According to a national survey of patients' experiences, the percentage of patients who could not schedule timely appointments with their physician increased between 1997 and 2001. During the same period, patients also reported increased problems reaching their medical provider on the phone and being able to get to their physician's office when it

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[3] Health Resources and Services Administration. State Health Workforce Profiles: Oregon. 2000.

[4] Gorrol AH, Berenson RA, Schoenbaum SC, et al. Fundamental Reform of Payment for Adult Primary Care: Comprehensive Payment for Comprehensive Care. Journal of General Internal Medicine. 2007;22(3):410-415.

[5] Labby D. Personal communication about the CareOregon primary care renewal demonstration project.

[6] Oregon Division of Health System Planning. Charts compiled using data from HRSA.

was open.[7] Access is further hindered by an increasing number of primary care practices that are closed to new patients, most often those covered through Medicare, Medicaid or Workers' Compensation. In 2006, 18.1% of Oregon's family or general medicine practices reported they were completely closed to new Medicare patients, 25.6% reported they were closed to new Workers' Compensation patients, and 14.9% reported they were closed to new Medicaid patients.[8]

Overwhelming workload for primary care providers – In the last several decades, evidence-based guidelines for management of chronic diseases and preventive care have generated an ever-increasing and complex workload for primary care providers.[9] Primary care providers do not have the resources and support they need to provide high-quality care in this new environment. For example, a recent study found that primary care providers would have to spend 10.6 hours per day (27% more time than is currently available on average for patient care) just to provide a 2,500 patient panel with all of the recommended care for ten chronic conditions.[10]

Needed care falling through the cracks – Given this overwhelming workload, it is not surprising that the quality of primary care is not ideal. On average, patients receive about 55% of the health care recommended by current guidelines.[11] Another study found that patients visiting their family physician were up to date on only 55% of screening tests, 24% of immunizations, and 9% of habit-related health counseling.[12]

Inadequate and inequitable reimbursement – Despite the growing and complex responsibilities associated with providing primary care, primary care physicians are paid substantially less than other physicians and have slower rates of salary growth despite similar work hours. The median income of primary care physicians is roughly half that of specialists, and the income gap is widening.[13] This income differential is cited as one of the reasons that fewer and fewer medical students are choosing to go into general primary care.[14] Furthermore, the majority of providers in the United States are paid on a fee-for-service basis, creating a system that rewards acute treatment of disease, rather

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[7] Strunk BC, Cunningham PJ. Treading Water: Americans' Access to Needed Medical Care, 1997-2001. Washington, DC, Center for Studying Health System Change. 2002.

[8] Oregon Physician Workforce Survey, Office for Oregon Health Policy and Research. May 2007.

[9] Bodenheimer T, Grumbach K. Improving Primary Care: Strategies and Tools for a Better Practice. Chapter 1: The Primary Care Home. McGraw Hill Companies Inc. 2007.

[10] Ostbye T, Yarnall KS, Krause KM, et al. Is There Time for Management of Patients with Chronic Disease in Primary Care? Annals of Family Medicine. 2003;1:149-155.

[11] Recommended health care includes chronic care, acute care and preventive care. McGlynn EA, Asch SM, Adams J, et al. The Quality of Health Care Delivered to Adults in the United States. New England Journal of Medicine. 2003;6:63-71.

[12] Stange KC, Flocke SA, Goodwin MA, et al. Direct Observation of Rates of Preventive Service Delivery in Community Family Practice. Preventive Medicine. 2000;31:167-176.

[13] Bodenheimer T, Berenson RA, Rudolf P. The Primary Care-Specialty Income Gap: Why it Matters. Annals of Internal Medicine. 2007;146(4):301-307.

[14] American College of Physicians. The Impending Collapse of Primary Care Medicine and Its Implications for the State of the Nation's Health Care. January 2006. Available: http://www.acponline.org/hpp/statehc06_1.pdf

than efforts to keep patients healthy, prevent costly diseases, and effectively manage chronic conditions.

Primary care providers are the backbone of the health care system. About one-third of physicians in Oregon practice primary care and they account for about half of all physician visits.[3,15] If adequately supported, these providers can deliver the majority of health care required by their patients in a low-cost, efficient way. However, if system changes are not implemented, the primary care system will remain unable to achieve these goals.

If health reform is to create sustainable change, it must include the primary care system. One model for primary care reform is the medical home model included in the Healthy Oregon Act. The Oregon Academy of Family Physicians, the Oregon Primary Care Association, and a number of national groups have endorsed this model.[16] The Oregon Health Policy Commission and the Public Employees' Benefits Board have also proposed moving towards the medical home model.[2]

The Medical Home Model of Primary Care

The concept of a "medical home" was initially proposed by the American Academy of Pediatrics in 1967 and has evolved over the last several decades. As health care has grown increasingly complex, fragmented, and disorganized, the medical home model represents a strategy for strengthening the primary care system's ability to deliver care that is patient-centered, evidence-based, and coordinated.[17] In short, a medical home is a regular source of medical care that delivers the services needed to achieve optimal individual and population health.

Many professional organizations have developed definitions that specify the characteristics of a medical home (see Appendix A). At the beginning of 2007, the four largest professional associations representing primary care practitioners, the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the American College of Physicians (ACP) and the American Osteopathic Association (AOA), agreed on a set of core features of a "Patient-Centered Medical Home" model. These groups have joined with employers, consumer advocacy and other stakeholder groups to form the Patient-Centered Primary Care Collaborative to promote this model nationwide.[18] The core features include the following:

- ***Personal Physician –*** Every patient has an established and continuous relationship with a personal physician.

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[15] Graham R, Roberts RG, Ostergaard DJ, et al. Family Practice in the United States. JAMA. 2002;288:1097-1101.

[16] American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Osteopathic Association. Joint Principles of the Patient-Centered Medical Home. March 2007.

[17] American College of Physicians. The Advanced Medical Home: A Patient-Centered, Physician-Guided Model of Health Care. ACP Policy Monograph; 2006.

[18] Patient-Centered Primary Care Collaborative. http://www.pcpcc.net

- ***Physician Directed Medical Practice* -** Physician directs a coherent team of providers who are collectively responsible for the patient's longitudinal health needs. Roles within the team are assigned to maximize the efficient use of resources and responsiveness to patient needs.
- ***Whole Person Orientation* –** Medical home assumes responsibility for providing for all of the patient's health care needs, including acute care, preventative, disease management services, and end of life care. The medical home provides direct care when possible and arranges for appropriate referrals to other providers.
- ***Coordinated and/or Integrated Care* -** Care received from the medical home is coordinated/integrated with care received from other providers and organizations, as well as with services provided within a patient's community, including public health, mental health, and behavioral health services. Coordination allows patients to receive appropriate care when and where they need it. Registries, information technology, information exchange, and other resources are utilized by the medical home to establish and facilitate coordination.
- ***Quality and Safety* –** Medical homes focus on quality improvement and safety, through physician participation in performance measurement and improvement efforts, use of clinical decision-support technology, and clinical standards and guidelines built on evidence-based medicine. Patients participate in shared decision-making, quality improvement efforts and practice evaluation.
- ***Enhanced Access*** – Patient access to both office-based and non-office based care is expanded through mechanisms such as longer hours, group visits, open scheduling, phone and email visits, and other web-based communication. [16, 19]

Many primary care practices currently strive to provide their patients with a regular source of care and at least some of the "medical home" set of services; however, very few providers are able to offer their patients a true patient-centered medical home. For instance, a recent national patient survey found that about 80% of patients have a regular source of care, but only 27% report that their provider meets four indicators of improved access to care, a necessary component of the medical home.[20] Oregon has a strong primary care base on which to build, but those involved in all aspects of health care delivery will need to rethink the way care is delivered in order for reforms to successfully provide all Oregonians with medical homes.

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[19] Robert Graham Center. The Patient Centered Medical Home: History, Seven Core Features, Evidence and Transformational Change. November 2007.

[20] Beal AC, Doty MM, Hernandez SE, et al. Closing the Divide: How Medical Homes Promote Equity in Health Care. The Commonwealth Fund. June 2007.

Benefits of the Medical Home

There is a substantial body of evidence supporting the value of a health care system built around a robust primary care core:

- States with a higher percentage of primary care providers have better health outcomes on a variety of measures while areas with more specialists have higher per capita costs and lower quality.[21,22,23]
- Countries with a strong primary care system have better health outcomes and lower per-capita costs than countries with weak primary care.[24]
- Improved access to primary care results in decreased hospitalization rates for ambulatory care sensitive conditions.[25,26]
- Patients with primary care physicians as their regular source of care have lower health care costs than those who list specialists as their regular source of care.[27]

The abundance and diversity of evidence on the positive effect of primary care lends support to the theory that any of a number of policy options to strengthen the primary care system would likely improve health system performance.[28] However, a distinction must be made between simply providing patients with access to the existing primary care system versus making structural changes in the delivery system to achieve the level of service called for by most definitions of medical home. While there have been few large-scale demonstrations of medical homes, there is growing evidence that demonstrates the benefits of the core features of the Patient Centered Medical Home model in achieving better health outcomes, higher patient satisfaction, and lower overall costs.

Continuity of Care – A comprehensive review of studies evaluating continuity of care found that continuity of care, usually measured as seeing the same provider over time, is consistently associated with a number of positive effects including improved delivery of preventive services, decreased emergency room utilization, decreased hospitalization

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[21] Shi L. Primary Care, Specialty Care and Life Chances. International Journal of Health Services. 1994:24:431-458.

[22] Shi L, Macinko J, Starfield B, et al. Primary Care, Social Inequalities and All-Cause, Heart Disease and Cancer Mortality in US Counties, 1990. American Journal of Public Health. 2005;95:674-680.

[23] Baicker K, Chandra A. Medicare Spending, the Physician Workforce, and Beneficiaries' Quality of Care. Health Affairs. Web Exclusive. 2004.

[24] Macinko J, Starfield B, Shi L. The Contribution of Primary Care Systems to Health Outcomes Within Organization for Economic Cooperation and Development (OECD) Countries, 1970-1988. Health Services Research. 2003;38:831-865.

[25] Backus L, Moron M, Bacchetti P, et al. Effect of Managed Care on Preventable Hospitalization Rates in California. Medical Care. 2002;20:315-324.

[26] Bodenheimer T, Fernandez A. High and Rising Health Care Costs. Part 4: Can Costs be Controlled While Preserving Quality? Annals of Internal Medicine. 2005;143:26-31.

[27] Franks P, Fiscella K. Primary Care Physicians and Physician Specialists as Personal Physicians. Health Care Expenditures and Mortality Experience. *Journal of Family Practice.* 1998;47:105-109.

[28] Starfield B, Shi L, Macinko J. Contribution of Primary Care to Health Systems and Health. Milbank Quarterly. 2005;83(3):457-502.

rates, and increased patient satisfaction.[29] In addition, strong, continuous physician-patient relationships have been associated with lower costs of care.[30]

Team-Based Approach to Care **–** A significant body of literature supports both short-term and long-term benefits of care delivered by a multidisciplinary team, especially for patients with chronic disease. For instance, studies of patients with diabetes have reported higher patient satisfaction, improved quality of life, better health outcomes, and decreased cost of care when patients are treated by a team, rather than by a single physician.[31]

Coordination of Care – A wealth of evidence exists to show that care management programs and other strategies to coordinate the care of patients with complex medical conditions can improve quality and reduce costs. This type of care management has been widely embraced across the country. However, the disease-specific approach is impractical in patients with multiple chronic conditions. Further, carved-out disease management programs duplicate services that could be delivered by a single, trusted medical home. A variety of studies have shown that various care coordination strategies (e.g. health care teams including full time RNs or care managers dedicated to care coordination) can improve care in certain populations of complex patients, such as children with special health care needs.[32] The goal of a medical home model is to provide person-based coordination of an individual's health care needs at the level of their primary provider, rather than coordination based on a specific disease or condition.

Health Information Systems – Health information systems such as electronic medical records will form the basis of many quality improvement efforts, including efforts to manage the health of populations at the primary care level. In addition, such systems will become essential as primary care providers are asked to generate practice and individual-level data under pay-for-performance financing models. Early studies of the implementation of electronic medical records have shown that such systems can reduce primary care practice costs and provide data that improves the quality of care.[33,34]

Improved Access **-** A recent national survey found that patients who are seen by a provider meeting four indicators of improved access to care (regular source of care, easy phone access, weekend/evening access and efficient, on-time visits) received better care

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[29] Saultz JW, Lochner J. Interpersonal Continuity of Care and Care Outcomes: A Critical Review. Annals of Family Medicine. 2005;3:159-166.

[30] Robert Graham Center, The Patient Centered Medical Home: History, Seven Core Features, Evidence and Transformational Change, November 2007.

[31] National Diabetes Education Program. Team Care: Comprehensive Lifetime Management of Diabetes. Available: http://ndep.nih.gov/diabetes/pubs/TeamCare.pdf

[32] Wise PH, Huffman LC, Brat G. A Critical Analysis of Care Coordination Strategies for Children With Special Health Care Needs. Technical Review No. 14. AHRQ Publication No. 07-0054. Rockville, MD: Agency for Healthcare Research and Quality. June 2007.

[33] Miller RH, West C, Brown TM, et al. The Value of Electronic Health Records in Solo or Small Group Practices. Health Affairs. 2005;24(5):1127-1137.

[34] Jamtvedt G, Young JM, Kristoffersen DT, et al. Audit and Feedback: Effects on Professional Practice and Health Care Outcomes. Cochrane Database of Systematic Reviews. 2006 (2): CD000259.

than patients seen by other providers (Figure 2).[19] Limited access to care is a key driver of socioeconomic health care disparities, and improving access reduces or eliminates health disparities by race and insurance status across the seven measures shown in Figure 2.[35] There is evidence that a variety of strategies to improve access (e.g., group visits, communication by phone and e-mail, after-hours accessibility) may improve the efficiency, equity, and efficacy of primary care.[36]

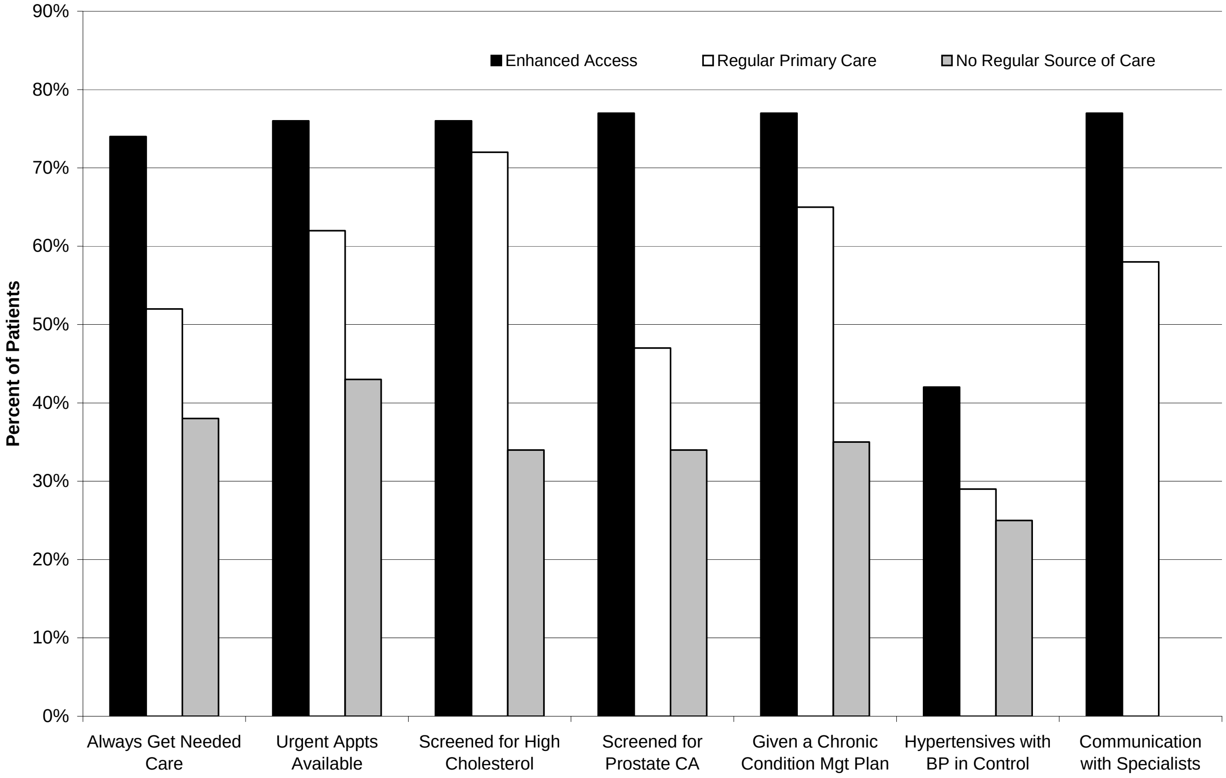

Figure 2: Effect of Enhanced Access to Care

Source: Beal, et al., Commonweath Fund, June 2007.

Overall Demonstrations of the Medical Home Model – While medical homes have not been implemented in the U.S. on a large scale, a number of local demonstration projects have shown that the medical home model can produce tangible results.

The Southcentral Foundation in Alaska (see ***Medical Home Initiatives***) lead an implementation of a medical home model at the Alaska Native Medical Center which improved a variety of care measures over a 5-year period, including decreased overall

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[35] Andrulis DP. Access to Care is the Centerpiece in the Elimination of Socioeconomic Disparities in Health. Annals of Internal Medicine. 1998;129(5):412-416.

[36] Bodenheimer T, Grumbach K. Improving Primary Care: Strategies and Tools for a Better Practice. Chapter 7: Alternatives to the 15-minute Visit. McGraw-Hill Companies, Inc. 2007.

and disease-specific hospitalizations, improved childhood immunization rates, decreased emergency room and provider visits, and decreased visits to specialists.[37]

Implementation of a care-management based medical home model at Intermountain Health Care in Salt Lake City resulted in significant health improvements, including improved glycemic control, decreased hospitalization rates and decreased death rates in elderly patients with diabetes, compared to patients at control clinics.[38]

The available evidence does not support the conclusion that there is one "right" model of primary care delivery. It does, however, show that redistribution of limited health care resources with investment to the medical home bundle of services can be an effective strategy for improving individual health, population health, and overall health system performance.

As the Oregon Health Fund Board works to integrate the medical home concept into the Oregon Health Fund Program, it will be important to consider the special needs of communities across the state. There may not be one model that works for everyone and the services provided by a medical home and the manner in which care is delivered will likely have to vary to meet the needs of specific populations, especially those considered to be vulnerable due to socioeconomic status, race or ethnicity, geographic location or chronic disease conditions. The resources dedicated to expanding primary care through the utilization of medical homes must be directed to help communities fulfill these individual needs while maximizing community health.

Provider Incentives and Financial Models

A critical barrier to the implementation of the medical home model is the current payment structure which supports only face-to-face office visits and limited reimbursement for case management services provided by nurses and other members of a care team.[39] Without changes in policy, primary care providers have little incentive to expand their activities to include optimal primary care functions such as care coordination or expanded access via extended hours, e-mail, or phone communication. In addition, physicians are not rewarded for reduced spending achieved through better disease management or for improving quality of care. Furthermore, there are few or no incentives to invest in electronic medical records, data collection systems, or other infrastructure changes to improve the quality and safety of care.

Researchers, professional societies and others have proposed a variety of mechanisms to finance a re-designed primary care system. While there is no clear consensus or evidence

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[37] Eby D. Healthcare Transformation. Presentation at the Oregon Community Health meeting. Southcentral Foundation Alaska Native Medical Center. December 2006

[38] McConnell J, Dorr D, Radican K, et al. Creating a Medical Home Through Care Management Plus. Presentation at Academy Health Annual Meeting. April 10, 2007.

[39] American Academy of Pediatrics. The Medical Home: Policy Statement. Pediatrics. July 2002; 110(1): 184-186.

to support a single, best financing mechanism, there is general agreement on a number of key attributes, including the following:

- Payment reform is critical component of any effort to re-design primary care and promote the medical home model.
- Funding mechanisms must be transparent to providers, plans, and consumers.
- Funding mechanisms must provide reimbursement for services and activities not currently covered under traditional fee-for-service (FFS) payments. These include coordination of care, improved access, and care management.
- Funding mechanism must reward providers for improving health outcomes, improving quality of care, and decreasing cost through better preventative and disease management services.
- Payers must recognize that there are transitional and start-up costs associated with moving to a medical home model, including investments in health information technologies.
- Regardless of the payment mechanism, resources will need to be redirected to optimize the level of primary care service.

Medical homes have been implemented under a diverse range of financing structures from capitated managed care plans to staff model HMOs to traditional multi-payer FFS systems with bonuses and carved out payments for specific services. Below is a summary of a number of payment models that could be employed by health plans to support medical homes. A table comparing these models is shown in Appendix B.

Pay for performance – Pay-for-performance programs provide enhanced FFS rates and/or bonus payments to providers based on the achievement of specific clinical outcomes or benchmarks. *Example incentive*: Annual bonus payment to providers for meeting a clinical outcome goal, such as a target immunization rate or percent of diabetics in good glycemic control.

Pay for process – Pay-for–process programs are similar to pay-for-performance ones, but they include bonuses for meeting process benchmarks and indicators, rather than specific clinical outcomes. *Example incentive*: Annual bonus payment to providers for meeting a process goal, such as implementation of an electronic medical record (EMR) or maintaining a diabetic registry.

Comprehensive prospective payments – Prospective payments could be given on a per-client basis, risk-adjusted for patient mix, to cover the full range of medical home services. Payments could include disbursement guidelines to require a certain practice structure, staffing level or other practice characteristic (e.g. EMR for every patient) to receive the full payment. Unlike traditional capitated payments, prospective payment would not require providers to assume financial risk for non-primary care costs such as specialty and hospital care. *Example incentive*: Annual payment of $500 per enrolled patient for providing a predetermined package of primary care services, with guidelines as to the appropriate level of service.

FFS reimbursement for non-reimbursed activities – Billing codes could be created for activities other than face-to-face office visits, such as case management, telephone and e-mail encounters, and group visits, to allow physicians and other providers to bill for these services. *Example incentive*: Case management reimbursement codes with assigned relative value units (used to track physician productivity and performance) could generate revenue for primary care practices, allowing them to bill for services consistent with the medical home model.

One-time start-up grants/demonstrations and technical assistance – One-time payments and educational services could be provided by payers to assist providers, especially those in small or solo practices, with systems change. *Example incentives*: $5,000 one-time grant payment to a small practice to support the implementation of an EMR, educational course for providers on staffing models for a medical home practice, or training course for primary care case managers.

Carved out case management and disease management services – Health plan could sponsor case managers/disease managers assigned to specific providers and/or regions. Unlike traditional disease management, case managers hired by a health plan would work closely with primary care providers through a shared medical record and frequent communication. Physicians could refer complex patients to the case manager for additional support and patient education. Shared information systems would allow the physicians to manage overall care and work collaboratively with case managers. *Example incentive*: Physician refers a complex patient to a case manager, who develops an ongoing management plan and educational interventions and shares plans with the physician. Utilization of case management could improve practice efficiency through the off-loading of work, which would motivate physicians to utilize case management.

Mixed models – A number of organizations have proposed mixed financing models that retain FFS payments for in-person visits but add various prospective and bonus payments to support medical home services.[40,41,42] The most common additions in mixed financing models include:

- Prospective payments to cover a bundle of specific services consistent with the medical home model. *Example incentive*: $100-200 annual payment per patient for practices accredited as medical homes.
- Prospective payments to cover specific overhead costs or practice improvements. *Example incentive*: $10 annual payment per patient for practices with an EHR.
- Incentive/bonus payments for quality improvement. *Example incentive*: $80 annual bonus per patient for meeting quality benchmarks for diabetic care, $5 annual bonus per patient for establishing patient education programs.

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[40] Kirschner N, Doherty R. A system in need of change; restructiring payment policies to support patient-centered care. American College of Physicians. October 2006.

[41] Spann SJ. Task Force Report 6. Report on financing the new model of family medicine. Annals of family medicine. 2004;2 supp 3:S1-S21.

[42] Bridges to Excellence Project. www.bridgestoexcellence.org

- Direct FFS reimbursement for currently non-reimbursed activities such as e-visits, telephone visits, etc.

The Patient-Centered Primary Care Collaborative developed a mixed payment model, which the group believes could realign incentives to support the primary care medical home. The model maintains traditional FFS for face-to-face office visits combined with a monthly risk-adjusted prospective "care coordination payment" to cover the cost of services outside of the face-to-face visit and necessary investment in health information technology. The collaborative model also includes a performance payment that rewards medical homes that are able to delivery high quality and cost-effective care.[43]

At this time, there is no strong evidence to support a single, best financing model, although mixed models appear to be the most common in practice. This is likely because it is easier to build on top of current FFS reimbursement than to develop entirely new systems. Financing models employed successfully in Oregon and elsewhere are discussed below in ***Medical Home Initiatives.***

Barriers to Delivery System Change in Primary Care

There are a number of key systems and cultural and policy barriers that must be addressed in any effort to move towards a medical home model of primary care. It will be necessary for the Oregon Health Fund Board to address these challenges if primary care revitalization is going to be incorporated into statewide delivery reform, but it is not necessary to completely reinvent the wheel. There are a number of organizations and programs in the state and across the nation that have started to address these issues and develop innovative solutions from which important lessons can be drawn. Demonstration projects and other efforts to transform primary care practices into medical homes have been initiated by many different stakeholders in the health care industry – public and private purchasers, private insurance carriers and public insurance programs, individual health systems and clinics, professional organizations, and non-profit organizations have all been involved.

Some of the barriers to delivery system change are explored below, along with a description of some efforts to overcome these obstacles. More comprehensive efforts to implement the patient-centered medical home model in real world settings are discussed below in ***Medical Home Initiatives.***

Inadequate funding – One major barrier to establishing medical homes is inadequate funding for primary care, especially in the areas of preventative care, disease management and care coordination services. In demonstration projects where implementation of a medical home model has produced positive results, additional resources have been directed towards the primary care system. These resources are typically used to improve infrastructure, hire support staff, and allow providers to deliver

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[43] Patient Centered Primary Care Collaborative. A New Physician payment System to Support Higher Quality, Lower Cost Care Through a Patient-Centered Medical Home. May 2007. Available: http://www.pcpcc.net/node/9

care outside of face-to-face visits. While multiple different funding mechanisms have been successfully employed, it is clear that quality and efficiency improvements in primary care will require a redistribution of financial resources.

Absence of common vision among primary care providers – While many leaders in primary care have embraced the concepts of the medical home model, it is not clear that a majority of practicing clinicians share this vision. In a 2006 physician survey, one-third of primary care providers felt that team-based care was cumbersome, and 21% felt it would increase medical errors.[44] Only 23% of primary care providers reported currently using an electronic medical record, and only 23% plan to implement an EMR in the near future. Less than half of respondents send their patients reminder notices for regular follow-up or preventive care. Fortunately, new efforts to build support for primary care reform among health care providers in Oregon could add needed grass-roots support for system reforms. Projects such as the Archimedes Movement, the Better Health Initiative, and the Oregon Health Reform Collaborative are working to build a unified vision of delivery system reform within the health care community.[45,46]

The medical home concept is also a significant part of the national dialogue on health reform and quality improvement. As discussed above, the Patient-Centered Primary Care Collaborative unites the major primary care physician associations, which together represent 330,000 primary care physicians, and major national employers, health benefits companies, trade association, academic centers and quality improvement associations around the medical home concept. The Collaborative supports a single set of core features of the medical home and works to promote and advance the patient-centered medical home on a national scale. The coalition held a national “Call-to-Action” summit focused on the medical home in Washington, DC in November 2007.[47]

Dilution of financial incentives – A large number of payers are involved in the financing of health care. In order for quality improvement incentives to be effective, they must be large enough to encourage primary care providers to change the way they practice. In a multi-payer market, if only a few payers provide modest financial incentives, incentives will be ineffective in creating change. The same will be true if many payers encourage different behaviors or outcomes. Organizations such as PEBB and the Oregon Health Care Purchasers Coalition are working to address this problem by trying to align payers around common quality improvement incentives in both the public and private sectors. Other states such as Minnesota have taken a similar approach, trying to align the incentives used by all public purchasers of health care.

Premature expectations of progress – Many proponents of primary care and the medical home model advise caution in expecting rapid progress. Experience shows that

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[44] Audet A, Davis, K and Schoenbaum SC, Adoption of Patient-Centered Care Practices by Physicians. Archives of Internal Medicine. 2006. 166(7):754-759.

[45] Oregon Health Reform Collaborative. http://www.oregonhealthreform.org/

[46] Archimedes Movement. http://www.archimedesmovement.org

[47] Patient-Centered Primary Care Collaborative. http://www.patientcenteredprimarycare.org/index.htm

investments in primary care systems can produce tangible results; however, they should be viewed as long-term investments, not short-term solutions to prevent budget problems in the next legislative cycle. While some demonstration projects have received results in a short time frame, this experience is not likely to be generalizable when a medical home model is implemented more widely. Efforts that focus on improving quality of care for one condition may see quicker results. However, the medical home concept requires system change that addresses all of a patient's needs, and this type of change does not occur quickly. Once a program is implemented, it can take years for system changes to become widespread and additional years to see cost and quality improvements. This is especially true in the management of chronic disease, where improvements in care are likely to prevent costly complications years or decades in the future. Likewise, the return on investment from preventative care may not be realized until significant time has lapsed.

Habituation to misaligned or absent incentives – The current health care system is not structured to advance the goals of improved quality, decreased cost, and enhanced efficiency. Providers are rewarded for increasing volume, while health plans control their costs by limiting and reducing benefits. Other than the beneficent desire of providers and plans to provide good care to patients and clients, there are few formal incentives to improve the quality of care, to coordinate care, or to make care more accessible. Everyone involved with health care has become accustomed to doing business under the current system with its absent and misaligned incentives. While "aligning incentives" seems an obvious solution, significant leadership and education will be needed to help habituated providers and administrators understand and embrace the vision of a health system centered on medical homes.

Lack of readiness for change – Nearly all of the research and demonstration projects surrounding medical home have been conducted in controlled environments where motivated and willing individuals became educated about health system re-design and created change, often after applying for grant funding to do so. Implementing widespread change of the primary care system will require change by those who have not been educated about system re-design and may not be motivated to change. Changing the way care is delivered and financed requires different skills than those needed to continue operating in the current system. Even with sufficient financial resources, those accustomed to the current system may need education, technical assistance and support to foster change. One model for providing such support at the health plan level is the PEBB "Council of Innovators" (see ***Medical Home Initiative***). At the practice level, CareOregon is developing expertise in supporting primary care re-design and professional societies such as the American Academy of Family Physicians have resources to help guide primary care practices through the re-design process.

An open system – The American health care system is often called an "open system." There are few restrictions on how patients access the health care system. For a medical home model to be most effective, the medical home should be the point of first contact for all non-emergent medical services. In communities where there is only one medical provider or a single hospital or health system, the open system problem is less severe. However, in urban areas with many specialists and hospitals, care can easily become fragmented and disorganized. Patient education and frequent contact with clinic staff can help combat the open system problem, as can health plan efforts to link patients with a primary care provider and encourage a single access point through the medical home.

Medical Home Initiatives and Demonstration Projects in Oregon and Elsewhere

(This section does not provide an exhaustive list of innovations and initiatives, but seeks to describe examples of efforts initiated by a variety of stakeholder groups)

National Organizations

National Committee for Quality Assurance – Before practitioners can be rewarded for providing medical home services to their patients, it is necessary to develop standards and metrics by which the characteristics of a medical home can be measured. The National Committee for Quality Assurance (NCQA) developed the Physician Practice Connection (PCC) tool to recognize practices that “use information to improve the quality of care delivered to patients”. The tool evaluates a practice’s ability to use systems to track patients’ treatments and conditions; manage patient care over time; support patient self-management; utilize electronic prescribing; track and follow up on lab results, imaging tests, and referrals; measure performance and efforts to improve performance; and move towards interoperable information systems. Recently, the NCQA updated the PCC so that it can be used to measure the degree to which a practice exemplifies “patient-centered primary homeness.” New measures capture patient communication by telephone and email, in addition to in-person visits, expanded access, care management, availability of culturally and linguistically appropriate services, and the overall patient experience. The tool can now be used to qualify and recognize primary care medical homes and measure the degree to which the characteristics of a medical home are associated with higher quality care.[48]

TransforMED **–** In 2006, TransforMED, an affiliate of the AAFP, launched a 24-month national demonstration project. Thirty-six sites were selected across rural, suburban, and urban settings to redesign their practices based on the TransforMED Medical Home Model (Figure 3). Central Oregon Family Medicine, PC, a medium size practice (4-6 physicians) in Redmond, OR was one of the practices selected. Eighteen of the practices are undergoing self-directed reform, whereas the other 18 are participating in a facilitated process that includes frequent site visits, message boards, blogs, conference calls, electronic seminars, and collaborative meetings. Real-time evaluation of all sites is being lead by The Center for Research in Family Medicine and Primary Care and is looking at patient satisfaction, physician and staff satisfaction and quality of life, clinical process and outcome measures, and financial impact on practice revenues and physician income. Lessons and best practices will be published in peer-reviewed journals so that other practices can learn from the demonstration project.[49]

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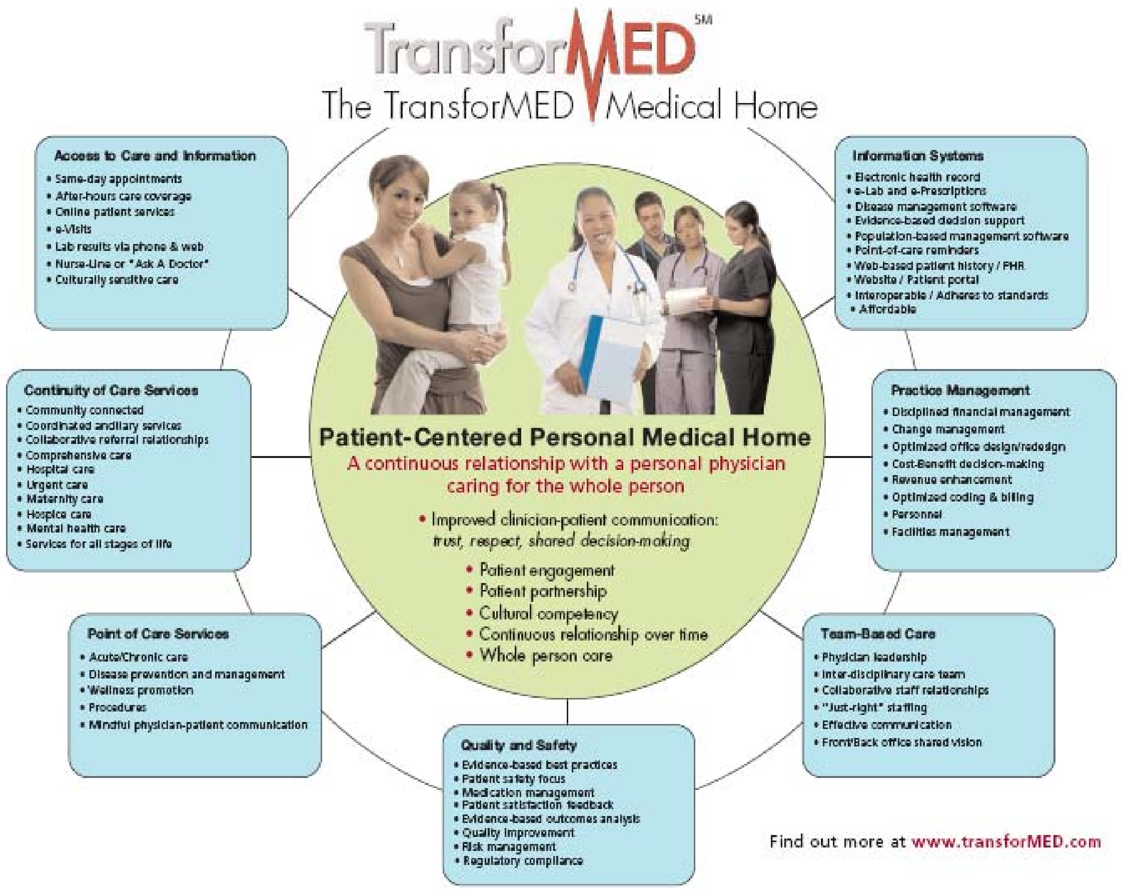
[48] Pawlson G. Executive Vice President, National Committee for Quality Assurance. Assessing the Patient-Centered Medical Home. Presentation at Patient-Centered Primary Care Collaborative Call-to-Action Summit. Washington, DC. November 7, 2007.

[49] TransforMED. http://www.transformed.com

Figure 3: TransforMed Medical Home Model



State Level

Q-Care in Minnesota - In 2006, Minnesota's governor signed an executive order to increase the impact of value-based purchasing efforts in the state. The executive order requires all state purchasers of health care to include a common set of "Q-Care" quality standards in their contracts with health plans and providers. Purchasers must also implement financial incentives (pay-for-performance) to achieve specific quality improvement targets. The initial Q-Care effort focuses on quality improvement in four areas: diabetes care, cardiovascular care, hospital care, and preventive care. At the primary care level, incentives will encourage the attainment of specific clinical targets, such as glycemic and cholesterol control for patients with diabetes, blood pressure control for cardiovascular patients, and rates of immunizations and disease screening in eligible populations. To encourage the use of Q-Care standards more widely, the state is partnering with private purchasers and local governments. The effort is being coordinated through the Governor's "Health Cabinet" and the State Center for Health Care Purchasing Improvement, which was established in 2006.[50] While these efforts in Minnesota are not specifically looking to establish a medical home model of care, payments based on quality improvement could provide additional revenue needed to support changes in the primary care system.

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[50] QCare. http://www.health.state.mn.us/healthinfo/qcare.html

Community Care of North Carolina – The North Carolina Department of Health and Human Services has built community health networks to deliver primary care to the state's Medicaid population. There are currently fourteen networks in the state, which include physicians, hospitals, pharmacists, local health departments, social service agencies, and other safety net and community-based providers. The state pays networks a per-member/per-month (PMPM) fee to manage care for a group of enrollees and hire case managers and medical management staff to support primary care physicians in the networks. The networks create the infrastructure to allow small practices to share case managers, while larger provider groups may be assigned their own support staff.[51] Primary care physicians in the networks are paid an additional PMPM payment to provide medical home services, including quality improvement and disease management efforts.[52] Each network has established medical and administrative committees that are tasked with developing tools to help providers in the network implement disease management services, manage high-risk patients and high-cost services, and build accountability among providers. Leading physicians from each network work together to establish clinical guidelines and best practices in different care areas and have established initiatives in the areas of asthma disease management, congestive heart failure disease management, diabetes disease management, emergency room, pharmacy management, and case management of high-risk and high-cost patients. These initiatives have resulted in significant cost savings for the state Medicaid program and improved health outcomes.[48]

Purchaser Level

Public Employees' Benefit Board (PEBB) – PEBB designs, purchases, and administers health care and other benefits for state employees and their dependents. PEBB is the largest employer-based purchaser in the state of Oregon, covering 120,000 lives. In 2004, PEBB decided to use its purchasing power to encourage delivery system reforms that improve the quality and affordability of health care. They developed a 2007 Vision for a "new state of health", which included the following principles: provision of evidence-based medicine; a focus on improving quality and outcomes; promotion of consumer education, healthy behaviors, and informed choice; alignment of market incentives; transparency at all levels of the system; and affordability. PEBB used these guiding principles to develop a value-based purchasing initiative and issued a request for proposals (RFP) for vendors interested in providing health benefits under this new plan.

Applicants were scored on technical criteria across seven dimensions that PEBB decided were closely aligned with the plan's ability to provide high-quality and high-value care to its enrollees. Heavy weight was given to vendors' ability to meet quality criteria in the domains of medical home (25% of score) and evidence-based care (20% of total score). Examples of technical criteria in the primary care area included systems measures

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[51] North Carolina Community Care. North Carolina Community Care Fact Sheet. October 2007. Available: http://www.communitycarenc.com/WordDocs/CCNC%20AT%20A%20GLANCE.doc

[52] Dobson LA. Former Assistant Secretary, North Carolina Department of Health and Human Services. Improving Medicaid Quality and Controlling Costs by Building Community Networks of Care. Presentation at Patient-Centered Primary Care Collaborative Call-to-Action Summit. Washington, DC. November 7, 2007.

(percent of primary care providers with an EMR), process measures (patient satisfaction surveys and care management programs) and financial/outcome measures (implementation of pay-for-performance and other incentive structures). The other dimensions used to score vendor applications included evidence-based care, member self-management, service integration, infrastructure, transparency, and managing for quality.[53]

PEBB received nineteen responses to their RFP and ultimately selected four vendors to provide health benefits: Kaiser Permanente, Regence BCBS, Providence Health, and Samaritan Health. Contract renewal will be contingent on the plans' ability to demonstrate improved performance and at least incremental change in reaching the high rating criteria established in the RFP. In order to achieve a high rating on the medical home dimension, plans will have to be able to document that all enrollees are offered a medical home, require providers to report on preventative and screening services, measure outcomes for enrollees with certain target conditions, and demonstrate that a large percent of their primary care physicians have access to EMRs. In addition, the vendors agreed to participate alongside PEBB representatives on a "Council of Innovators" to focus on continued quality improvement and review and make recommendations regarding implementation of the 2007 Vision.[54] The Council provides a unique opportunity for public and private representatives to work together to explore options for encouraging primary care revitalization centered around the medical home model, as well as larger delivery and quality improvement reforms.

Oregon Health Care Purchasers Coalition (OHCPC) – The OHCPC is a non-profit organization of public and private purchasers of health care (including PEBB), working to improve purchasers' ability to buy high-value health care for their employees. The OHCPC seeks to use the joint purchasing power of the public and private membership to change the way health is delivered and improve health outcomes across the state. In 2007, the OHCPC started to use eValue8, an evidence-based survey tool which collects and compiles information from health plans on hundreds of process and outcome measures. Eight Oregon plans agreed to submit data to eValue8, and data was collected and evaluated in the areas of plan profile, consumer engagement, provider measurement, prevention and health promotion, pharmaceutical management, chronic disease management, and behavioral health. While the tool does not specifically measure a plan's ability to offer its enrollees a medical home, many of the desired characteristics of a medical home are captured in the other dimensions. In this first year, results were used for quality improvement efforts – plans were able to compare their own performance with other plans in the state and nation and the OHCPC members were given the opportunity to meet and discuss results with each participating plan. In the future, OHCPC will seek opportunities to increase the number of plans that participate in the survey and release

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[53] PEBB Vision for 2007. http://pebb.das.state.or.us/DAS/PEBB/vision.shtml

[54] Aron Consulting. PEBB Guiding Principles and RFP Preferences. November 16, 2004. Available:http://egov.oregon.gov/DAS/PEBB/docs/Word/2PEBBVisionRFPGuidingPrinciplesRevised111204.doc

results to a wider audience.[55] By providing a standard set of measures by which quality and performance can be evaluated and plan performance can be differentiated, eValue8 can help purchasers make value-based purchasing decisions. The eValue8 process also helps plans to realize the importance of consumer engagement and health promotion strategies identify areas for improvement.

<u>Plan/Health System Level</u>

Southcentral Foundation "Alaska Model" – The Alaska Native Medical Center (ANMC), owned and managed by the Southcentral Foundation, is a group medical practice and tertiary referral hospital in Anchorage, Alaska. The center serves Alaska natives in a large area of southwest Alaska. The medical center is supported by funds from the Indian Health Service, as well as payments from insured patients through Medicaid, Medicare, and private insurers. The primary care system of the ANMC has served as a model and illustration of ways in which the medical home can be used to improve health care. The model is built on the values of the community it serves, which include a holistic approach to health and the importance of strong relationships between providers and patients. Small primary care teams are formed around the patient, which include the patient's family and primary care provider, as well as support from a medical assistant, nurse, and behavioral health specialist. Consultations with specialists frequently occur as brief phone conversations. Providers and others on the patient care team also provide a number of visits and checkups over the phone in addition to in-person visits. The increased efficiency and quality improvements achieved at ANMC are discussed above.

Regence Blue Cross Blue Shield – Regence is a not-for-profit insurer providing coverage for Oregonians across the state. As a traditional insurance company operating primarily as a preferred provider organization, Regence has two major lines of business: traditional insured clients and administrative only clients who are self-insured by large employers. Regence has four pilots underway that are helping providers build provider capacity to provide medical home services to their enrollees. The first is the Clinical Performance Improvement Pilot Program, which was designed to create partnerships with physician groups to improve quality of care. Regence provided grants to seven practices in 2006 and five practices in 2007 and criteria for selection included the intention to implement the patient-centered chronic care model. Most of the projects have focused on improving quality of care for patients with diabetes. In addition, Regence has worked with physicians at Oregon Health and Science University (OHSU) to evaluate a reimbursement system tied to quality improvement of patients with diabetes. In the model, reimbursement is provided for group visits, remote care and team case management. Regence has also worked with a number of primary care practices to use patient-satisfaction surveys to direct patient improvement plans and to build provider capacity using health information technology. Regence is currently planning a more comprehensive pilot to develop Primary Care Home Collaboratives in Oregon and Washington.

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[55] Thorne J. Administrator, Public Employees' Benefit Board. Value-Based Health Care Purchasing. Presentation at Oregon Health Fund Board Delivery System Committee. November 15, 2007. Wilsonville, OR.

At the national level, the Blue Cross Blue Shield (BCBS) Association and more than twenty BCBS companies, including Regence in Oregon, recently announced a partnership with the Patient-Centered Primary Care Collaborative to develop a medical home demonstration project. The Patient-Centered Primary Care Collaborative will be sponsoring the companies' design of alternative models of patient-centered medical homes. The companies will also explore options for aligning provider incentives with the goals of a medical home and integrating quality improvement and care management into the primary care home model. Patients will be educated about the benefits of a medical home and be given the opportunity to receive care through a medical home site.[56]

Samaritan Health System – Samaritan is a not-for-profit health system covering three counties in southeast Oregon. Samaritan owns five hospitals and has over 200 employed physicians. The health system has a strong sense of community mission and community involvement. It also operates four insurance products: a Medicaid managed care plan, a Medicare managed care plan, self-insurance for its employees, and a contract with PEBB for state employees. Samaritan has just completed the implementation of an EMR and is actively considering how to develop measurement systems and payment incentives to support quality improvement in primary care. One step the plan has adopted is uniform productivity-based payment for its providers, regardless of patient insurance status. There have been no formal efforts to re-design primary care practices in a medical home model, though Samaritan is considering how to implement performance improvement measures under its contract with PEBB.

CareOregon– CareOregon is the largest Medicaid managed care plan in Oregon. It is currently operating a medical home demonstration called the Primary Care Renewal Project at five safety-net clinics in the Portland area. The demonstration is providing grant support and technical assistance to these clinics, with the goal of re-designing primary care practice using Southcentral Foundation model (see above). The focus of the demonstration project includes restructuring primary care teams to provide increased support and patient management from nurses, medical assistants, and on-site behavioral health experts. Technical assistance focuses on quality improvement and performance measures at each practice. If the project is successful in the first year, CareOregon may investigate alternative reimbursement mechanisms to continue supporting these re-designed practices.

The five safety-net demonstration clinics participating in the CareOregon Primary Care Renewal Project are Legacy Emmanuel Internal Medicine, Oregon Health Sciences OHSU Richmond Family Health Center, Old Town Clinic, Multnomah County Mid-County Health Center, and Virginia Garcia. While each of the clinics is taking a different approach to the project, common features include empanelment of patients with small primary care teams, implementing team-based care with increased support from RNs, case managers and medical assistants, "scrubbing" charts before visits to identify care needs, "max-packing" visits to deliver all needed services (including prevention) at each

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[56] BCBSA Demonstration Project Press Release. November 7, 2007. Available: http://www.pcpcc.net/node/50

visit, and outreach to patients in need of disease management or preventive services. There is a strong focus on quality improvement and performance improvement at each site, as well as an effort to move towards population-based care management.

Kaiser Permanente – Kaiser Permanente is the largest non-profit health plan in the country and serves its enrollees with an integrated health delivery system designed to provide and coordinate care across all of patients' health needs. All Kaiser members select a single primary care provider to serve as their personal physician and enrollees are encouraged to access their physicians through phone and email encounters, as well as office visits. In addition, every Kaiser patient has an electronic medial record and all care provided by any Kaiser provider is documented within the system. Members can access some of the information in their medical record, including appointments, medical conditions, lab results and vaccination records, through the Kaiser website.

Provider/Clinic Level

OHSU Care Management Plus Project – The Care Management Plus Project is a medical home demonstration project operated by a research team at OHSU. The team piloted this primary care model at Intermountain Health in Utah and is now developing similar programs in the General Internal Medicine practice at OHSU and in other practices around the state; currently, over 40 clinics have adopted or are adopting the program. The Care Management Plus model enhances the primary care team by designating care managers as a primary contact in the medical home for patients with complex needs and older adults. The program (development and dissemination funded by The John A. Hartford Foundation) trains care managers to help patients set goals, achieve lifestyle changes, and follow individualized treatment programs. Information technology use is assessed and recommendations are made to enhance use of IT to better meet the longitudinal needs of patients; a freely available tool is provided on the website. Care managers go through a specific training, which has been developed by the Care Management Plus Project. While grant support is used to train care managers, manager salaries are supported by their associated clinic. Care managers work with several (5-10) providers on a referral basis to coordinate the care of complex patients and assist with patient self-management. Data from Care Management Plus at Intermountain Health in Utah is discussed above.[57] The program has compared its additional functionality with the NCQA Physician Practice Connection tool, and found that the differential approach of a care manager can help meet a number of the specifications of the tool. The research team also has informaticians who map the expected functionalities of electronic health records from the Certification Commission for Health Information Technology to better support the specific longitudinal needs of patients with complex illnesses.

GreenField Health – GreenField Health is a redesigned medical practice in Portland. GreenField focuses on expanded access to care through e-mail and phone consultations with providers, same day appointments and improved work flow and practice design. GreenField supports its activities through traditional FFS insurance payments and an annual patient fee that provides about 50% of practice revenues. This fee supports

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[57] OHSU Care Management Plus. www.caremanagementplus.org

clinician time to provide services that are not covered by insurance. It also supports a panel size of about 1,000 patients per full time provider. In addition to providing primary care, GreenField runs a consulting business to help other practices and medical systems with practice management and primary care redesign.

Oregon Primary Care Association (OPCA) – The Oregon Primary Care Association is working to build a more robust primary care model in community health centers in Oregon that meets the various needs of vulnerable populations. As part of these efforts, OPCA provides technical support and training to these clinics for implementing elements of the primary care home model and is working with the centers to measure the value of different elements of the model. Safety net clinics and community health centers may be uniquely positioned to provide patients with medical homes able to address health care and other social needs simultaneously. Many community health centers already offer enabling (non-medical) services, such as social case management, interpreter services, and transportation, tailored to meet the needs of the community they serve.

Key Considerations for the Oregon Health Fund Board

Below are eight steps for the Oregon Health Fund Board to consider that could encourage system change and build the state's capacity to provide all Oregonians with a primary care medical home.

#1 – *Encourage and reward efforts to inform providers of the need for primary care reform and the characteristics of a patient-centered medical home.* Support could build on efforts of ongoing initiatives such as the Better Health Initiative, Archimedes Movement, the Oregon Health Reform Collaborative, and the partnership between the Community Health Advocates of Oregon and the Oregon Primary Care Association.

#2 – *Develop a standard definition of medical home and standard measures to determine whether primary care providers meet this definition. This definition should be broad enough to allow for innovation and encompass various models that provide medical home services to their patients.* Current medical home definitions and metrics, such as the NCQA, PCC, or Medical Home Index developed for use in pediatric practices could serve as a starting point for this effort.[58]

#3 – *Coordinate lessons from current demonstrations of medical home models in Oregon and encourage more demonstrations.* Expansion and coordination of current demonstrations, as well as larger multi-payer local or regional demonstrations, could help build the knowledge and experiential base for the development of medical homes across Oregon.

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[58] Cooley WC, McAllister JW, Sherrieb K, et al. The Medical Home Index: Development and Validation of a New Practice-level Measure of Implementation of the Medical Home Model. Ambulatory Pediatrics. 2003; 3:173-180.

#4 – *Consider specific support for demonstration projects targeted at small practices and rural providers.* There is little ongoing work to support the development of the medical home model in small practices and rural areas in Oregon, and these practices are likely to face unique challenges. Results of the AAFP TransforMED project may provide valuable data in this area.

#5 – *Consider specific support for demonstration projects targeted at high need or vulnerable populations.* Research has demonstrated that increased access to medical homes may decrease disparities in health outcomes, but the model will have to be tailored to meet individual and community needs. Such efforts could build on the current CareOregon demonstrations.

#6 – *Develop a sustainable financing model that supports medical home services.* Such a model could be based on the results of local demonstration projects or other national models.

#7 – *Partner with other purchasers of health care to develop a uniform set of standards or common measures of clinical performance outcomes.* This effort could build on the ongoing work of PEBB and the Oregon Health Care Purchaser's Coalition.

#8 – *Consider how best to provide adequate funding for technical support, education and dissemination of best practices to support patient-centered primary care practice re-design.* Primary care providers and health systems are likely to need specific assistance in multiple areas (e.g. practice redesign, staff training, and understanding new payment structures) as they work to implement the medical home model. This effort could build on current efforts such as the OHSU Care Management Plus, the CareOregon Primary Care Renewal Project, and the PEBB Council of Innovators.

Conclusion

Reforming the health care delivery system to revitalize primary care and promote the medical home model will require change at all levels of the system. Nevertheless, undertaking this change will likely provide significant improvements in the health of Oregonians, while also reducing the overall cost of health care delivery. Oregon has already begun implementing measures to reform its primary care system, and the OHFB can take advantage of these efforts as it works to develop a comprehensive reform plan for the state. Transforming the state's primary care practices into patient-centered primary care medical homes will be an important step in redesigning the health care delivery system to better serve the needs of people across the state. However, efforts in this realm will not be successful in isolation and must be seen as one part of a comprehensive effort to redesign the way health care is delivered and financed across the state.

Appendix A: Multiple Definitions of Medical Home

Joint Statement "Patient-Centered Medical Home" [16]	**AAFP "TransforMED model"** [59]	**ACP "Advanced Medical Home"** [17]	**AAP *"Medical Home"*** [15]	**OPCA "Primary Care Home"** [60]	**Commonwealth *"Medical Home"*** [19]
Personal physician	Personal Medical Home	Personal Physician	Long-term continuity	First point of access	Regular source of care
Physician-directed team practice	Team approach	Team Approach	Team-based care	Team-based care	
Whole person orientation – (comprehensive)	• Patient-centered care • Whole-person orientation • Consistent set of services	• Partnership with patients/families • Range of medical services	Comprehensive set of primary care services	Comprehensive and integrated care	• Patient-centered care
Integrated/Coordinated care across the health system, patient's community and culture	Integrated approach to care	Chronic Care model of care for all patients	• Coordination of subspecialty care and community resources • Cultural/developmental competence • Family-centered care	• Sustained patient/family-provider partnerships • Health system navigation and coordination • Cultural competence	
Improved access	• Elimination of access barriers • Re-designed offices	Improved access	24/7 Accessibility	Immediate access	• Evening/weekend access • Phone accessibility
Focus on Quality and Safety	• Focus on Quality and Safety • Data-based information systems • Electronic health record	• POC Evidence-based medicine and tools • Health information technology • Quality improvement programs	Confidential health record	Identifying and measuring process and outcomes measures	Efficient, well-organized, on-time visits
Payment that reflects value of services	Sustainable reimbursement	Revised reimbursement system		Working on multiple solutions	

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[59] American Academy of Family Physicians. The New Model. TransforMed. www.transforMED.com. Accessed 7/3/07.
[60] Hostetler C. Testimony to the Oregon Senate Committee on Health Policy and Public Affairs. March 12, 2007

Appendix B: Comparison of Primary Care Financing Models[*]

	Pay for Performance	**Pay for Process**	**Global Prospective Payments**	**FFS Payment for Non-Visit Services**	**One-Time Grants and Technical Assistance**	**Carved-Out Case Management**	**Mixed Models**
***Incentives and Impacts*[†] [4]**							
Includes Monthly per-patient payments	+/-	+/-	+	-			+
Includes Visit-based payments	+	+	-	+			+
Encourages providers to improve quality	+	+	+/-	-		+	+
Encourages providers to limit practice size	-	-	-	+		-	-
Encourages providers to care for complex patients	-	-	+	+		+	+/-
Encourages providers to re-design their practices	+/-	+	+/-	+	+		+/-
Supports adoption of infrastructure improvements (e.g. EHRs)	+	+	+	-	+		+
Increases requirements and responsibility of PCPs	+	+	+	-	-	-	+
***Support of the Medical Home Principles*[‡]**							
Personal Physician	-	-	+	-	-	-	+/-
Physician-directed Team Practice	+	+	++	++	-	+	+
Whole-person Orientation to Care	+/-	+	++	++	-	+/-	+
Care Coordination/Integration	-	++	+	+	+/-	+	+
Quality and Safety Improvement	++	+	+/-	-	+/-	+/-	+

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[*] This table was compiled by the author based on reviewed literature and discussions with experts about the impact of various financing models.

[†] + Indicates that the financing model would encourage a certain provider/practice behavior, – indicates that the financing model would not encourage the behavior, and +/- indicates that the financing model may or may not do so, depending on specific policies adopted in designing the payment structure.

[‡] + indicates that the financing model would support or strongly support (++) the development of a medical home characteristic in primary care practices, - indicates that the financing model would not have a strong impact on the development of a medical home characteristic, and +/- indicates that the model may or may not impact the development of a medical home characteristic, depending on specific policies adopted in designing the payment structure.

NEWS RELEASE

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WHEN MINORITY PATIENTS HAVE INSURANCE AND A MEDICAL HOME, THEIR HEALTH CARE IMPROVES, SAYS NEW SURVEY

Insurance Coverage Contributes to Reduced Racial and Ethnic Health Care Disparities by Connecting Minority Patients to Regular Physicians and Easily Accessible Medical Services

New York, NY, June 27, 2007—Providing minority patients a "medical home" in which they have a regular doctor or health professional who oversees and coordinates their care would help eliminate racial and ethnic health disparities and promote more health care equity, says a new report from The Commonwealth Fund. The report, based on a 2006 survey of more than 2,830 adults, shows that linking minority patients with a health care setting that offers timely, well-organized care where they can routinely seek physicians and medical advice can help them better manage chronic conditions and obtain critical preventive care services.

According to the report, *Closing the Divide: How Medical Homes Promote Equity in Health Care*, in 2006 nearly one-half of Hispanics and more than one of four African Americans were uninsured at some point during the year. In contrast, 21 percent of whites and 18 percent of Asian Americans lacked coverage. In addition to being the groups most likely to go without health insurance, African Americans and Hispanics are least likely to have a regular doctor or source of care. While health insurance coverage is an important determinant of whether people can obtain essential care, the authors say insurance alone cannot eliminate racial and ethnic disparities in health.

"Insurance coverage helps people gain access to health care, but the next thing you have to ask is 'access to what?'" says lead co-author Anne Beal, M.D., senior program officer at The Commonwealth Fund. "We found many disparities in care; however, disparities are not immutable. This survey shows if you can provide both insurance and access to a true medical home, racial and ethnic differences in getting needed medical care are often eliminated," she adds.

According to the report, patients have a medical home when they:

- have a regular provider or place of care,
- report no difficulty contacting a provider by phone,
- report no difficulty getting advice or medical care when needed on weekends or evenings,
- always or often find office visits well-organized and efficiently run.

Although there are many places that are already functioning as models of such care, what most limited a health setting from being designated a medical home in this survey was the ability to dispense medical advice or care after hours or on weekends, according to the report. Only two-thirds of adults who have a regular provider or source of care report that it is easy to get care or medical advice after hours. Among all groups surveyed, Hispanics have the hardest time seeking care or advice after hours, and they are least likely to have a medical home.

The survey shows that, when they have a medical home, the vast majority of adults of all races say they can always get the care they need when they need it. Nearly three-quarters of adults with a medical home report getting the care they need compared with only 52 percent of those with a regular provider that is not a medical home and 38 percent of adults without any regular source of provider.

Key survey findings on the role of a medical home in eliminating health care disparities:

Racial/Ethnic Disparities Are Still Common.

- African Americans and Hispanics are less likely to be insured, and less likely to have a regular doctor or source of care.
- Hispanics are least likely to have a medical home; only 15 percent of Hispanics report having a medical home compared with 28 percent of whites, 34 percent of African Americans and 26 percent of Asian Americans.

Preventive Care Is More Routine.

- Minority adults with a medical home experienced no disparities in receiving preventive care reminders, which significantly improve rates of routine screening for conditions such as heart disease and cancer. For example, eight of 10 adults who received a preventive reminder had their cholesterol checked in the past five years compared with half of adults who did not get a reminder.

- Two-thirds (65%) of adults who have a medical home receive preventive reminders, according to the survey.

Chronic Care is Better Managed.

- Adults with a medical home are better prepared to manage chronic conditions such as diabetes or hypertension. Only 23 percent of adults with a medical home report their doctor or doctor's office did not give them a plan to manage their care at home, compared with 65 percent who have no regular source of care.
- Forty-two percent of hypertensive adults with a medical home report that they check their blood pressure and it is well controlled compared with 25 percent of those without a medical home.

Having Health Insurance Matters.

- More than half of insured adults received a reminder from a doctor's office to schedule preventive visits compared with only 36 percent of uninsured adults; when African American and Hispanic patients are insured, they are just as likely as white adults to receive reminders to schedule needed preventive care.

Health Care is More Coordinated.

- All adults with medical homes reported greater levels of coordination by their provider than patients with only a regular provider. Three-fourths of adults with a medical home who saw a specialist report their regular doctor helped them decide which specialist to see and communicated with the specialist about their medical history, compared with 58 percent of adults without a medical home.

Community Health Centers and Other Public Clinics Are Important Providers of Care to Vulnerable Patients.

- Although they care for a large proportion of uninsured, low-income, and minority adults, patients report that community health centers (CHCs) or other public clinics are less likely to have all four characteristics that comprise what the survey defined as a "medical home." Twenty-one percent of CHCs or public clinics have all four indicators of a medical home, compared with 32 percent of private doctors' offices.
- The main reason CHCs and other public clinics do not function as medical homes is because patients say they have more difficulty getting medical advice or care in the evenings or weekends. Since these safety net providers play a critical role in the care of vulnerable patients, the authors say it is important to find ways to support CHCs and public clinics becoming medical homes.

Promoting standards for the medical home through public reporting of performance and rewarding providers that meet these performance benchmarks would go a long way toward improving the way care is delivered and eliminating disparities, say Commonwealth Fund authors.

“We know the medical home is a promising model of care for narrowing health care disparities and providing patients with much higher quality care in terms of prevention and chronic disease management,” says Fund Executive Vice President Stephen C. Schoenbaum, M.D. “Adopting policies to encourage practitioners to embrace this model would improve care for everyone, particularly those in safety net settings,” he adds.

Methodology

The survey was conducted by Princeton Survey Research Associates International from May 30 through October 19, 2006. The survey consisted of 25-minute telephone interviews in English or Spanish among a random, nationally representative sample of 3,535 adults at least 18 years of age living in the continental United States. The report restricts the analysis to the 2,837 respondents ages 18-64. The sample was designed to target African American, Hispanic, and Asian households and it classifies adults by insurance status and annual income. The survey has an overall margin of sampling error of +/- 2.9 percentage points at the 95 percent confidence level.

American Academy of Family Physicians (AAFP)
American Academy of Pediatrics (AAP)
American College of Physicians (ACP)
American Osteopathic Association (AOA)

Joint Principles of the Patient-Centered Medical Home
February 2007

Introduction

The Patient-Centered Medical Home (PC-MH) is an approach to providing comprehensive primary care for children, youth and adults. The PC-MH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family.

The AAP, AAFP, ACP, and AOA, representing approximately 333,000 physicians, have developed the following joint principles to describe the characteristics of the PC-MH.

Principles

Personal physician - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

Physician directed medical practice – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

Whole person orientation – the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.

Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Quality and safety are hallmarks of the medical home:

- Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family.

- Evidence-based medicine and clinical decision-support tools guide decision making
- Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.
- Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met
- Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication
- Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model.
- Patients and families participate in quality improvement activities at the practice level.

Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.

Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:

- It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit.
- It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.
- It should support adoption and use of health information technology for quality improvement;
- It should support provision of enhanced communication access such as secure e-mail and telephone consultation;
- It should recognize the value of physician work associated with remote monitoring of clinical data using technology.
- It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits).
- It should recognize case mix differences in the patient population being treated within the practice.

- It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.
- It should allow for additional payments for achieving measurable and continuous quality improvements.

Background of the Medical Home Concept

The American Academy of Pediatrics (AAP) introduced the medical home concept in 1967, initially referring to a central location for archiving a child's medical record. In its 2002 policy statement, the AAP expanded the medical home concept to include these operational characteristics: accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care.

The American Academy of Family Physicians (AAFP) and the American College of Physicians (ACP) have since developed their own models for improving patient care called the "medical home" (AAFP, 2004) or "advanced medical home" (ACP, 2006).

For More Information:

American Academy of Family Physicians
http://www.futurefamilymed.org

American Academy of Pediatrics:
http://aappolicy.aappublications.org/policy_statement/index.dtl#M

American College of Physicians
http://www.acponline.org/advocacy/?hp

American Osteopathic Association
http://www.osteopathic.org

Draft- For Discussion Purposes Only

TENTATIVE WORKPLAN FOR HEALTH EQUITIES COMMITTEE

DECEMBER 20th, 8 am to 12 pm, Room 1-B, Portland State Office Building, 800 NE Oregon st., Portland

TOPIC: OUTREACH and ELIGIBILTY

- Brief update on OHFB and other committees
- Review of Draft Charter changes
- Review of Tentative Workplan
- Invited testimony: Jeanny Phillips, DMAP and Karen House, CAF
- **Action Item:** Developing consensus: Health Equities Committee recommendations on Oregon Health Fund outreach strategies in communities experiencing insurance disparities (review outreach strawperson).
- Invited testimony: Karen House, DHS Children and Families regarding current federal program eligibility related to citizenship or immigration status.
- **Action Item:** Developing consensus: Oregon Health Fund program requirements related to citizenship and immigration status (review draft strawperson).
- **Public testimony**

JANUARY 10th, 9 am – 12 noon (LOCATION TBD)

TOPIC: MEDICAL HOME

- Standing Agenda Items
  - Update on OHFB and other committees
  - Review summary of draft recommendations and minutes from the last meeting.
- **Action item:** Approve final recommendations concerning outreach policy to reduce disparities in insurance status.
- **Action item:** Approve final recommendations concerning OHF program eligibility.
- Background and invited testimony on the use of Medical Home models to reduce health disparities.
- **Action item:** Draft recommendations concerning the use of Medical Home models to reduce health disparities that occur within the delivery system will be developed and approved by the committee.

JANUARY 24th, 9 am – 12 noon (LOCATION TBD)

TOPIC: PROVIDER WORKFORCE ISSUES

- Standing Agenda Items
  - Update on OHFB and other committees
  - Review Summary of draft recommendations and minutes from last meeting
- **Action item:** Approve final recommendations concerning the use of Medical Home models to reduce health disparities that occur within the delivery system.
- Background and invited testimony concerning provider workforce issues
  - Recruitment of minority healthcare providers

  - Training a culturally-competent provider workforce
  - Recruitment of an adequate rural healthcare workforce
- **Action item:** Draft recommendations concerning provider workforce issues

FEBRUARY MEETINGS: (DATES AND LOCATIONS TBD)

TOPIC: FINANCIAL INCENTIVES TO REDUCE HEALTH DISPARITIES

- Standing Agenda Items
  - Update on OHFB and other committees
  - Review Summary of draft recommendations and minutes from last meeting
- **Action item:** Approve final recommendations concerning provider workforce issues
- Background and Invited testimony on payment reform, including efforts to reduce targeted health disparities with provider incentives, and efforts to provide sustainability for elements of the medical home such as linguistic services and case management.
- Brainstorming on funding mechanisms for **upstream interventions,** such as targeted public health interventions, and **care that occurs outside of the delivery system**, such as Community Health Worker programs.
- Background and Invited testimony on strategies to empower and incentivize individuals to make health lifestyle choices through program policy.
- **Action item:** Draft recommendations on financial incentives to reduce health disparities.

MARCH MEETINGS (DATES AND LOCATIONS TBD)

TOPIC: BENEFIT DESIGN

- Standing Agenda Items
  - Update on OHFB and other committees
  - Review Summary of draft recommendations and minutes from last meeting
- **Action item:** Approve final recommendations on financial incentives to reduce health disparities.
- Background and Invited Testimony on benefit designs that support the health of women of childbearing age.
- Background and Invited Testimony on benefit designs that support the health of individuals with physical or mental health disabilities.
- Background and Invited Testimony on Value-Based Purchasing and brainstorming on benefit designs that reduce health disparities.
- **Action item:** Draft recommendations on benefit designs.

APRIL MEETINGS (DATES AND LOCATIONS TBD)
TOPIC: DATA COLLECTION AND WRAP-UP

- Standing Agenda Items
  - Update on OHFB and other committees
  - Review Summary of draft recommendations and minutes from last meeting
- **Action item:** Approve final recommendations on benefit designs.

- Background and Invited Testimony on current data collection efforts and strengths/limitations of available data. Discussion of the role of data collection in reducing health disparities.
- **Action item:** Draft recommendations on a plan to improve collection of health-related data for people of color and other under-represented populations using techniques that are culturally sensitive and accurate.
- Wrap-up: Discussion and brainstorming of parking-lot issues.
- **Action item: Finalize Health Equities Committee Recommendations to the Oregon Health Fund Board.**

OREGON HEALTH FUND BOARD
HEALTH EQUITIES COMMITTEE
Approved by OHFB ________________

Objective

The Health Equities Committee is chartered with developing multicultural strategies for program eligibility and enrollment procedures as well as with making policy recommendations to reduce health disparities through delivery system reform and benefit design of the Oregon Health Fund program. The work of the Health Equities Committee will be submitted directly to the Oregon Health Fund Board (OHFB) as well as integrated into the work of other OHFB committees.

Scope

The Health Equities Committee will focus its study of strategies to reduce health disparities in Oregon, including but not limited to:

1. Providing the Eligibility & Enrollment Committee with recommendations concerning but not limited to:
    - Best practices for outreach in communities of color, homeless adults and youth, with individuals who live in geographic isolation, and with individuals who experience other barriers to enrollment.
    - Strategies to reduce disparities in insurance status by decreasing barriers to enrollment and streamlining enrollment policies & practices
2. Providing the Delivery Committee with recommendations concerning reducing health disparities in Oregon. Recommendations may include but are not limited to topics such as:
    - Elements of the Medical Home model that reduce health disparities and provide culturally competent care.
    - Financial incentive programs to reduce targeted health disparities and quality care through provider fee increases and value-based purchasing
    - A plan to increase collection of health-related data for people of color and other under-represented populations using techniques that are culturally sensitive and accurate.
    - Provider workforce issues such as recruitment of minority and rural providers, retention, and cultural-competence training.
    - Methods to empower and incentivize individuals to make healthy lifestyle choices.
    - Methods to ensure competent linguistic access within the healthcare delivery system.
3. Providing the Benefits Committee with recommendations concerning benefit designs that support the health of women, minorities, and other vulnerable populations including but not limited to:

- Benefits related to women's health and benefit designs that target women of childbearing age.
- An emphasis on reducing health disparities in developing a benefit package of essential health services.
- Ensuring an affordable benefit package that promotes the health of individuals who have physical or mental health disabilities.
- Reimbursement options for health promotion activities that occur outside of the traditional healthcare delivery system.

Committee Membership

Name	Affiliation	City
Yves LeFranc, MD	Adventist Health Systems	Portland
Ella Booth, Ph.D.	Oregon Health & Science University (OHSU)	Portland
Honora Englander, MD	OHSU Division of Hospital Medicine	Portland
Scott Ekblad	Office of Rural Health, OHSU	Portland
Maria Michalczyk, RN, MA,	Healthcare Interpreter Training program, Portland Community College	Portland
Michelle Berlin, MD, MPH	Center of Excellence in Women's Health, OHSU	Portland
Tricia Tillman, MPH	Multnomah County Health Department	Portland
Noelle Wiggins	Multnomah County Health Department	Portland
John Duke, MBA	Outside-In Homeless Youth Clinic	Portland
Jackie Mercer	NARA	Portland
Ed Blackburn	Central City Concern	Portland
Bruce Bliatout, Ph.D.,	Multnomah County Health Department	Portland
Laurie Powers, Ph.D.	Portland State University, Regional Research Institute	Portland
Melinda Muller, MD	Legacy Health Systems	Portland
Joe Finkbonner	Northwest Portland Indian Health Board	Portland
Holden Leung, MSW	Asian Health and Service Center	Portland

Staff Resources

- Heidi Allen, (Lead Staff) OHREC Director and Medicaid Advisory Committee, OHPR – Heidi.Allen@state.or.us; 503-373-1608
- Nate Hierlmaier, Policy Analyst, OHPR – Nate.Hierlmaier@state.or.us; 503-373-1632
- Shawna Kennedy-Walters, Office Specialist, OHPR – Shawna.Kennedy-Walters@state.or.us; 503-373-1598

Timing

The Committee will provide its recommendation(s) to Oregon Health Fund Board and the Eligibility and Enrollment Committee no later than January 15, 2008, recommendations to the Oregon Health Fund Board and Delivery Committee no later than March 15, 2008, and recommendations to the Oregon Health Fund Board and Benefits Committee no later than March 15, 2008. The Committee will continue to act as a resource to the Oregon Health Fund Board and the committees of the Board as needed throughout the 2008 policy planning process.

Office for Oregon Health Policy & Research
Brief for Health Fund Board-Health Equities Committee
December 2007

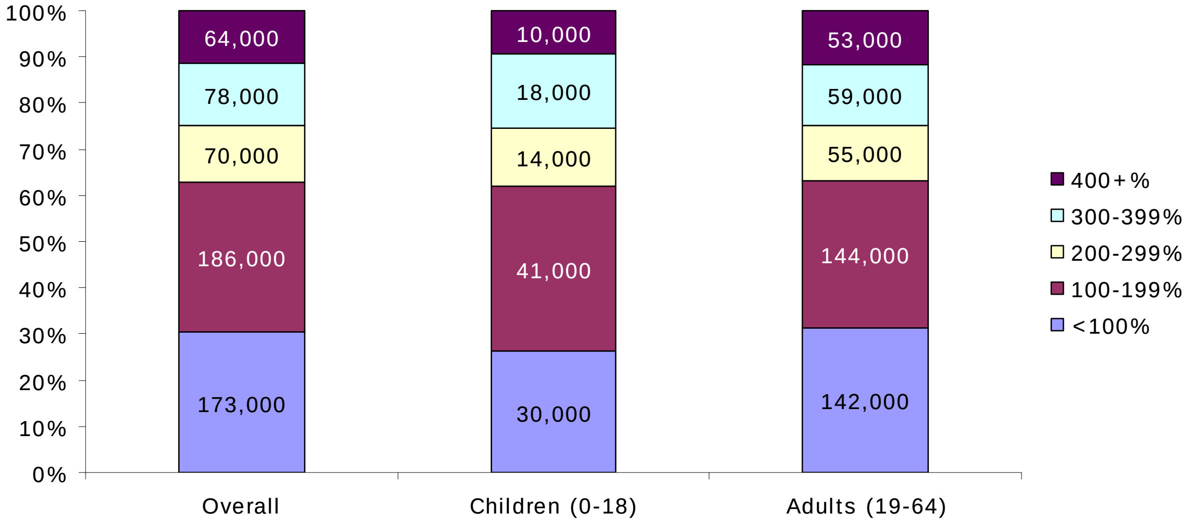
Uninsured in Oregon by OPS Region, 2006

Source: Profile of Oregon's Uninsured, 2006: Summary findings from the 2006 Oregon Population Survey; Office for Oregon Health Policy & Research, August 2007

Region	Percent Uninsured	Number of Uninsured
Region 1: Clatsop, Columbia, Lincoln, Tillamook	**14.7%**	22,647
Region 2: Clackamas, Multnomah, Washington, Yamhill	**14.7%**	244,144
Region 3: Benton, Lane, Linn, Marion, Polk	**17.1%**	154,832
Region 4: Coos, Curry, Douglas, Jackson, Josephine	**15.8%**	73,916
Region 5: Gilliam, Hood River, Morrow, Sherman, Umatilla, Wasco, Wheeler	**14.4%**	19,445
Region 6: Crook, Deschutes, Jefferson	**19.1%**	37,923
Region 7: Grant, Harney, Klamath, Lake	**13.5%**	11,920
Region 8: Baker, Malheur, Union, Wallowa	**14.6%**	11,745

Uninsured in Oregon by Federal Poverty Level and Age, 2006

Source: 2006 Oregon Population Survey; Office for Oregon Health Policy & Research



Office for Oregon Health Policy & Research
Brief for Health Fund Board-Health Equities Committee
December 2007

Uninsured in Oregon by Hispanicity and Race, 2006

Source: Profile of Oregon's Uninsured, 2006: Summary findings from the 2006 Oregon Population Survey; Office for Oregon Health Policy & Research, August 2007

	Group	Percent Uninsured	Number of Uninsured	Uninsured Distribution
Hispanicity	Spanish, Hispanic or Latino	32.7%	120,680	21.0%
Race	White	14.4%	447,574	77.7%
	African-American/Black	14.1%	8,861	1.5%
	Asian	9.8%	4,702	0.8%
	American Indian/ Native Alaskan	28.5%	38,764	6.7%
	Other	32.0%	57,810	10.0%
	2 or more races	13.0%	20,256	3.5%

FACT SHEET ABOUT IMMIGRATION STATUS AND PERSONAL HEALTH CARE COVERAGE

submitted to the Equities Committee of the Oregon Health Fund Board
by Tina Castañares, MD   12/17/07

Disclaimer: *I'm not a trained expert in this field, so the "salient points" I've chosen to send you here should be checked with those who are such experts for accuracy before any policy recommendations might draw on them.*

- Unauthorized aliens (the federal term of art for people often referred to elsewhere as "undocumented workers," "illegal immigrants," and other such terms) have always been excluded from eligibility for federally-sponsored public health insurance (Medicaid, Medicare, and SHCIP). Exceptions are Alien-Waived Emergency Medicaid (called CAWEM in Oregon and some other states) and, in some states, certain uses of state-only Medicaid- or SCHIP-administered funds. Sometimes such latter exceptions have included prenatal care, HIV/AIDS care, hospice care, children's insurance, and other services. However, Oregon has not, in general, made such investments.

- H2A-program (agricultural guestworker) participants are not granted any exceptions to these exclusions. Interest in the H2A program is growing among Oregon farmers due to recent and projected labor shortages.

- No distinctions between naturalized and native-born citizens have ever been applied to date for eligibility for public health insurance. "Citizens are citizens."

- Lawful permanent residents (immigrants with "green cards"), prior to 1996, were eligible for public health insurance on the same basis as citizens.

- In 1996, the "Personal Responsibility Act" (Welfare Reform), spearheaded by the Clinton administration and enacted into law by Congress, for the first time distinguished lawful permanent residents from citizens by barring LPRs from eligibility from certain public programs, including public health insurance, until they had been lawfully present in the USA for no fewer than 5 years. States were given the option of making this bar longer or permanent. The 5-year bar was adopted and remains in effect in Oregon for Medicaid and SCHIP. The federal government applies it for Medicare.

- Thus, not only unauthorized aliens but also hundreds of thousands of lawfully present immigrants nationally, who would meet other eligibility criteria for Medicaid and SCHIP, are currently ineligible due to their not yet having reached 5 years of legal residency.

- Medicare eligibility is similar. Only after five years from legal entry may a lawful permanent resident who meets age and/or disability criteria be eligible for Medicare. If s/he has worked 40 qualifying quarters paying into the U.S. Social Security system, free Medicare benefits have parity with those of citizens. Certain family members are allowed to contribute their own qualifying quarters to meet this criterion. If the criterion is not met, benefits are available for a privately paid monthly premium. In other words, such lawful permanent residents may "buy in" to Medicare after their 5-year bar.

- Efforts to restore intake and enrollment in Medicaid to pre-2004 processes are desirable because new requirements for proof of citizenship, nativity, or lawful immigration status have been demonstrated to deny eligibility to many US citizens, among others. However, success on this front alone will not address immigrants' great losses to eligibilty since 1996, nor the 20th-21st century US cultural denial of most public benefits to unauthorized aliens. (Public K-12 schooling is a notable exception, and there are others with less economic impact.) Certain other "first world" countries also deny benefits like we do, but many do not. Those who do not tend to cite cultural/ethical values (equity) and public health rationales for their investments.

- Emergency Medicaid (CAWEM) is, essentially, very restrictive hospitalization coverage for people who would be otherwise eligible for Medicaid were it not for their immigration status (unauthorized, or before passage of their 5-year ban). CAWEM can pay for life-saving or life-stabilizing treatment of serious medical conditions in a hospital setting. Obstetrical delivery is covered. All outpatient care and long-term care are excluded, with the exception of Emergency Department services meeting the serious/lifesaving sorts of criteria. Among specific services excluded are: outpatient medication coverage; cancer chemotherapy; hemodialysis; hospice or palliative care; rehabilitation services; durable medical equipment; sterilizations; prenatal care; scheduled (non-emergent) labs and imaging; primary care; non-emergent specialty consultation; home health care; and more.

- For unauthorized aliens and for lawful permanent residents (and those applicants "in process") who have not yet been legally present in the US for 5+ years, the availability of CAWEM for many hospital-based needed services means that their greatest gap in coverage is arguably for primary care.

  This observation is relevant to the Health Fund Board's committees' deliberations on benefit package, financing, eligibility and the delivery system. The Delivery System committee, in particular, is examining how it might support and enhance the primary care home concept. Efforts to create privately subsidized insurance plans for group or individual market s-- available to low-income workers who are not eligible for public insurance (for whatever reason) and who do not have commercial insurance provided by their employers – might well consider designing such plans to focus on services provided at or arranged by primary care homes. As for foreign-born Oregonians who could benefit from such plans, most now obtain outpatient services in the safety net system. Taking care to ensure adequate coverage/ compensation for safety net providers is obviously vital to the success of a new effort. I would add that ensuring coverage for services provided by trained Community Health Workers, who are likeliest to speak the relevant foreign languages and be effective in multicultural settings, is also vital. Such coverage does not, for the most part, exist today in public or commercial insurance plans.

DRAFT- FOR DISCUSSION ONLY

Policy Recommendations “Straw-Person” on OHFB Eligibility Related to Immigration or Citizenship Status

Problem or Issue:

Not having universal eligibility poses several problems for the Oregon Health Fund Board Program.

- The cost-shift from uncompensated care
- Public health concerns
- Equity (multiple state programs are provided regardless of citizenship for the good of society and in recognition of basic human worth such as law-enforcement, ambulance and fire, emergency medical care, and education).
- Current insurance market policy does not require an individual to demonstrate citizenship before purchasing a private insurance product with personal funds. This is consistent with other market practices that do not require individuals to demonstrate citizenship before making purchases.
- Many non-citizen individuals who are here legally still do not qualify for public programs because of federal restrictions.

Including individuals who are currently ineligible for public programs because of citizenship status within the Oregon Health Fund Board creates policy complications.

- No matching federal funds on subsidized insurance programs
- In the current political comment, state subsidies for immigrant populations not currently eligible for federal eligibility may be unrealistic, as seen in the Healthy Kids legislative process.
- Without subsidies, many individuals would not be able to afford to purchase insurance in the public market place or within the Oregon Health Fund insurance exchange.

Health Equities Committee Policy Recommendations on Citizenship

1. *As consistent with current practices in the private marketplace,* ***no citizenship documentation requirements will be in place to participate in the Oregon Health Fund program.***
2. *Beyond existing programs****, no state dollars will be used to subsidize the health care of individuals who are not eligible to participate in federal programs such as Medicare or Medicaid because of citizenship status.***
3. ***A fund will be established within the Oregon Health Fund program where foundations, providers, managed care groups, targeted employers, and others may continually contribute funds, on a voluntary basis, that will be appropriated to provide subsidies to individuals that do not qualify for state subsidies but are unable to afford purchasing healthcare without them.***
4. ***Individuals and families receiving subsidies through the Trust will be required to participate in an insurance product that ensures patient centered-primary care in a culturally-appropriate and linguistically-competent medical home.***

5. ***A small portion of these trust funds may be appropriated for an uncompensated-care pool that will support community-based safety-net clinics in providing a medical home for the remaining uninsured.***

State Coverage for Immigrants

	Pregnant Women		Children		Parents	Elderly & Disabled People	Limited to Prenatal Care or LTC	Eligibility and Funding Notes
	State Funds	SCHIP Option	State Funds	SCHIP-Medicaid				
Arkansas		X					Yes	Prenatal care regardless of immigration status
California	X					X	Yes	Counties, cities and hospital districts, at their own discretion, can provide health care and other services to all residents (regardless of citizenship). New reform proposal would provide state funds to cover all kids regardless of immigration status.
Florida				Cap			No	Children covered regardless of immigration status. Funding is capped; current waiting list.
Illinois			X				No	The "All Kids" program covers all children regardless of immigration status
Massachusetts						Cap	No	Under the new laws, immigrants that do not meet federal qualifications can still apply for MassHealth Limited, which covers emergency services only, and Health Safety Net Pool, which is available for low-income individuals.
Missouri		X					Yes	Prenatal care regardless of immigration status
Nebraska		X					Yes	Prenatal care regardless of immigration status
New Jersey	X						Yes	Prenatal care regardless of immigration status; there is no citizenship verification requirement for Charity Care program that covers all uninsured individuals with incomes up to 200 percent of the Federal Poverty Level. There is a sliding-fee scale for individuals with incomes between 200 percent and 300 percent of FPL.

State Coverage for Immigrants

	Pregnant Women		Children		Parents	Elderly & Disabled People	Limited to Prenatal Care or LTC	Eligibility and Funding Notes
	State Funds	SCHIP Option	State Funds	SCHIP-Medicaid				
New York	X		X				Yes	Immigrant children are currently eligible regardless of federal qualifications for the Child Health Plus B program
Rhode Island		X					No	Immigrant children that do not meet federal requirements that were not enrolled prior to 12/31/06 are no longer eligible for the state's Medicaid program.
Washington	X						No	All immigrant children that do not meet federal requirements are eligible for Basic Health, which has limited benefits, cost-sharing, and a waiting list.
Washington DC	X		Cap		X	X	No	Children are eligible for public health insurance regardless of immigration status; capped at 800 children and a one to two month waiting list. All other immigrants are eligible for the DC Healthcare Alliance, which provides limited benefits.

Policy Recommendations "Straw-Person" on Outreach

Problem or Issue:

In Oregon, there are marked disparities of insurance status by race, ethnicity, and geography. Many of these individuals would qualify for current programs such as Oregon Health Plan Standard (if it were open to new enrollment) and Oregon Health Plan Plus for children.

Department of Medical Assistance Programs (DMAP) has not had sustainable funding for targeted outreach programs that would reduce disparities in health insurance status.

During the process of developing the Healthy Kids program proposal, the Medicaid Advisory Committee convened a group of multi-cultural stakeholders to develop policy concerning outreach. Broadly speaking, this committee felt the state should develop a ***sustainable*** outreach funding source that supports a ***community-developed and implemented***, ***culturally-specific*** approach to outreach and does not put agencies that serve vulnerable populations in competition with one another.

The resulting Healthy Kids legislation that passed the Oregon Legislature and was voted on in Oregon (defeated by Oregon voters) had two mechanisms for this:

1. Community grants for targeted outreach. The Office of Private Health Partnerships (OPHP) was tasked with development and implementation of these grants.
2. Certified Application Agent (CAA) program to train individuals within a community who are outside of social service or provider organizations to become certified application assistance, allowing them to receive a small fee per completed application. This is likely one of the most economical and grass-roots approaches to outreach in the national literature but later became a political target by being associated with putting a "bounty" on each uninsured child.

Recommendation from the Health Equities Committee

A media-only approach to outreach for the Oregon Health Fund Board is not an adequate response to reducing health disparities in health insurance status in Oregon. A sustainable funding mechanism, with additional Medicaid matching funds, must support community-based organizations in delivering culturally-specific and targeted outreach and application assistance to members of racial/ethnic/language minority communities, individuals living in geographic isolation, and populations that encounter additional barriers such as individuals with physical disabilities or behavioral health disorders and individuals in homelessness. These community-based approaches should be collaborative rather than competitive among agencies that serve vulnerable populations. The Office of Multicultural Health and county health departments should have a key role in ensuring that barriers to outreach and enrollment are addressed at both the community and system level and efforts are coordinated between the Oregon Health Fund Program, Department of Medical Assistance Programs, and community-grantees.

Oregon Health Fund Board
Health Equities Committee Meeting

Tuesday, November 27, 2007
2:00 – 4:00 pm

Northwest Health Foundation
221 NW Second Ave, Suite 300
Portland, OR

AGENDA

Time (est)	Item	Lead	Action Items
2:00 pm **10 min**	**Call to Order, Introductions of Committee Members & Staff**	**Heidi Allen**	
2:10 **10 min**	**Review & Adoption of By-laws**	**Heidi Allen**	X
2:20 **10 min**	**Nominations & Election of Committee Chair and Vice Chair**	**Heidi Allen**	X
2:30 **30 min**	**Introduction to SB 329 Reform Process and Assumptions for Reform**	**Barney Speight**	
3:00 **30 min**	**Review of Draft Committee Charter and Timeline**	**Chair**	
3:30 **10 min**	**Future Meetings**	**Chair**	
3:40 **20 min**	**Public Testimony**	**Chair**	
4:00	**Adjourn**	**Chair**	

Next Meeting: TBD

EXHIBIT MATERIALS:
A. OHFB Health Equities Committee Members List
B. OHFB Health Equities Organizational Documents
C. SB 329 *
D. Summary of SB 329
E. Oregon Health Policy Committee Roadmap for Health Care Reform**
F. Oregon Business Council Policy Playbook***
G. Description of OHPR Programs
H. Racial & Ethnic Health Task Force Report to the Governor - November 2000±

*Available at: http://www.leg.state.or.us/07reg/measpdf/sb0300.dir/sb0329.en.pdf
** Available at: http://egov.oregon.gov/DAS/OHPPR/HPC/OHPCReformRoadMapFINAL.pdf
*** Available at: http://www.oregonbusinessplan.org/pdf/OBP%20POLICY%20PLAYBOOK%202.5%20_FINAL_.pdf
± Available at: http://www.oregon.gov/DHS/ph/omh/tf2000/index.shtml

OREGON HEALTH FUND BOARD
HEALTH EQUITIES COMMITTEE
Draft By-Laws
Adopted by OHFB __________

ARTICLE I
The Committee and its Members

- The Health Equities Committee ("Committee") is created by the Oregon Health Fund Board ("Board"). The Committee's function is to study, review, discuss, take public comment on and develop policy options and recommendations to the Board, consistent with the Committee's scope of work as determined by the Board.

- The Executive Director of the Board and staff employed or arranged for by the Executive Director shall serve as staff to the Committee. The Office for Oregon Health Policy and Research (OHPR) and other state agencies will support the work of the Committee in a manner mutually agreed upon by the Executive Director and the respective entity(ies).

- The Members of the Committee will be appointed by, and serve at the pleasure of, the Board. The Committee shall cease to exist upon a majority vote of the Board to disband the Committee.

- Members of the Committee are not entitled to compensation for services or reimbursement of expenses for serving on the Committee.

ARTICLE II
Committee Officers and Duties

- The Committee shall select a Chair and up to two Vice Chairs from among its Members. The Officers will serve for 24-months from the date of their election or until the Board disbands the Committee, whichever occurs first.

- Duties of the Chair are:
    - Serve as a non-voting Member of the Board. The Chair will sit with the Board and participate in all Board discussions, but shall not be permitted to make, second or vote on motions, resolutions or other formal actions of the Board.
    - Preside at all meetings of the Committee.

    - Coordinate meeting agendas after consultation with Committee staff.
    - Review all draft Committee meeting minutes prior to the meeting at which they are to be approved.
    - Be advised of all presentations or appearances of the Executive Director or staff before Legislative or Executive committees or agencies that relate to the work of the Committee.
    - The Chair may designate, in the absence of the Vice-Chair or when expedient to Committee business, other Committee Members to perform duties related to Committee business such as, but not limited to, attending other agency or public meetings, meetings of the Board, training programs, and approval and review of documents that require action of the Chair.

- Duties of the Vice Chair are:
    - Perform all of the Chair's duties in his/her absence or inability to perform;
    - Accompany the Chair to meetings of the Board at which final recommendations of the Committee are presented; and
    - Perform any other duties assigned by the Chair.

ARTICLE III

Committee Meetings

- The Committee shall meet at the call of the Chair in consultation with the Committee Members and staff.

- The Committee shall conduct all business meetings in public and in conformity with Oregon Public Meetings Laws. The Committee will provide opportunity for public comment at every meeting in accordance with policies and procedures adopted by the Board.

- The preliminary agenda will be available from the Committee staff and posted on the Board website [healthfundboard.oregon.gov] at least two working days prior to the meeting. The final agenda will be established by Committee members at the beginning of each Committee meeting.

- A majority of Committee Members shall constitute a quorum for the transaction of business.

- All actions of the Committee shall be expressed by motion or resolution. Official action by the Committee requires the approval of a majority of a quorum of Members.

- On motions, resolutions, or other matters, a voice vote may be used. At the discretion of the Chair, or upon the request of a Committee Member, a roll call vote may be conducted. Proxy votes are not permitted.

- If a Committee Member is unable to attend a meeting in person, the Member may participate by conference telephone or internet conferencing provided that the absent Committee Member can be identified when speaking, all participants can hear each other and members of the public attending the meeting can hear any Member of the Committee who speaks during the meeting. A Committee Member participating by such electronic means shall be considered in constituting a quorum.

- Committee Members shall inform the Chair or Committee staff with as much notice as possible if unable to attend a scheduled Committee meeting. Committee staff preparing the minutes shall record the attendance of Committee Members at the meeting for the minutes.

- The Committee will conduct its business through discussion, consensus building and informal meeting procedures. The Chair may, from time to time, establish procedural processes to assure the orderly, timely and fair conduct of business.

ARTICLE IV

Amendments to the By-Laws and Rules of Construction

- These By-laws may be amended upon the affirmative vote of five (5) Members of the Board.

OREGON HEALTH FUND BOARD
HEALTH EQUITIES COMMITTEE
Approved by OHFB ________________

Objective

The Health Equities Committee is chartered with developing multicultural strategies for program eligibility and enrollment procedures as well as with making policy recommendations to reduce health disparities through delivery system reform and benefit design of the Oregon Health Fund program. The work of the Health Equities Committee will be submitted directly to the Oregon Health Fund Board (OHFB) as well as integrated into the work of other OHFB committees.

Scope

The Health Equities Committee will focus its study of strategies to reduce health disparities in Oregon, including but not limited to:

1. Providing the Eligibility & Enrollment Committee with recommendations concerning but not limited to:
    - Best practices for outreach in communities of color, homeless adults and youth, and with individuals who live in geographic isolation
    - Strategies to reduce disparities in insurance status by decreasing barriers to enrollment and streamlining enrollment policies & practices
2. Providing the Delivery Committee with recommendations concerning reducing health disparities in Oregon. Recommendations may include but are not limited to topics such as:
    - Elements of the Medical Home model that reduce health disparities and provide culturally competent care.
    - Financial incentive programs to reduce targeted health disparities and quality care through provider fee increases and value-based purchasing
    - A plan to increase collection of health-related data for people of color and other under-represented populations using techniques that are culturally sensitive and accurate.
    - Provider workforce issues such as recruitment of minority and rural providers, retention, and cultural-competence training.
    - Methods to empower and incentivize individuals to make healthy lifestyle choices.
    - Reimbursement options for health promotion activities that occur outside of the traditional healthcare delivery system.
3. Providing the Benefits Committee with recommendations concerning benefit designs that support the health of women, minorities, and other vulnerable populations including but not limited to:

- Benefits related to women's health and benefit designs that target women of childbearing age.
- An emphasis on reducing health disparities in developing a benefit package of essential health services.
- Ensuring an affordable benefit package that promotes the health of individuals who have physical or mental health disabilities.

Committee Membership

Name	Affiliation	City
Yves LeFranc, MD	Legacy Health Systems	Portland
Ella Booth, Ph.D.	Oregon Health & Science University (OHSU)	Portland
Honora Englander, MD	OHSU Division of Hospital Medicine	Portland
Scott Ekblad	Office of Rural Health, OHSU	Portland
Maria Michalczyk, RN, MA,	Healthcare Interpreter Training program, Portland Community College	Portland
Michelle Berlin, MD, MPH	Center of Excellence in Women's Health, OHSU	Portland
Tricia Tillman, MPH	Multnomah County Health Department	Portland
Noelle Wiggins	Multnomah County Health Department	Portland
John Duke, MBA	Outside-In Homeless Youth Clinic	Portland
Jackie Mercer	NARA	Portland
Ed Blackburn	Central City Concern	Portland
Bruce Bliatout, Ph.D.,	Multnomah County Health Department	Portland
Laurie Powers, Ph.D.	Portland State University, Regional Research Institute	Portland
Melinda Muller, MD	Legacy Health Systems	Portland
Joe Finkbonner	Northwest Portland Indian Health Board	Portland
Holden Leung, MSW	Asian Health and Service Center	Portland

Staff Resources

- Heidi Allen, (Lead Staff) OHREC Director and Medicaid Advisory Committee, OHPR – Heidi.Allen@state.or.us; 503-373-1608
- Nate Hierlmaier, Policy Analyst, OHPR – Nate.Hierlmaier@state.or.us; 503-373-1632
- Shawna Kennedy-Walters, Office Specialist, OHPR – Shawna.Kennedy-Walters@state.or.us; 503-373-1598

Timing

The Committee will provide its recommendation(s) to the Eligibility and Enrollment Committee on outreach and insurance coverage no later than January 15, 2008, Delivery Committee on reducing health disparities no later than February 15, 2008, Benefits Committee on benefit designs no later than March 15, 2008 and all other recommendation(s) to the Board for review and public comment no later than April 30, 2008.

Summary of SB 329

<u>Section 1</u> – Names provisions of SB 329 the "Healthy Oregon Act"

<u>Section 2</u> – Definitions

<u>Section 3</u> - Principles

Oregon Health Fund program is based on 16 principles:

Principle		Description
1	Expanding access	The state Medicaid program, the Oregon State Children's Health Insurance Program and the Family Health Insurance Assistance Program must be expanded to include the current uninsured population in Oregon to the greatest extent possible.
2	Equity	All individuals must be eligible for and have timely access to at least the same set of essential and effective health services.
3	Financing	…of the health care system must be equitable, broadly based and affordable.
4	Population benefit	The public must set priorities to optimize the health of Oregonians.
5	Responsibility	…for optimizing health must be shared by individuals, employers, health care systems and communities.
6	Education	…is a powerful tool for health promotion. The health care system, health plans, providers and government must promote and engage in education activities for individuals, communities and providers.
7	Effectiveness	The relationship between specific health interventions and their desired health outcomes must be backed by unbiased, objective medical evidence.
8	Efficiency	The administration and delivery of health services must use the fewest resources necessary to produce the most effective health outcome.
9	Explicit decision-making	Decision-making will be clearly defined and accessible to the public, including lines of accountability, opportunities for public engagement and how public input will be used in decision-making.
10	Transparency	The evidence used to support decisions must be clear, understandable and observable to the public.
11	Economic sustainability	Health service expenditures must be managed to ensure long-term sustainability, using efficient planning, budgeting and coordination of resources and reserves, based on public values and recognizing the impact that public and private health expenditures have on each other.
12	Aligned financial incentives	Financial incentives must be aligned to support and invest in activities that will achieve the goals of the Oregon Health Fund program.
13	Wellness	Health and wellness promotion efforts must be emphasized and strengthened.
14	Community-based	The delivery of care and distribution of resources must be organized to take place at the community level to meet the needs of the local population, unless outcomes or cost can be improved at regional or statewide levels.
15	Coordination	Collaboration, coordination and integration of care and resources must be emphasized throughout the health care system.
16	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.

Section 4 - Goals

The Oregon Health Fund program will develop a comprehensive plan that meets these 12 goals:

Goal		Means
1	Cover the current uninsured in Oregon	Expand the state Medicaid program, the Oregon State Children's Health Insurance Program and the Family Health Insurance Assistance Program.
2	Reform the health care delivery system	Maximize federal and other public resources without compromising proven programs supported by federal law that ensure to vulnerable populations access to efficient and high quality care.
3	Give Oregonians timely access to a health benefit plan	Ensure access to and participation in health benefit plans that provide high quality, effective, safe, patient-centered, evidence-based and affordable health care delivered at the lowest cost.
4	Finance coverage of essential health services	Develop a method to finance the coverage of a defined set of essential health services for Oregonians that is not necessarily tied directly to employment.
5	Encourage participation	Allow the potential for employees, employers, individuals and unions to participate in the program, or to purchase primary coverage or offer, purchase or bargain for coverage of benefits beyond the defined set of essential health services.
6	Encourage public and private health care partnerships	Allow a system of public and private health care partnerships that integrate public involvement and oversight, consumer choice and competition within the health care market.
7	Control costs and over-utilization, encourage care management	Use proven models of health care benefits, service delivery and payments that control costs and over utilization, with emphasis on preventive care and chronic disease management using evidence-based outcomes and a health benefit model that promotes a primary care medical home.
8	Improve end-of-life care	Provide services for dignified end-of-life care.
9	Change payment structure	Restructure the health care system so that payments for services are fair and proportionate among various populations, health care programs and providers.
10	Establish high quality, transparent health care delivery	Fund a high quality and transparent health care delivery system that will be held to high standards of transparency and accountability and allows users and purchasers to know what they are receiving for their money.
11	Make funding equitable and affordable	Ensure that funding for health care is equitable and affordable for all Oregon residents, especially the uninsured
12	Try to limit inflation to cost of living	Ensure, to the greatest extent possible, that annual inflation in the cost of providing access to essential health care services does not exceed the increase in the cost of living for the previous calendar year, based on the Portland-Salem, OR-WA, Consumer Price Index. for All Urban Consumers for All Items, as published by the Bureau of Labor Statistics of the United States Department of Labor.

Oregon Health Fund Board (Sections 5-12)

<u>Section 5</u> – Board Location within State Government

The Board is established within the Department of Human Services (DHS).

<u>Section 5</u> – Board Membership

Seven members appointed by the Governor and confirmed by the Senate.

Members need:

- Ability to represent the best interests of Oregon as a whole
- Expertise, knowledge and experience in consumer advocacy, management, finance, labor, health care
- Represent geographic and ethnic diversity of Oregon
- Majority of Board (4) not recently and significantly associated with health care industry or health insurance industry.
- Four (4) year term of appointment
  - Serve until successor is appointed
  - Eligible for reappointment (no limit in statute)
- Immediate appointment by Governor for vacancy for balance of unexpired term
- Board selects Chairperson and Vice Chairperson
  - Terms, duties and powers determined by Board (i.e., bylaws)
- Majority (4) constitutes quorum for transaction of business
- Official action by Board requires approval of a majority (4)
- Not entitled to compensation, but entitled to expenses [ORS 292.495(2)]

<u>Section 5</u> – Responsibility

Board will develop the Oregon Health Fund program comprehensive plan.

<u>Section 6</u> – Executive Director

Executive Director of the Oregon Health Fund Board serves at the pleasure of the Governor.

<u>Section 7</u> – Purchasing Rules

The Board is generally exempt from public contracting statutes.

<u>Section 8</u> – Fund's Administration and Organization

The Oregon Health Fund is established separate from the General Fund. The funds may include:

- Employer and employee health care contributions
- Individual health care premium contributions
- Federal funds
- US Government contributions
- Money appropriated by the Legislature
- Interest
- Gifts, grants, contributions

<u>Section 9</u> – Board Committees and Subcommittees

(1) Committee to examine impact of federal law

- Full Board approves report

- Committee is public body (ORS chapter 192) and must provide for public testimony
- Report sent to Oregon congressional delegation no later than Jul 31, 2008
- Request delegation hold
  - One hearing in Oregon
  - Congressional hearings in Washington, D.C.

(2) Subcommittees to develop proposals for Board's comprehensive plan

- Assisted by Health Policy Commission, OHPR, Health Services Commission and Medicaid Advisory Committee
- Subcommittees will include persons other than Board members
  - Include individuals with actuarial and financial management experience, health care providers, consumers of health care
- Subcommittees are public bodies (ORS chapter 192) and must provide for public testimony
- Subcommittees select chairperson and determine term and duties
  - Subcommittee chairpersons serve as ex-officio members of Board

Subcommittee proposals for reform comprehensive plan to Board

- Financing Oregon Health Fund program (report due from OHPC to Board by 2/1/08). Provide recommendations on:
  - Model for rate setting
  - Collecting employer, employee and individual health care premium contributions
  - Implementing health insurance exchange
  - Utilizing vehicles for making insurance more accessible to the uninsured
  - Addressing medical liability and medical errors
  - Requesting federal waivers as needed
  - Evaluating statutory and regulatory barriers to the provision of cost-effective services

- Delivering health services in the Oregon Health Fund program (report due from OHPR to Board by 2/1/08). Provide recommendations on:
  - Delivering health services in the Oregon Health Fund program
  - An efficient and effective delivery system model
  - Design and implementation of public partnership with AHPs to provide coverage of defined set of essential health services
  - Using information technology
  - Education and incentives to encourage increased personal responsibility for health
  - Establishing and maintaining a registry of advance directives and POLST forms
  - Combining, reorganizing or eliminating state agencies to maximize effectiveness and efficiency

- Establishing the defined set of essential health services (report due from the Health Services Committee to Board by 2/1/08).

- Eligibility requirements and enrollment procedures (report due from Medicaid Advisory Committee to Board by 2/1/08). Recommendation topics include:
  - Public subsidies
  - Streamlined enrollment procedures
  - Grievance and appeal process

  - Standards for disenrollment and changing enrollment in AHPs
  - Outreach plan regarding the program, eligibility requirements and enrollment procedure
  - Allowing employers to offer insurance of employer's choice and to contract for coverage beyond the defined set of essential health services

Subcommittee Structure

- Membership should represent Oregon's diversity and include individuals with actuarial and financial management experience, health care providers, persons with disabilities and individuals with complex medical needs.
- Subcommittee chairs serve as ex officio members of Oregon Health Fund Board.
- Committee, subcommittees are public bodies and must provide opportunity for public testimony.
- All agencies of state government are directed to assist the committee, subcommittees and Board.

<u>Section 10</u> – Board reports to Legislature

- The Board reports to the Legislature on the design and implementation of a health insurance exchange. The report is due by February 1, 2008.

- The Board reports to the Legislature by Feb 29, 2008 describing the progress of subcommittees and Board in developing a comprehensive plan to:
  - Decrease number of children and adults without health insurance
  - Ensure universal access to health care
  - Contain health care costs
  - Address issues of quality of health care services

<u>Section 11</u> – Finalizing the comprehensive plan

- The Board will present the finalized comprehensive plan to the Governor, House Speaker and Senate President by October 1, 2008.
- The plan can be submitted as a measure request to the Legislative Counsel at the start of 75th Legislative Assembly.

<u>Section 12</u> – Authority for Ensuring Participation

- The Oregon Health Fund program has responsibility for ensuring that Oregon residents participate in the Oregon Health Fund program
- The following individuals are exempted from mandatory enrollment in the Oregon Health Fund program and may enroll voluntarily if they choose:
  - An Oregon resident who is a beneficiary of a health benefit plan providing coverage of the defined set of essential health services.
  - Oregon residents enrolled in commercial health insurance plan, self-insured program, health plan funded by Taft-Hartley trust, or state or local government health insurance pool.
  - An Oregon resident who is enrolled in a medical assistance program.
  - A non-resident of Oregon who is an employee of an employer located in Oregon; if the employee's physical worksite is in Oregon.

Section 13 - Evaluation

- OHPR Administrator (with help from OHREC and others) will develop a plan for evaluating the implementation and outcomes of the legislation, with particular focus on Medicaid, SCHIP and FHIAP beneficiaries.
- The OHPR Administrator will also develop recommendations for a model quality institute to:
    - Improve methods for collecting and reporting quality information
    - Expand use of electronic health records
    - Develop capacity of workforce to use electronic health records
    - Improve system transparency and public understanding of quality
    - Support Patient Safety Commission's efforts to improve patient safety
    - Improve system infrastructure, integrated care and health outcomes

Sections 14-23 – OHPR moves to DHS

Section 24 – OHF Board gets $1 GF for the 07-09 biennium

Section 25 – OHFB related money to DHS for the 07-09 biennium

- DHS gets $1,215,350 in state funds to carry out required duties
- DHS gets $671,971 in federal funds to carry out required duties

Section 26 – Money is transferred from DAS to DHS

Section 27 – Sections 1 – 13 are repealed 1/2/10

Section 28 – Amendments in Section 15 become operative on 1/2/10

Section 29 – Act takes effect on its passage

74th OREGON LEGISLATIVE ASSEMBLY--2007 Regular Session

Enrolled

Senate Bill 329

Printed pursuant to Senate Interim Rule 213.28 by order of the President of the Senate in conformance with presession filing rules, indicating neither advocacy nor opposition on the part of the President (at the request of Senate Interim Commission on Health Care Access and Affordability)

CHAPTER ....

AN ACT

Relating to the Oregon Health Fund program; creating new provisions; amending ORS 414.221, 414.312, 414.314, 414.316, 414.318, 414.320 and 442.011 and sections 2 and 3, chapter 314, Oregon Laws 2005; appropriating money; limiting expenditures; and declaring an emergency.

Whereas improving and protecting the health of Oregonians must be a primary issue and an important goal of the state; and

Whereas the objective of Oregon′s health care system is health, not just the financing and delivery of health care services; and

Whereas health is more than just the absence of physical and mental disease, it is the product of a number of factors, only one of which is access to the medical system; and

Whereas persons with disabilities and other ongoing conditions can live long and healthy lives; and

Whereas Oregonians cannot achieve the objective of health unless all individuals have timely access to a defined set of essential health services; and

Whereas Oregonians cannot achieve the objective of health unless the state invests not only in health care, but also in education, economic opportunity, housing, sustainable environmental stewardship, full participation and other areas that are important contributing factors to health; and

Whereas the escalating cost of health care is compromising the ability to invest in those other areas that contribute to the health of the population; and

Whereas Oregon cannot achieve its objective of health unless Oregonians control costs in the health care system; and

Whereas Oregon cannot control costs unless Oregonians:

(1) Develop effective strategies through education of individuals and health care providers, development of policies and practices as well as financial incentives and disincentives to empower individuals to assume more personal responsibility for their own health status through the choices they make;

(2) Reevaluate the structure of Oregon′s financing and eligibility system in light of the realities and circumstances of the 21st century and of what Oregonians want the system to achieve from the standpoint of a healthy population; and

(3) Rethink how Oregonians define a “benefit” and restructure the misaligned financial incentives and inefficient system through which health care is currently delivered; and

Whereas public resources are finite, and therefore the public resources available for health care are also finite; and

Whereas finite resources require that explicit priorities be set through an open process with public input on what should and should not be financed with public resources; and

Whereas those priorities must be based on publicly debated criteria that reflect a consensus of social values and that consider the good of individuals across their lifespans; and

Whereas those with more disposable private income will always be able to purchase more health care than those who depend solely on public resources; and

Whereas society is responsible for ensuring equitable financing for the defined set of essential health services for those Oregonians who cannot afford that care; and

Whereas health care policies should emphasize public health and encourage the use of quality services and evidence-based treatment that is appropriate and safe and that discourages unnecessary treatment; and

Whereas health care providers and informed patients must be the primary decision makers in the health care system; and

Whereas access, cost, transparency and quality are intertwined and must be simultaneously addressed for health care reform to be sustainable; and

Whereas health is the shared responsibility of individual consumers, government, employers, providers and health plans; and

Whereas individual consumers, government, employers, providers and health plans must be part of the solution and share in the responsibility for both the financing and delivery of health care; and

Whereas the current health care system is unsustainable in large part because of outdated federal policies that reflect the realities of the last century instead of the realities of today and that are based on assumptions that are no longer valid; and

Whereas the ability of states to maintain the public's health is increasingly constrained by those federal policies, which were built around "categories" rather than a commitment to ensure all citizens have timely access to essential health services; and

Whereas the economic and demographic environment in which state and federal policies were created has changed dramatically over the past 50 years, while the programs continue to reflect a set of circumstances that existed in the mid-20th century; and

Whereas any strategies for financing, mandating or developing new programs to expand access must address what will be covered with public resources and how those services will be delivered; otherwise, those strategies will do little to stem escalating medical costs, make health care more affordable or create a sustainable system; and

Whereas incremental changes will not solve Oregon's health care crisis and comprehensive reform is required; now, therefore,

Be It Enacted by the People of the State of Oregon:

SECTION 1. Sections 2 to 13 of this 2007 Act shall be known and may be cited as the Healthy Oregon Act.

SECTION 2. As used in sections 2 to 13 of this 2007 Act, except as otherwise specifically provided or unless the context requires otherwise:

(1) "Accountable health plan" means a prepaid managed care health services organization described in ORS 414.725 or an entity that contracts with the Oregon Health Fund Board to provide a health benefit plan, as defined in ORS 743.730, through the Oregon Health Fund program.

(2) "Core health care safety net provider" means a safety net provider that is especially adept at serving persons who experience significant barriers to accessing health care, including homelessness, language and cultural barriers, geographic isolation, mental illness, lack of health insurance and financial barriers, and that has a mission or mandate to deliver services to persons who experience barriers to accessing care and serves a substantial share of persons without health insurance and persons who are enrolled in Medicaid or Medicare, as well as other vulnerable or special populations.

(3) "Defined set of essential health services" means the services:

(a) Identified by the Health Services Commission using the methodology in ORS 414.720 or an alternative methodology developed pursuant to section 9 (3)(c) of this 2007 Act; and

(b) Approved by the Oregon Health Fund Board.

(4) "Employer" has the meaning given that term in ORS 657.025.

(5) "Oregon Health Card" means the card issued by the Oregon Health Fund Board that verifies the eligibility of the holder to participate in the Oregon Health Fund program.

(6) "Oregon Health Fund" means the fund established in section 8 of this 2007 Act.

(7) "Oregon Health Fund Board" means the board established in section 5 of this 2007 Act.

(8) "Safety net provider" means providers that deliver health services to persons experiencing cultural, linguistic, geographic, financial or other barriers to accessing appropriate, timely, affordable and continuous health care services. "Safety net providers" includes health care safety net providers, core health care safety net providers, tribal and federal health care organizations and local nonprofit organizations, government agencies, hospitals and individual providers.

<u>SECTION 3.</u> The Oregon Health Fund program shall be based on the following principles:

(1) Expanding access. The state Medicaid program, the Oregon State Children's Health Insurance Program and the Family Health Insurance Assistance Program must be expanded to include the current uninsured population in Oregon to the greatest extent possible.

(2) Equity. All individuals must be eligible for and have timely access to at least the same set of essential and effective health services.

(3) Financing of the health care system must be equitable, broadly based and affordable.

(4) Population benefit. The public must set priorities to optimize the health of Oregonians.

(5) Responsibility for optimizing health must be shared by individuals, employers, health care systems and communities.

(6) Education is a powerful tool for health promotion. The health care system, health plans, providers and government must promote and engage in education activities for individuals, communities and providers.

(7) Effectiveness. The relationship between specific health interventions and their desired health outcomes must be backed by unbiased, objective medical evidence.

(8) Efficiency. The administration and delivery of health services must use the fewest resources necessary to produce the most effective health outcome.

(9) Explicit decision-making. Decision-making will be clearly defined and accessible to the public, including lines of accountability, opportunities for public engagement and how public input will be used in decision-making.

(10) Transparency. The evidence used to support decisions must be clear, understandable and observable to the public.

(11) Economic sustainability. Health service expenditures must be managed to ensure long-term sustainability, using efficient planning, budgeting and coordination of resources and reserves, based on public values and recognizing the impact that public and private health expenditures have on each other.

(12) Aligned financial incentives. Financial incentives must be aligned to support and invest in activities that will achieve the goals of the Oregon Health Fund program.

(13) Wellness. Health and wellness promotion efforts must be emphasized and strengthened.

(14) Community-based. The delivery of care and distribution of resources must be organized to take place at the community level to meet the needs of the local population, unless outcomes or cost can be improved at regional or statewide levels.

(15) Coordination. Collaboration, coordination and integration of care and resources must be emphasized throughout the health care system.

(16) 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.

SECTION 4. **The intent of the Healthy Oregon Act is to develop an Oregon Health Fund program comprehensive plan, based upon the principles set forth in section 3 of this 2007 Act, that meets the intended goals of the program to:**

(1) As a primary goal, cover the current uninsured population in Oregon through the expansion of the state Medicaid program, the Oregon State Children's Health Insurance Program and the Family Health Insurance Assistance Program;

(2) Reform the health care delivery system to maximize federal and other public resources without compromising proven programs supported by federal law that ensure to vulnerable populations access to efficient and high quality care;

(3) Ensure that all Oregonians have timely access to and participate in a health benefit plan that provides high quality, effective, safe, patient-centered, evidence-based and affordable health care delivered at the lowest cost;

(4) Develop a method to finance the coverage of a defined set of essential health services for Oregonians that is not necessarily tied directly to employment;

(5) Allow the potential for employees, employers, individuals and unions to participate in the program, or to purchase primary coverage or offer, purchase or bargain for coverage of benefits beyond the defined set of essential health services;

(6) Allow for a system of public and private health care partnerships that integrate public involvement and oversight, consumer choice and competition within the health care market;

(7) Use proven models of health care benefits, service delivery and payments that control costs and overutilization, with emphasis on preventive care and chronic disease management using evidence-based outcomes and a health benefit model that promotes a primary care medical home;

(8) Provide services for dignified end-of-life care;

(9) Restructure the health care system so that payments for services are fair and proportionate among various populations, health care programs and providers;

(10) Fund a high quality and transparent health care delivery system that will be held to high standards of transparency and accountability and allows users and purchasers to know what they are receiving for their money;

(11) Ensure that funding for health care is equitable and affordable for all Oregon residents, especially the uninsured; and

(12) Ensure, to the greatest extent possible, that annual inflation in the cost of providing access to essential health care services does not exceed the increase in the cost of living for the previous calendar year, based on the Portland-Salem, OR-WA, Consumer Price Index for All Urban Consumers for All Items, as published by the Bureau of Labor Statistics of the United States Department of Labor.

SECTION 5. **(1) There is established within the Department of Human Services the Oregon Health Fund Board that shall be responsible for developing the Oregon Health Fund program comprehensive plan. The board shall consist of seven members appointed by the Governor, subject to confirmation by the Senate pursuant to section 4, Article III of the Oregon Constitution. The members of the board shall be selected based upon their ability to represent the best interests of Oregon as a whole. Members of the board shall have expertise, knowledge and experience in the areas of consumer advocacy, management, finance, labor and health care, and to the extent possible shall represent the geographic and ethnic diversity of the state. A majority of the board members must consist of individuals who do not receive or have not received within the past two years more than 50 percent of the individual's income or the income of the individual's family from the health care industry or the health insurance industry.**

(2) Each board member shall serve for a term of four years. However, a board member shall serve until a successor has been appointed and qualified. A member is eligible for reappointment.

(3) If there is a vacancy for any cause, the Governor shall make an appointment to become effective immediately for the balance of the unexpired term.

(4) The board shall select one of its members as chairperson and another as vice chairperson, for such terms and with duties and powers necessary for the performance of the functions of such offices as the board determines.

(5) A majority of the members of the board constitutes a quorum for the transaction of business.

(6) Official action by the board requires the approval of a majority of the members of the board.

(7) A member of the board is not entitled to compensation for services as a member, but is entitled to expenses as provided in ORS 292.495 (2).

SECTION 6. **(1) Within 30 days after the effective date of this 2007 Act, the Governor shall appoint an executive director of the Oregon Health Fund Board who will be responsible for establishing the administrative framework for the board.**

(2) The executive director appointed under this section may employ and shall fix the duties and amounts of compensation of persons necessary to carry out the provisions of sections 2 to 13 of this 2007 Act. Those persons shall serve at the pleasure of the executive director.

(3) The executive director shall serve at the pleasure of the Governor.

SECTION 7. **Except as otherwise provided by law, and except for ORS 279A.250 to 279A.290, the provisions of ORS chapters 279A, 279B and 279C do not apply to the Oregon Health Fund Board.**

SECTION 8. **(1) The Oregon Health Fund is established separate and distinct from the General Fund. Interest earned from the investment of moneys in the Oregon Health Fund shall be credited to the fund. The Oregon Health Fund may include:**

(a) Employer and employee health care contributions.

(b) Individual health care premium contributions.

(c) Federal funds from Title XIX or XXI of the Social Security Act, and state matching funds, that are made available to the fund, excluding Title XIX funds for long term care supports, services and administration, and reimbursements for graduate medical education costs pursuant to 42 U.S.C. 1395ww(h) and disproportionate share adjustments made pursuant to 42 U.S.C. 1396a(a)(13)(A)(iv).

(d) Contributions from the United States Government and its agencies for which the state is eligible provided for purposes that are consistent with the goals of the Oregon Health Fund program.

(e) Moneys appropriated to the Oregon Health Fund Board by the Legislative Assembly for carrying out the provisions of the Healthy Oregon Act.

(f) Interest earnings from the investment of moneys in the fund.

(g) Gifts, grants or contributions from any source, whether public or private, for the purpose of carrying out the provisions of the Healthy Oregon Act.

(2)(a) All moneys in the Oregon Health Fund are continuously appropriated to the Oregon Health Fund Board to carry out the provisions of the Healthy Oregon Act.

(b) The Oregon Health Fund shall be segregated into subaccounts as required by federal law.

SECTION 9. **(1)(a) The Oregon Health Fund Board shall establish a committee to examine the impact of federal law requirements on reducing the number of Oregonians without health insurance, improving Oregonians′ access to health care and achieving the goals of the Healthy Oregon Act, focusing particularly on barriers to reducing the number of uninsured Oregonians, including but not limited to:**

(A) Medicaid requirements such as eligibility categories and household income limits;

(B) Federal tax code policies regarding the impact on accessing health insurance or self-insurance and the affect on the portability of health insurance;

(C) Emergency Medical Treatment and Active Labor Act regulations that make the delivery of health care more costly and less efficient; and

(D) Medicare policies that result in Oregon′s health care providers receiving significantly less than the national average Medicare reimbursement rate. The committee shall survey providers and determine how this and other Medicare policies and procedures affect costs, quality and access. The committee shall assess how an increase in Medicare reimbursement rates to Oregon providers would benefit Oregon in health care costs, quality and access to services, including improved access for persons with disabilities and improved access to long term care.

(b) With the approval of the Oregon Health Fund Board, the committee shall report its findings to the Oregon congressional delegation no later than July 31, 2008.

(c) The committee shall request that the Oregon congressional delegation:

(A) Participate in at least one hearing in each congressional district in this state on the impacts of federal policies on health care services; and

(B) Request congressional hearings in Washington, D.C.

(2) The Oregon Health Fund Board shall develop a comprehensive plan to achieve the Oregon Health Fund program goals listed in section 4 of this 2007 Act. The board shall establish subcommittees, organized to maximize efficiency and effectiveness and assisted, in the manner the board deems appropriate, by the Oregon Health Policy Commission, the Office for Oregon Health Policy and Research, the Health Services Commission and the Medicaid Advisory Committee, to develop proposals for the Oregon Health Fund program comprehensive plan. The proposals may address, but are not limited to, the following:

(a) Financing the Oregon Health Fund program, including but not limited to proposals for:

(A) A model for rate setting that ensures providers will receive fair and adequate compensation for health care services.

(B) Collecting employer and employee contributions and individual health care premium contributions, and redirecting them to the Oregon Health Fund.

(C) Implementing a health insurance exchange to serve as a central forum for uninsured individuals and businesses to purchase affordable health insurance.

(D) Taking best advantage of health savings accounts and similar vehicles for making health insurance more accessible to uninsured individuals.

(E) Addressing the issue of medical liability and medical errors including, but not limited to, consideration of a patients′ compensation fund.

(F) Requesting federal waivers under Titles XIX and XXI of the Social Security Act, or other federal matching funds that may be made available to implement the comprehensive plan and increase access to health care.

(G) Evaluating statutory and regulatory barriers to the provision of cost-effective services, including limitations on access to information that would enable providers to fairly evaluate contract reimbursement, the regulatory effectiveness of the certificate of need process, consideration of a statewide uniform credentialing process and the costs and benefits of improving the transparency of costs of hospital services and health benefit plans.

(b) Delivering health services in the Oregon Health Fund program, including but not limited to proposals for:

(A) An efficient and effective delivery system model that ensures the continued viability of existing prepaid managed care health services organizations, as described in ORS 414.725, to serve Medicaid populations.

(B) The design and implementation of a program to create a public partnership with accountable health plans to provide, through the use of an Oregon Health Card, health insur-

ance coverage of the defined set of essential health services that meets standards of affordability based upon a calculation of how much individuals and families, particularly the uninsured, can be expected to spend for health insurance and still afford to pay for housing, food and other necessities. The proposal must ensure that each accountable health plan:

(i) Does not deny enrollment to qualified Oregonians eligible for Medicaid;

(ii) Provides coverage of the entire defined set of essential health services;

(iii) Will develop an information system to provide written information, and telephone and Internet access to information, necessary to connect enrollees with appropriate medical and dental services and health care advice;

(iv) Offers a simple and timely complaint process;

(v) Provides enrollees with information about the cost and quality of services offered by health plans and procedures offered by medical and dental providers;

(vi) Provides advance disclosure of the estimated out-of-pocket costs of a service or procedure;

(vii) Has contracts with a sufficient network of providers, including but not limited to hospitals and physicians, with the capacity to provide culturally appropriate, timely health services and that operate during hours that allow optimal access to health services;

(viii) Ensures that all enrollees have a primary care medical home;

(ix) Includes in its network safety net providers and local community collaboratives;

(x) Regularly evaluates its services, surveys patients and conducts other assessments to ensure patient satisfaction;

(xi) Has strategies to encourage enrollees to utilize preventive services and engage in healthy behaviors;

(xii) Has simple and uniform procedures for enrollees to report claims and for accountable health plans to make payments to enrollees and providers;

(xiii) Provides enrollment, encounter and outcome data for evaluation and monitoring purposes; and

(xiv) Meets established standards for loss ratios, rating structures and profit or nonprofit status.

(C) Using information technology that is cost-neutral or has a positive return on investment to deliver efficient, safe and quality health care and a voluntary program to provide every Oregonian with a personal electronic health record that is within the individual's control, use and access and that is portable.

(D) Empowering individuals through education as well as financial incentives to assume more personal responsibility for their own health status through the choices they make.

(E) Establishing and maintaining a registry of advance directives and Physician Orders for Life-Sustaining Treatment (POLST) forms and a process for assisting a person who chooses to execute an advance directive in accordance with ORS 127.531 or a POLST form.

(F) Designing a system for regional health delivery.

(G) Combining, reorganizing or eliminating state agencies involved in health planning and policy, health insurance and the delivery of health care services and integrating and streamlining their functions and programs to maximize their effectiveness and efficiency. The subcommittee may consider, but is not limited to considering, the following state agencies, functions or programs:

(i) The Health Services Commission;

(ii) The Oregon Health Policy Commission;

(iii) The Health Resources Commission;

(iv) The Medicaid Advisory Committee;

(v) The Department of Human Services, including but not limited to the state Medicaid agency, the Office for Oregon Health Policy and Research, offices involved in health systems planning, offices involved in carrying out the duties of the department with respect to cer-

tificates of need under ORS 443.305 to 443.350 and the functions of the department under ORS chapter 430;

(vi) The Department of Consumer and Business Services;

(vii) The Oregon Patient Safety Commission;

(viii) The Office of Private Health Partnerships;

(ix) The Public Employees′ Benefit Board;

(x) The State Accident Insurance Fund Corporation; and

(xi) The Office of Rural Health.

(c) Establishing the defined set of essential health services, including but not limited to proposals for a methodology, consistent with the principles in section 3 of this 2007 Act, for determining and continually updating the defined set of essential health services. The Oregon Health Fund Board may delegate this function to the Health Services Commission established under ORS 414.715.

(d) The eligibility requirements and enrollment procedures for the Oregon Health Fund program, including, but not limited to, proposals for:

(A) Public subsidies of premiums or other costs under the program.

(B) Streamlined enrollment procedures, including:

(i) A standardized application process;

(ii) Requirements to ensure that enrollees demonstrate Oregon residency;

(iii) A process to enable a provider to enroll an individual in the Oregon Health Fund program at the time the individual presents for treatment to ensure coverage as of the date of the treatment; and

(iv) Permissible waiting periods, preexisting condition limitations or other administrative requirements for enrollment.

(C) A grievance and appeal process for enrollees.

(D) Standards for disenrollment and changing enrollment in accountable health plans.

(E) An outreach plan to educate the general public, particularly uninsured and underinsured persons, about the program and the program′s eligibility requirements and enrollment procedures.

(F) Allowing employers to offer health insurance coverage by insurers of the employer′s choice or to contract for coverage of benefits beyond the defined set of essential health services.

(3) On the effective date of this 2007 Act, the Oregon Health Policy Commission, the Office for Oregon Health Policy and Research, the Health Services Commission and the Medicaid Advisory Committee are directed to begin compiling data and conducting research to inform the decision-making of the subcommittees when they are convened. No later than February 1, 2008, the Oregon Health Policy Commission, the Office for Oregon Health Policy and Research, the Health Services Commission and the Medicaid Advisory Committee shall present reports containing data and recommendations to the subcommittees as follows:

(a) The Oregon Health Policy Commission shall report on the financing mechanism for the comprehensive plan;

(b) The Administrator of the Office for Oregon Health Policy and Research shall report on the health care delivery model of the comprehensive plan;

(c) The Health Services Commission shall report on the methodology for establishing the defined set of essential health services under the comprehensive plan; and

(d) The Medicaid Advisory Committee shall report on eligibility and enrollment requirements under the comprehensive plan.

(4) The membership of the subcommittees shall, to the extent possible, represent the geographic and ethnic diversity of the state and include individuals with actuarial and financial management experience, individuals who are providers of health care, including safety net providers, and individuals who are consumers of health care, including seniors, persons with disabilities and individuals with complex medical needs.

(5) Each subcommittee shall select one of its members as chairperson for such terms and with such duties and powers necessary for performance of the functions of those offices. Each chairperson shall serve as an ex officio member of the Oregon Health Fund Board. Chairpersons shall collaborate to integrate the committee recommendations to the extent possible.

(6) The committee and the subcommittees are public bodies for purposes of ORS chapter 192 and must provide reasonable opportunity for public testimony at each meeting.

(7) All agencies of state government, as defined in ORS 174.111, are directed to assist the committee, the subcommittees and the Oregon Health Fund Board in the performance of their duties and, to the extent permitted by laws relating to confidentiality, to furnish such information and advice as the members of the committees, the subcommittees and the Oregon Health Fund Board consider necessary to perform their duties.

(8) The Oregon Health Fund Board shall report to the Legislative Assembly not later than February 29, 2008. The report must describe the progress of the subcommittees and the board toward developing a comprehensive plan to:

(a) Decrease the number of children and adults without health insurance;

(b) Ensure universal access to health care;

(c) Contain health care costs; and

(d) Address issues regarding the quality of health care services.

(9) The Oregon Health Fund Board shall present a plan to the Legislative Assembly not later than February 1, 2008, for the design and implementation of the health insurance exchange described in subsection (2)(a)(C) of this section.

SECTION 10. The Oregon Health Fund Board shall conduct public hearings on the draft Oregon Health Fund program comprehensive plan developed under section 9 of this 2007 Act and solicit testimony and input from advocates representing seniors, persons with disabilities, tribes, consumers of mental health services, low-income Oregonians, employers, employees, insurers, health plans and providers of health care including, but not limited to, physicians, dentists, oral surgeons, chiropractors, naturopaths, hospitals, clinics, pharmacists, nurses and allied health professionals.

SECTION 11. (1) The Oregon Health Fund Board shall finalize the Oregon Health Fund program comprehensive plan developed under section 9 of this 2007 Act with due consideration to the information provided in the public hearings under section 10 of this 2007 Act and shall present the finalized comprehensive plan to the Governor, the Speaker of the House of Representatives and the President of the Senate no later than October 1, 2008. The board is authorized to submit the finalized comprehensive plan as a measure request directly to the Legislative Counsel upon the convening of the Seventy-fifth Legislative Assembly.

(2) Upon legislative approval of the comprehensive plan, the board is authorized to request federal waivers deemed necessary and appropriate to implement the comprehensive plan.

(3) Upon legislative approval of the comprehensive plan, the board is authorized immediately to implement any elements necessary to implement the plan that do not require legislative changes or federal approval.

SECTION 12. (1) The Oregon Health Fund program comprehensive plan described in section 11 of this 2007 Act must ensure, except as provided in subsection (2) of this section, that a resident of Oregon who is not a beneficiary of a health benefit plan providing coverage of the defined set of essential health services and who is not eligible to be enrolled in a publicly funded medical assistance program providing primary care and hospital services participates in the Oregon Health Fund program. A resident of Oregon who is a beneficiary of a health benefit plan or enrolled in a medical assistance program described in this subsection may choose to participate in the program. An employee of an employer located in this state may participate in the program if Oregon is the location of the employee′s physical worksite, regardless of the employee′s state of residence.

(2) Oregon residents who are enrolled in commercial health insurance plans, self-insured programs, health plans funded by a Taft-Hartley trust, or state or local government health insurance pools may not be required to participate in the Oregon Health Fund Program.

SECTION 13. **(1) The Administrator of the Office for Oregon Health Policy and Research, in collaboration with the Oregon Health Research and Evaluation Collaborative and other persons with relevant expertise, shall be responsible for developing a plan for evaluating the implementation and outcomes of the legislation described in section 11 of this 2007 Act. The evaluation plan shall focus particularly on the individuals receiving health care covered through the state Medicaid program, the Oregon State Children's Health Insurance Program and the Family Health Insurance Assistance Program and shall include measures of:**

(a) Access to care;

(b) Access to health insurance coverage;

(c) Quality of care;

(d) Consumer satisfaction;

(e) Health status;

(f) Provider capacity;

(g) Population demand;

(h) Provider and consumer participation;

(i) Utilization patterns;

(j) Health outcomes;

(k) Health disparities;

(L) Financial impacts, including impacts on medical debt;

(m) The extent to which employers discontinue coverage due to the availability of publicly financed coverage or other employer responses;

(n) Impacts on the financing of health care and uncompensated care;

(o) Adverse selection, including migration to Oregon primarily for access to health care;

(p) Use of technology;

(q) Transparency of costs; and

(r) Impact on health care costs.

(2) The administrator shall develop recommendations for a model quality institute that shall:

(a) Develop and promote methods for improving collection, measurement and reporting of information on quality in health care;

(b) Provide leadership and support to further the development of widespread and shared electronic health records;

(c) Develop the capacity of the workforce to capitalize on health information technology;

(d) Encourage purchasers, providers and state agencies to improve system transparency and public understanding of quality in health care;

(e) Support the Oregon Patient Safety Commission's efforts to increase collaboration and state leadership to improve health care safety; and

(f) Coordinate an effort among all state purchasers of health care and insurers to support delivery models and reimbursement strategies that will more effectively support infrastructure investments, integrated care and improved health outcomes.

SECTION 14. ORS 442.011 is amended to read:

442.011. (1) There is created in the [*Oregon Department of Administrative Services*] **Department of Human Services** the Office for Oregon Health Policy and Research. The Administrator of the Office for Oregon Health Policy and Research shall be appointed by the Governor and the appointment shall be subject to Senate confirmation in the manner prescribed in ORS 171.562 and 171.565. The administrator shall be an individual with demonstrated proficiency in planning and managing programs with complex public policy and fiscal aspects such as those involved in the Oregon Health Plan. Before making the appointment, the Governor must advise the President of the Senate and the

Speaker of the House of Representatives of the names of at least three finalists and shall consider their recommendation in appointing the administrator.

(2) In carrying out the responsibilities and duties of the administrator, the administrator shall consult with and be advised by the Oregon Health Policy Commission **and the Oregon Health Fund Board**.

SECTION 15. ORS 442.011, as amended by section 14 of this 2007 Act, is amended to read:

442.011. (1) There is created in the Department of Human Services the Office for Oregon Health Policy and Research. The Administrator of the Office for Oregon Health Policy and Research shall be appointed by the Governor and the appointment shall be subject to Senate confirmation in the manner prescribed in ORS 171.562 and 171.565. The administrator shall be an individual with demonstrated proficiency in planning and managing programs with complex public policy and fiscal aspects such as those involved in the Oregon Health Plan. Before making the appointment, the Governor must advise the President of the Senate and the Speaker of the House of Representatives of the names of at least three finalists and shall consider their recommendation in appointing the administrator.

(2) In carrying out the responsibilities and duties of the administrator, the administrator shall consult with and be advised by the Oregon Health Policy Commission [*and the Oregon Health Fund Board*].

SECTION 16. ORS 414.221 is amended to read:

414.221. The Medicaid Advisory Committee shall advise the Administrator of the Office for Oregon Health Policy and Research and the [*Department*] **Director** of Human Services on:

(1) Medical care, including mental health and alcohol and drug treatment and remedial care to be provided under ORS chapter 414; and

(2) The operation and administration of programs provided under ORS chapter 414.

SECTION 17. ORS 414.312, as amended by section 1, chapter 2, Oregon Laws 2007 (Ballot Measure 44 (2006)), is amended to read:

414.312. (1) As used in ORS 414.312 to 414.318:

(a) "Pharmacy benefit manager" means an entity that, in addition to being a prescription drug claims processor, negotiates and executes contracts with pharmacies, manages preferred drug lists, negotiates rebates with prescription drug manufacturers and serves as an intermediary between the Oregon Prescription Drug Program, prescription drug manufacturers and pharmacies.

(b) "Prescription drug claims processor" means an entity that processes and pays prescription drug claims, adjudicates pharmacy claims, transmits prescription drug prices and claims data between pharmacies and the Oregon Prescription Drug Program and processes related payments to pharmacies.

(c) "Program price" means the reimbursement rates and prescription drug prices established by the administrator of the Oregon Prescription Drug Program.

(2) The Oregon Prescription Drug Program is established in the [*Oregon Department of Administrative Services*] **Department of Human Services**. The purpose of the program is to:

(a) Purchase prescription drugs or reimburse pharmacies for prescription drugs in order to receive discounted prices and rebates;

(b) Make prescription drugs available at the lowest possible cost to participants in the program; and

(c) Maintain a list of prescription drugs recommended as the most effective prescription drugs available at the best possible prices.

(3) The Director of [*the Oregon Department of Administrative Services*] **Human Services** shall appoint an administrator of the Oregon Prescription Drug Program. The administrator shall:

(a) Negotiate price discounts and rebates on prescription drugs with prescription drug manufacturers;

(b) Purchase prescription drugs on behalf of individuals and entities that participate in the program;

(c) Contract with a prescription drug claims processor to adjudicate pharmacy claims and transmit program prices to pharmacies;

(d) Determine program prices and reimburse pharmacies for prescription drugs;

(e) Adopt and implement a preferred drug list for the program;

(f) Develop a system for allocating and distributing the operational costs of the program and any rebates obtained to participants of the program; and

(g) Cooperate with other states or regional consortia in the bulk purchase of prescription drugs.

(4) The following individuals or entities may participate in the program:

(a) Public Employees′ Benefit Board;

(b) Local governments as defined in ORS 174.116 and special government bodies as defined in ORS 174.117 that directly or indirectly purchase prescription drugs;

(c) Enrollees in the Senior Prescription Drug Assistance Program created under ORS 414.342;

(d) Oregon Health and Science University established under ORS 353.020;

(e) State agencies that directly or indirectly purchase prescription drugs, including agencies that dispense prescription drugs directly to persons in state-operated facilities; and

(f) Residents of this state who do not have prescription drug coverage.

(5) The state agency that receives federal Medicaid funds and is responsible for implementing the state′s medical assistance program may not participate in the program.

(6) The administrator may establish different reimbursement rates or prescription drug prices for pharmacies in rural areas to maintain statewide access to the program.

(7) The administrator shall establish the terms and conditions for a pharmacy to enroll in the program. A licensed pharmacy that is willing to accept the terms and conditions established by the administrator may apply to enroll in the program.

(8) Except as provided in subsection (9) of this section, the administrator may not:

(a) Contract with a pharmacy benefit manager;

(b) Establish a state-managed wholesale or retail drug distribution or dispensing system; or

(c) Require pharmacies to maintain or allocate separate inventories for prescription drugs dispensed through the program.

(9) The administrator shall contract with one or more entities to provide the functions of a prescription drug claims processor. The administrator may also contract with a pharmacy benefit manager to negotiate with prescription drug manufacturers on behalf of the administrator.

(10) Notwithstanding subsection (4)(f) of this section, individuals who are eligible for Medicare Part D prescription drug coverage may participate in the program.

SECTION 18. ORS 414.314 is amended to read:

414.314. (1) An individual or entity described in ORS 414.312 (4) may apply to participate in the Oregon Prescription Drug Program. Participants shall apply annually on an application provided by the [*Oregon Department of Administrative Services*] **Department of Human Services**. The department may charge participants a nominal fee to participate in the program. The department shall issue a prescription drug identification card annually to participants of the program.

(2) The department shall provide a mechanism to calculate and transmit the program prices for prescription drugs to a pharmacy. The pharmacy shall charge the participant the program price for a prescription drug.

(3) A pharmacy may charge the participant the professional dispensing fee set by the department.

(4) Prescription drug identification cards issued under this section must contain the information necessary for proper claims adjudication or transmission of price data.

SECTION 19. ORS 414.316 is amended to read:

414.316. The Office for Oregon Health Policy and Research shall develop and recommend to the [*Oregon Department of Administrative Services*] **Department of Human Services** a preferred drug list that identifies preferred choices of prescription drugs within therapeutic classes for particular diseases and conditions, including generic alternatives, for use in the Oregon Prescription Drug

Program. The office shall conduct public hearings and use evidence-based evaluations on the effectiveness of similar prescription drugs to develop the preferred drug list.

SECTION 20. ORS 414.318 is amended to read:

414.318. The Prescription Drug Purchasing Fund is established separate and distinct from the General Fund. The Prescription Drug Purchasing Fund shall consist of moneys appropriated to the fund by the Legislative Assembly and moneys received by the [*Oregon Department of Administrative Services*] **Department of Human Services** for the purposes established in this section in the form of gifts, grants, bequests, endowments or donations. The moneys in the Prescription Drug Purchasing Fund are continuously appropriated to the [*Oregon Department of Administrative Services*] **department** and shall be used to purchase prescription drugs, reimburse pharmacies for prescription drugs and reimburse the department for the costs of administering the Oregon Prescription Drug Program, including contracted services costs, computer costs, professional dispensing fees paid to retail pharmacies and other reasonable program costs. Interest earned on the fund shall be credited to the fund.

SECTION 21. ORS 414.320 is amended to read:

414.320. The [*Oregon Department of Administrative Services*] **Department of Human Services** shall adopt rules to implement and administer ORS 414.312 to 414.318. The rules shall include but are not limited to establishing procedures for:

(1) Issuing prescription drug identification cards to individuals and entities that participate in the Oregon Prescription Drug Program; and

(2) Enrolling pharmacies in the program.

SECTION 22. Section 2, chapter 314, Oregon Laws 2005, is amended to read:

Sec. 2. In addition to the notices required under ORS 183.335 (15), the [*Oregon Department of Administrative Services*] **Department of Human Services** shall give notice to the individual members of any interim or session committee with authority over the subject matter of the rule if the department proposes to adopt a rule under ORS 414.320.

SECTION 23. Section 3, chapter 314, Oregon Laws 2005, is amended to read:

Sec. 3. Section 2**, chapter 314, Oregon Laws 2005,** [*of this 2005 Act*] applies to rules adopted by the [*Oregon Department of Administrative Services*] **Department of Human Services** for the Oregon Prescription Drug Program on or after [*the effective date of this 2005 Act*] **June 28, 2005**.

SECTION 24. **(1) There is appropriated to the Oregon Health Fund Board, for the biennium beginning July 1, 2007, out of the General Fund, the amount of $1 for the purpose of carrying out the provisions of sections 2 to 13 of this 2007 Act.**

(2) Notwithstanding any other law limiting expenditures, the amount of $1 is established for the biennium beginning July 1, 2007, as the maximum limit for payment of expenses from fees, moneys or other revenues, including Miscellaneous Receipts, but excluding lottery funds and federal funds, collected or received by the Oregon Health Fund Board.

SECTION 25. **(1) There is appropriated to the Department of Human Services, for the biennium beginning July 1, 2007, out of the General Fund, the amount of $1,215,350 for the purpose of carrying out the provisions of sections 2 to 13 of this 2007 Act.**

(2) Notwithstanding any other law limiting expenditures, the amount of $671,971 is established for the biennium beginning July 1, 2007, as the maximum limit for payment of expenses from federal funds collected or received by the Department of Human Services, for the purpose of carrying out sections 2 to 13 of this 2007 Act.

SECTION 26. **(1) The unexpended balances of amounts authorized to be expended by the Oregon Department of Administrative Services for the biennium beginning July 1, 2007, from revenues dedicated, continuously appropriated, appropriated or otherwise made available for the purpose of administering and enforcing the duties, functions and powers transferred by the amendments to statutes and session laws by sections 14 and 16 to 23 of this 2007 Act are transferred to and are available for expenditure by the Department of Human Services, for the purposes of administering and enforcing the duties, functions and powers transferred by the amendments to statutes and session laws by sections 14 and 16 to 23 of this 2007 Act.**

(2) The expenditure classifications, if any, established by Acts authorizing or limiting expenditures by the Oregon Department of Administrative Services remain applicable to expenditures by the Department of Human Services under this section.

SECTION 27. Sections 1 to 13 of this 2007 Act are repealed on January 2, 2010.

SECTION 28. The amendments to ORS 442.011 by section 15 of this 2007 Act become operative on January 2, 2010.

SECTION 29. This 2007 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2007 Act takes effect on its passage.

Passed by Senate June 20, 2007

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Secretary of Senate

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President of Senate

Passed by House June 22, 2007

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Speaker of House

Received by Governor:

........................M.,..., 2007

Approved:

........................M.,..., 2007

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Governor

Filed in Office of Secretary of State:

........................M.,..., 2007

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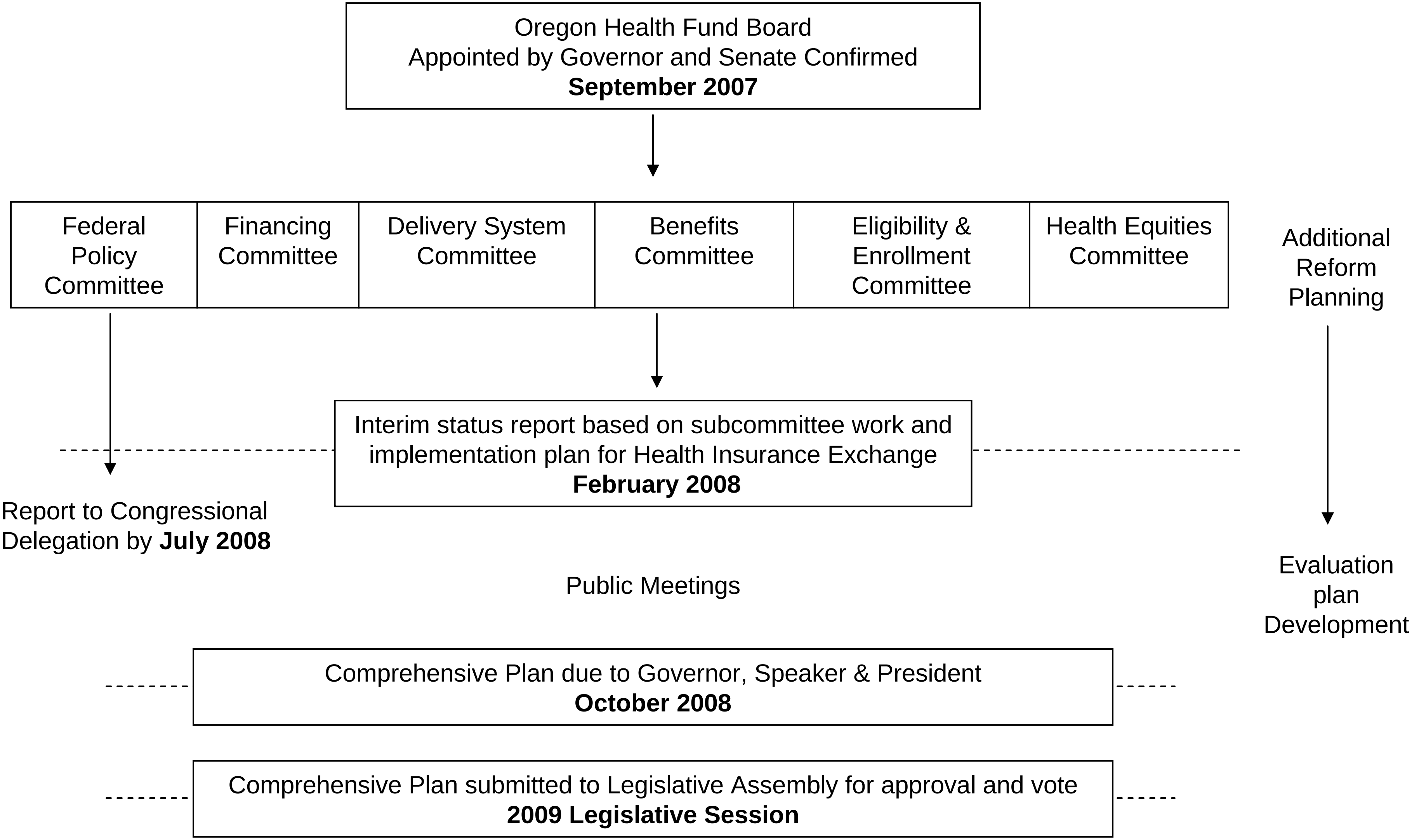
Secretary of State

Timeline for Oregon Health Fund Board Reform 2007-2008



Oregon Health Fund Board
Appointed by Governor and Senate Confirmed
September 2007

Federal Policy Committee	Financing Committee	Delivery System Committee	Benefits Committee	Eligibility & Enrollment Committee	Health Equities Committee

Additional Reform Planning

Interim status report based on subcommittee work and implementation plan for Health Insurance Exchange
February 2008

Report to Congressional Delegation by **July 2008**

Evaluation plan Development

Public Meetings

Comprehensive Plan due to Governor, Speaker & President
October 2008

Comprehensive Plan submitted to Legislative Assembly for approval and vote
2009 Legislative Session

10/09/07 Office for Oregon Health Policy & Research

SB 329 Overview

Duties of Committees & the Office for Oregon Health Policy & Research (OHPR)

Financing Subcommittee

- Health Insurance Exchange (initial plan due Feb. 2008)
- Strategic Revenue Model
- Collection of employer/individual contributions
- Maximizing federal funds

Delivery Committee

- Efficient, effective, high-value delivery system model
- Information technology
- Consumer education
- Primary care revitalization and wellness
- Developing Quality Institute (along with OHPR)
- Streamlining current state health agencies/functions

Federal Policy Committee

- Medicaid waivers
- Federal tax code
- EMTALA Waivers
- Medicare policies

Eligibility & Enrollment Subcommittee

- Affordability
- Enrollment procedures
- Outreach
- Portability

Benefits Committee

- Benefit Package(s)
- Cost Sharing

Health Equities Committee

- Enrolling vulnerable populations
- Reducing disparities through delivery reform
- Benefit design to support vulnerable populations

OHPR

- Oregon Prescription Drug Plan Operation
- Evaluation Plan
- Current other duties include:
  - -Health Resources Commission
  - -OHREC
  - -Hospital financial, utilization, & quality data
  - - Uninsured data
  - - Long term care utilization
  - - Medicaid monitoring
  - -Data, research, and evaluation outside of health care reform

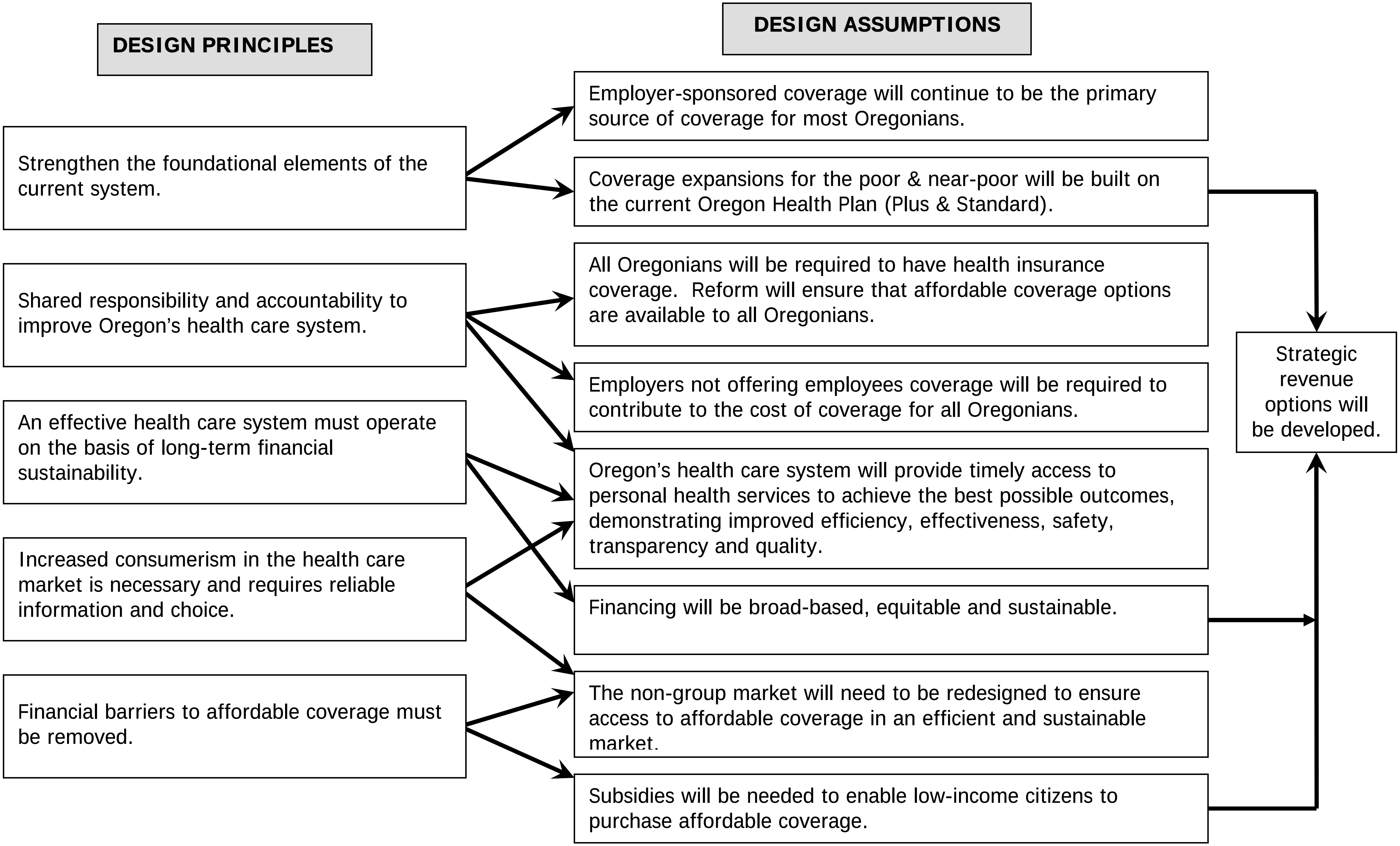
DRAFT 10-16-07

OREGON HEALTH FUND BOARD
Preliminary Board and Committee Timeline

	Nov-07	Dec-07	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08
Board	Health Care Cost Drivers	Primary Care	Approve Exchange report by end Jan.	Exchange report to Leg. Feb 1, Progress Report Feb. 29	Board begins to receive recommendations from committees		Board develops "Straw Person" Plan by mid-June	Statewide Public Hearings on Plan		Board receives revised draft of plan from staff by 8/31	Board meets to review revised plan by mid Sept.	Board presents plan to Leg.
Finance Committee	Strategic Revenue Options	Review Modeling	Finalize initial Exchange report and send to Board mid-Jan	Review Modeling	Refine exchange and strategic financing recommendations by 4/30							
Exchange Work Group	Exchange Options		Initial report to full committee by beg. Jan	Finalize work group recommendations								
Delivery Committee	Strategies to create High Performance Delivery System				Refine Institute and High Performance Delivery recommendations by 4/30							
Institute for Health Systems Improvement Work Group	Developing an Institute for Health Systems Improvement for Oregon		Finalize work group recommendations									
Eligibility & Enrollment Committee	Affordability Across Market Segments		Barriers to eligibility/outreach strategy/portability		Refine E&E recommendations by 4/30							
Benefits Committee	Defined set of essential health services and cost sharing				Refine Benefits recommendations by 4/30							
Health Equities Committee	Multicultural outreach/ Strategies to reduce health disparities through delivery reform and benefit design				Refine Committee recommendations by 4/30							
Federal Policy Committee	Effects of Federal Policies on Oregon's Health Care System						Public Hearings on Federal Policy Report		Final Federal Policy Report to Leg.			
Evaluation Plan									Evaluation plan developed			Eval plan incorporated into comp. plan

DRAFT **10/16/07**

OREGON HEALTH FUND BOARD
A Comprehensive Plan for Reform: Design Principles and Assumptions
Approved by OHFB ___________



DESIGN PRINCIPLES

Strengthen the foundational elements of the current system.

Shared responsibility and accountability to improve Oregon's health care system.

An effective health care system must operate on the basis of long-term financial sustainability.

Increased consumerism in the health care market is necessary and requires reliable information and choice.

Financial barriers to affordable coverage must be removed.

DESIGN ASSUMPTIONS

Employer-sponsored coverage will continue to be the primary source of coverage for most Oregonians.

Coverage expansions for the poor & near-poor will be built on the current Oregon Health Plan (Plus & Standard).

All Oregonians will be required to have health insurance coverage. Reform will ensure that affordable coverage options are available to all Oregonians.

Employers not offering employees coverage will be required to contribute to the cost of coverage for all Oregonians.

Oregon's health care system will provide timely access to personal health services to achieve the best possible outcomes, demonstrating improved efficiency, effectiveness, safety, transparency and quality.

Financing will be broad-based, equitable and sustainable.

The non-group market will need to be redesigned to ensure access to affordable coverage in an efficient and sustainable market.

Subsidies will be needed to enable low-income citizens to purchase affordable coverage.

Strategic revenue options will be developed.

OREGON PUBLIC MEETING LAWS
Guidelines for the Oregon Health Fund Board and its Committees

History
The Oregon Public Meetings Law, ORS 192.610 to 192.690 was enacted in 1973 in an effort to ensure that deliberations and decisions of governing bodies are made openly.

Definitions
Since the Oregon Health Fund Board and its Committees were created by statute, they are considered to be "*public bodies*." A "*governing body*" is a group of members of a public body with the authority to make decisions for or recommendations to a public body on policy or administration, which in the case of the Bard and its Committees is at least a quorum.

Statute defines "*decision*" as any determination, action, vote or final disposition upon a motion, proposal, resolution, order, ordinance or measure of which a vote of a governing body is required. "*Meeting*" is defined as the convening of a governing body or a public body in order to make a decision or deliberate toward a decision on any matter.

Meeting Requirements
Any time a quorum of the Board or one of its Committees meets to deliberate towards a decision, the meeting must be open to the public. Meetings cannot take place in locations which practice discrimination and must be accessible to disabled persons.

Public notices for all meetings must be provided to interested parties at least 48 hours prior to the start of the meeting. Meeting notices must include the time and location of the meeting, as well as a list of the principal subjects expected to be discussed.

A sound, video or digital recording or a set of written minutes must be taken at every meeting and must be made available to the public within a reasonable time after the meeting. The minutes must be a true reflection of the matters discussed at the meeting and the views of the participants and must include the following information: all members present; all motions, proposals, resolutions, orders, ordinances and measures proposed and their disposition; the results of all votes and the vote of each member; the substance of any discussion; a reference to any document discussed at the meeting.

Notice rules still apply to meetings held by phone or other electronic means. In such cases, at least one place will be made available to the public where the public can listen to the meeting in real time.

Public Record

All documents distributed to the Board or its Committees, discussed at meetings or produced by the Board and its Committees will be considered public record. Documents will be made available at meetings and upon request from any member of the public. Correspondence, including but not limited to, letters, memoranda, notes and electronic messages that communicate formal approvals, direction for action and information about the Board and its Committees are considered part of administrative record and thus are subject to public record requirements.

Enforcement

Decisions made the Board or its Committees in violation of the Public Meeting Laws will be voided, unless it is reinstated while in compliance. A reinstated decision is effective from the date it was initially adopted.

Oregon Health Fund Board

October 2007 Update

About the Oregon Health Fund Board

Created by SB 329 (the Healthy Oregon Act), the Oregon Health Fund Board is a 7 member board appointed by the Governor and confirmed by the Oregon Senate. The Board is developing a comprehensive plan to ensure access to health care for all Oregonians, contain health care costs, and address issues of quality in health care. The members of the Board have experience, knowledge and expertise in the areas of consumer advocacy, management, finance, labor and health care, and represent the geographic and ethnic diversity of the state. Barney Speight, Executive Director, and the staff of the Office for Oregon Health Policy and Research assist the Board.

OHFB Board Members

- **Bill Thorndike, Chair**
  CEO, Medford Fabrication
- **Jonathan Ater , Vice-Chair**
  Chair and Senior Partner, Ater Wynne LLP
- **Eileen Brady, Vice-Chair**
  Co-Owner, New Seasons Market
- **Tom Chamberlain**
  President, Oregon AFL-CIO
- **Charles Hofmann, MD**
  Physician
- **Ray Miao**
  President, Oregon Chapter, AARP
- **Marcus Mundy**
  President, Urban League of Portland

Getting Started

This month the Oregon Health Fund Board met for the first time, as did four of its six committees.

The full board met on October 2 in order to review and confirm its bylaws, elect a chair and vice-chairs, and appoint committee membership for four of the committees. Bill Thorndike, CEO of Medford Fabrication, was elected chair, and Jonathan Ater, Senior Partner and Chair of Ater Wynne, LLP and Eileen Brady, Co-Owner of New Seasons Market, were chosen as vice-chairs. At its first meeting, the board established a sixth committee: the Health Equities committee. Additional members will be appointed to the committees in order to round out membership with individuals representing consumer, small business and other viewpoints and areas of the state.

The committees met in the second half of the month, getting organized and prepared to tackle their respective health care reform topics. Committees and the full board will each be meeting once a month through the early part of 2008. In March and April, committees may meet more frequently in order to finalize recommendations for the board's review.

Staff has been busy as well, working to get the OHFB website up and running. The website will allow you to find: information about upcoming meetings, including agendas, written materials, and digital recordings of meetings; rosters of board and committee members; contact information for each committee; and links to committee reports.

Opportunity for Public Comment at Meetings

The Oregon Health Fund Board and its committees are interested in receiving public comment on health care reform and the work of the board. Approximately 30 minutes will be reserved at every meeting for public comment.

We encourage citizens to follow these guidelines:

1. Please complete the meeting sign-up sheet and indicate you wish to testify.
2. Whenever possible, submit written comments so they can be included in the official meeting records.
3. Oral comments should be limited, summary comments – 3 to 5 minutes – to permit others the opportunity to speak.
4. Comments can also be submitted by email to: OHFB.Info@state.or.us . Staff will distribute summaries of email communications to Board and committee members on a routine basis. *Thank you!*

Board Meeting Calendar:

November 6, 2007
1 pm – 4 pm
Oregon State Library
Room 103
250 Winter St. NE
Salem, OR

December 12, 2007
1 pm – 4 pm
Wilsonville Training Center
Rooms 111-112
29353 Town Ctr. Loop E
Wilsonville, OR

Committee Meeting Calendar:

Benefits

November 8, 2007
9:30 am – 1:30 pm
Wilsonville Training Center
Room 112
29353 Town Center Loop E
Wilsonville, OR

Delivery Systems

November 15, 2007
1 pm -5 pm
Wilsonville Training Center
Room 112
29353 Town Center Loop E
Wilsonville, OR

December 12, 2007
1 pm – 4 pm
Wilsonville Training Center
Rooms 111-112
29353 Town Center Loop E
Wilsonville, OR
(Combined with Health Fund Board meeting)

Finance

November 19, 2007
and
December 19, 2007
1 pm -5 pm
Wilsonville Training Center
Room 112
29353 Town Center Loop E
Wilsonville, OR

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Message from Barney Speight:

About 4 months ago, Governor Kulongoski signed SB 329 (Chapter 697, Oregon Laws 2007). In the brief interval since then, the Oregon Health Fund Board has been appointed by the Governor and confirmed by the Oregon Senate, and six committees have been organized with some 90 citizens volunteering to work on various issues related to the development of a comprehensive plan to reform Oregon's health care system. The outpouring of interest and support for the work of the Board is both energizing and gratifying.

The Board and its Committees will be supported by the professional and administrative staff of the Office for Oregon Health Policy & Research (OHPR) and new personnel authorized in the Board's biennial budget. In addition, several state agencies (Human Services, Consumer & Business Services, Office of Private Health Partnerships, et al), supplemented by local and national consultants, will assist with policy research, economic modeling and related analytic work.

Guided by project charters, the OHFB committees will begin their work in November with frequent meetings into the early spring, 2008. The Board will devote its meetings of November 6 and December 12 to briefings and discussion of cost drivers in health care, current insurance regulation, the potential role of an insurance exchange and the need to transform primary care.

The Board is committed to effective public outreach and feedback. While our communications plan is being finalized, the Board's website – *healthfundboard.oregon.gov* – is a resource for meeting dates, agendas and materials distributed at meetings. The public may also send the Board comments on reform to our Salem office or by email to OHFB.Info@state.or.us. Staff will routinely monitor the email and summarize messages for the Board.

The organizational phase of SB 329 is concluding…now the difficult work of building a comprehensive plan for reform begins!

Contact Information

Executive Director Barney Speight and the staff of the Oregon Health Fund Board can be reached at:

1225 Ferry Street, SE, 1st Floor
Salem, OR 97301
Phone: 503-373-1538

Fax: 503-378-5511
Web: http://healthfundboard.oregon.gov
Email: OHFB.INFO@state.or.us

Committee Meeting Calendar (continued):

Eligibility & Enrollment

November 13
9 am – Noon
Oregon State Library
Room 103
250 Winter Street NE
Salem, OR

November 28
2 pm – 5 pm
General Services Building
Mt. Mazama Room
(In basement)
1225 Ferry Street SE
Salem, OR

December 11
10 am – 1 pm
General Services Building
Mt. Mazama Room
(In basement)
1225 Ferry Street SE
Salem, OR

Federal Laws

November 29
9:30-11:30 am
Wilsonville Training Center
Room 111
29353 Town Center Loop E
Wilsonville, OR

Health Equities

Meeting dates TBD

The Office for Oregon Health Policy and Research

The Office for Oregon Health Policy and Research (OHPR) is responsible for the development and analysis of health policy in Oregon and serves as the policymaking body for the Oregon Health Plan. The Office provides analysis, technical, and policy support to assist the Governor and the Legislature in setting health policy. It carries out specific tasks assigned by the Legislature and the Governor, provides reports and conducts analyses relating to health care costs, utilization, quality, and access.

The Office for Oregon Health Policy and Research also carries out its responsibilities by providing staff support to statutorily established advisory bodies responsible for health care policy recommendations including: the Oregon Health Policy Commission, the Health Services Commission, the Health Resources Commission, the Advisory Committee on Physician Credentialing, the Medicaid Advisory Committee, and the Safety Net Advisory Council. It also coordinates the work of the Oregon Health Research and Evaluation Collaborative and the Oregon Prescription Drug Program.

For further information on the Office for Oregon Health Policy and Research contact the OHPR Interim Acting Administrator, Jeanene Smith MD, MPH at (503) 373-1625.

The Oregon Health Policy Commission (OHPC) was enacted in the 72nd Legislative session. This Commission is responsible for health policy and planning for the state. The OHPC identifies and analyzes significant health care issues affecting the state and makes policy recommendations to the Governor, the Legislature and OHPR. Additionally, the Commission partners with health care experts and stakeholders around the state to develop projects focused on improving Oregonians' health status and access to effective and efficient health care services. The OHPC is currently working to develop a health care reform plan for a more affordable health care system that is accessible to all Oregonians. For more information on this Commission, please contact Nora Leibowitz MPP, OHPC Director at (503) 373-1547.

The Health Services Commission (HSC) prioritizes health services and benefit categories for the Oregon Health Plan. The Health Services Commission created and maintains the Prioritized List of Healthcare Services, which ranks health services by efficacy and cost for Oregon's Medicaid program, the Oregon Health Plan. For more information on this Commission, please contact Darren Coffman, HSC Director at (503) 373-1616

The Health Resources Commission (HRC) was established in 1991. This Commission conducts medical technology assessments to assure that Oregonians are not incurring health expenses for redundant or ineffective services. The Commission encourages the rational and appropriate allocation and use of medical technology in Oregon by informing and influencing health care decision makers through its analysis and dissemination of information concerning the effectiveness and cost of medical technologies and their impact on the health and health care of Oregonians. Currently, the Commission is focusing on the Practitioner-managed Prescription Drug Plan, working with Oregon Health and Science University (OHSU)'s Evidence-based Practice

Center to review the medical literature to determine the effectiveness of certain groups of prescription drugs. For more information on this Commission, please contact David Pass MD, HRC Director at (503) 373-0887.

Advisory Committee on Physician Credentialing Information (ACPCI) develops minimum uniform credentialing information of physicians for Oregon's hospitals and health plans. For more information, please contact Dorothy Allen at (503)373-1985.

The Medicaid Advisory Committee (MAC) advises the Oregon Health Policy Commission, OHPR and the Department of Human Services on the operation of Oregon's Medicaid program, the Oregon Health Plan. The MAC recently submitted its *Healthy Kids Plan* report to Governor Kulongoski, in response to his request for recommendations on a state plan to cover all Oregon children who do not have health insurance. The report is available on the web at www.ohpr.state.or.us. For more information, please contact Heidi Allen at (503) 373-1608.

The Oregon Health Research and Evaluation Collaborative (OHREC) is a statewide organization that includes health care researchers from Oregon's distinguished universities, state and county agencies, representatives of managed care organizations, hospital systems, mental health and substance abuse advocates and a variety of other stakeholders. OHREC produces and presents research focused on the impacts of policy changes to the Oregon Health Plan population. For more information on this collaborative, please contact Heidi Allen at (503) 373-1608.

The Oregon Prescription Drug Program (OPDP) is a prescription drug purchasing pool authorized by the 2003 Oregon Legislature to help increase access to prescription drugs by the uninsured and lower costs for state and city governments to help them stay within budgeted goals. The OPDP will meet these goals by pooling prescription drug purchasing power, using evidence-based research to develop a preferred drug list of lowest cost drugs, negotiating competitive discounts with pharmacies and bringing transparent pharmacy benefit management services to groups. The OPDP hopes to unite Oregon's prescription drug purchasers to leverage the best prices on the most effective medicines. The OPDP went "live" on March 1, 2005 enrolling over 1,000 eligible Oregonians. For more information on OPDP or to get an application visit www.opdp.org or call OPDP at (503) 378-2422 ext. 416 or contact Missy Dolan, Administrator at (503) 373-1595.

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

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

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

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.

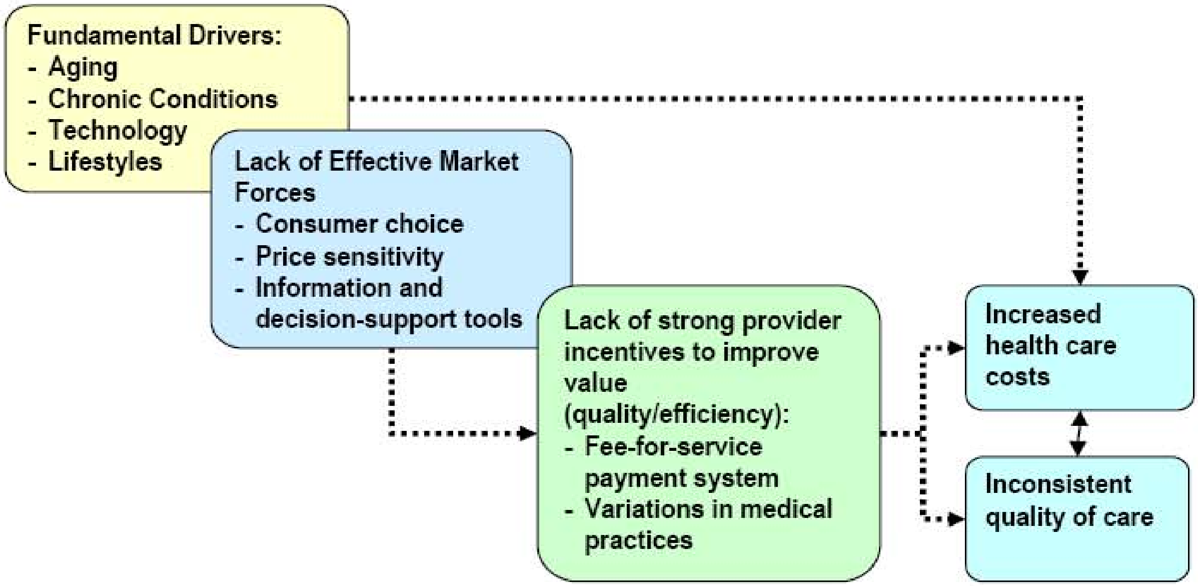
Information. It is difficult to obtain useful and reliable data to compare the cost and quality of health plans and providers. Consumers are often not in a position to make informed decisions about the diagnosis and treatment of diseases, and must rely on providers to tell them what medication or treatment 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 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.

Figure 1.

THE ROOT CAUSES OF HEALTH CARE COST INCREASES



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

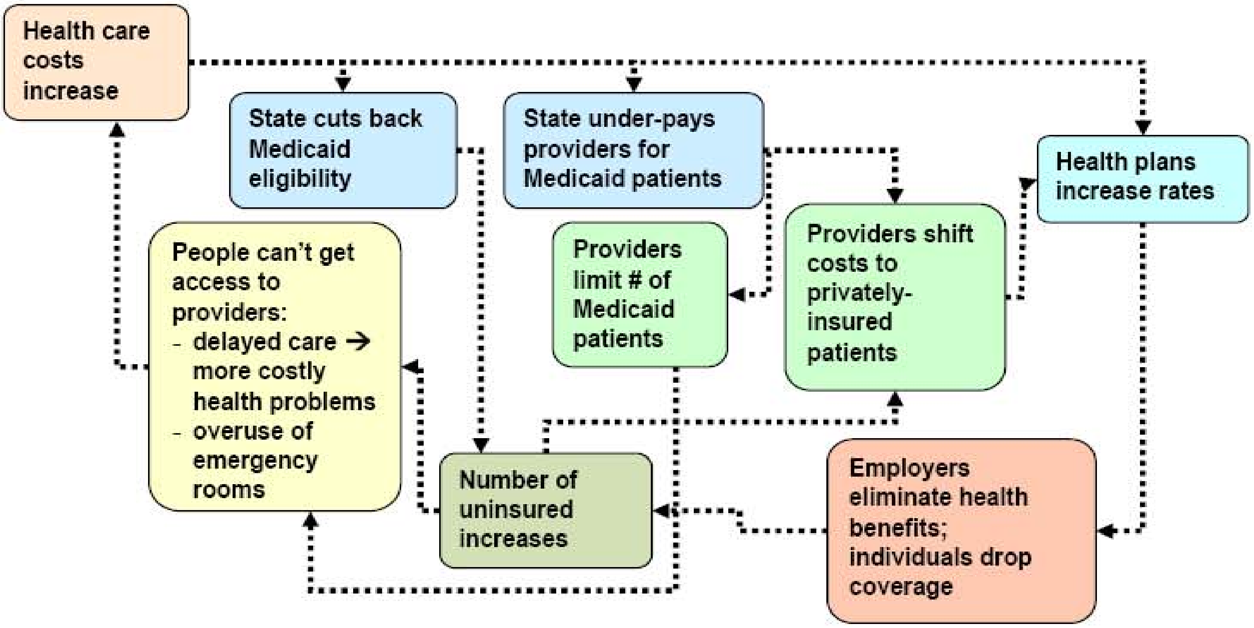
There is a complex but powerful relationship between rising costs and deteriorating access to care.

- 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.)

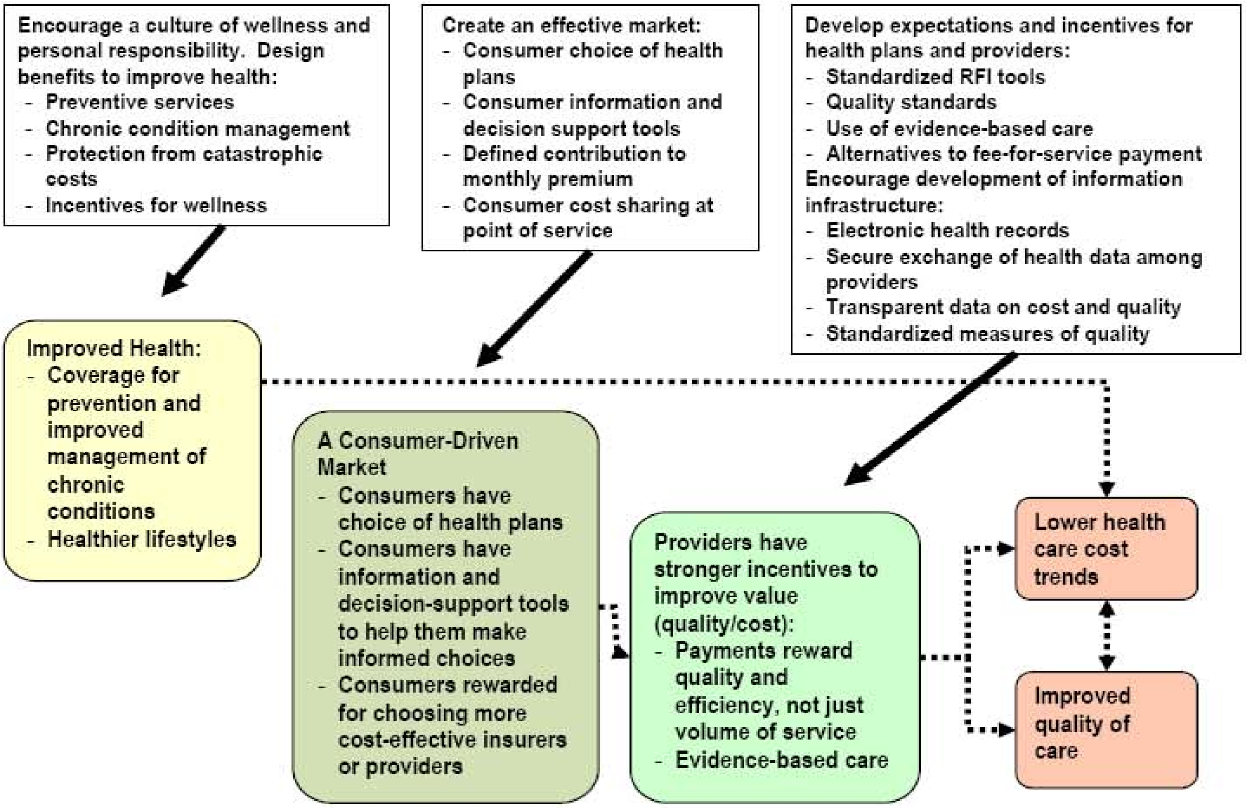
Break the Vicious Cycle of Costs and Access.

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



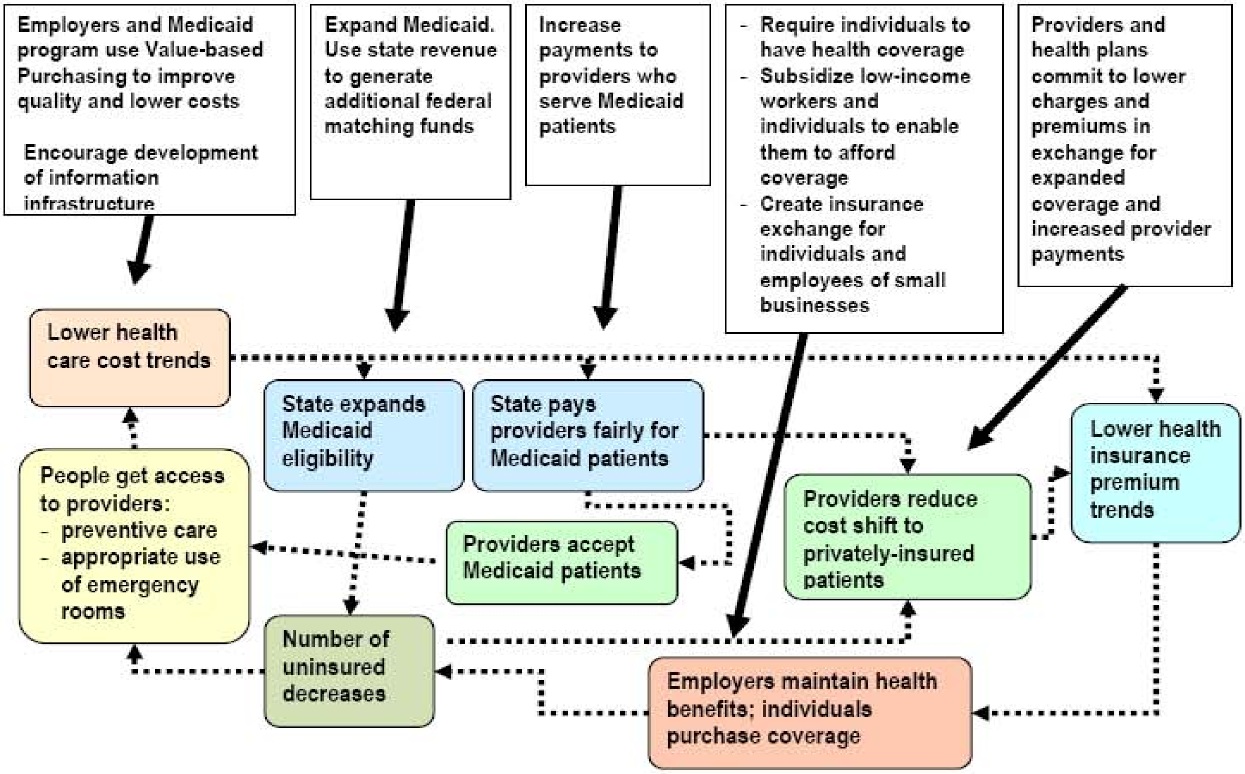
Increase access to coverage for individuals and small businesses. This is needed to address the special problems that individuals and small businesses face in obtaining coverage. For many, coverage is unaffordable. Some individuals who can afford coverage, however, choose to forego insurance. When they 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.

Oregon Health Policy Commission
Road Map for Health Care Reform

Creating a High-Value,
Affordable Health Care System

Please direct questions on this report or about the OHPC to Gretchen Morley, OHPC Director, at 503-373-1641

July 2007

**Office for Oregon Health
Policy & Research**

Oregon

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July 2007

The Honorable Theodore R. Kulongoski
900 Court Street NE, Room 160
Salem, Oregon 97301-4047

Dear Governor Kulongoski:

On behalf of the Oregon Health Policy Commission, I respectfully submit the attached final report, *Road Map for Health Care Reform: Creating a High-Value, Affordable Health Care System*. The Commission presents this report in response to your February 2006 letter requesting the Commission develop recommendations for establishing a system of affordable health care that is accessible to all Oregonians.

Throughout 2006, the Commission worked collaboratively to develop concrete, realistic reforms that Oregonians can implement over the next five years. In early 2007, a draft version of the report was shared with the public and feedback was solicited. The final report, which outlines the Commission vision and provides a framework Oregon can use to move the health care system forward, reflects the Commission's work and input from a wide range of stakeholders. The Commission's recommendations were among the many ideas discussed and included in the development of Senate Bill 329 passed by the 2007 Oregon Legislature.

The Commission recommendations are based on a vision of universal participation in an affordable health care system that offers high-value health care and adequate financial protection. High-value health care is high quality, coordinated and safe, efficient and evidence-based, and continuously improving. The following principles shaped the Commission's recommendations:

- Recognize that health care is a shared social responsibility;
- Recommend reforms that can be realistically implemented over the next five years that both improve current existing structures and define new ways to provide more effective health care;
- Recognize that access, cost, transparency, and quality are intertwined and must all be addressed;
- Achieve access for all Oregonians through rational coverage decisions;
- Maintain a broad, strong safety net;
- Encourage delivery system integration and alignment of payment incentives that prioritize prevention, continuity of care, and care management;
- Maximize available financing; and
- Coordinate with other reform efforts in the state.

To create a high-value health system, the Commission recommends the following reforms:

- Create a Health Insurance Exchange to connect individuals and employers with affordable coverage options and public subsidies in a way that currently does not exist in Oregon;
- Require that every Oregonian purchase affordable health insurance;
- Expand publicly-financed coverage and insurance subsidies to ensure affordable coverage for lower-income Oregonians; and
- Explore sustainable, broad-based financing sources that ensure everyone's participation and equalize the burden between employers that offer employee coverage and those that do not.

To create a sustainable system that delivers value and controls costs, the Commission recommends private and public delivery system reforms, including:

- State-driven public-private collaboration on value-based purchasing, managing for quality, and increased transparency;
- Development of widespread and sharable electronic health records;
- Improvements to health care safety;
- Establishment of a primary care home for every Oregonian; and
- Support for community-based innovations that align resources for more cost-effective, higher quality care.

This report is a resource for the Legislature, state agencies and other stakeholders. The information and reform recommendations provided can be used during the implementation of SB 329 and beyond. As tasked by SB 329, the Commission will participate in reform planning and implementation by developing detailed recommendations for a state health insurance exchange, by participating in Health Fund Board subcommittee work on reform financing, and by providing other information, analysis and support to the Health Fund Board.

Recognizing that real reform requires delivery system change, the Commission plans to include in this work a focus on changing system incentives to improve health care quality, safety, and transparency. The Commission's Quality and Transparency Work Group also stands ready to help the Office for Oregon Health Policy and Research develop a quality institute model as directed by SB 329.

The Commission looks forward to engaging in additional health care reform discussions with you, the State Legislature and other interested parties across the state. Together we can make the changes that will improve Oregonians' access to high quality, effective and efficient care.

Sincerely,

Kerry Barnett

Kerry Barnett
Chair

Oregon Health Policy Commission
Road Map for Health Care Reform

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The Commission acknowledges the contribution to this report from:
OHPC Local Delivery Systems Workgroup
OHPC Quality and Transparency Workgroup
Safety Net Advisory Council
(See Appendix A for a full listing of workgroup and council members.)
Dr. John McConnell, Oregon Health and Science University, Portland, Oregon whose work was supported by a grant from The Northwest Health Foundation, Portland, Oregon.

Oregon Health Policy Commission Road Map for Health Care Reform

Executive Summary

The Oregon Health Policy Commission (OHPC) was asked by Governor Kulongoski to develop recommendations for a system of affordable health care that is accessible to all Oregonians. The Commission has worked diligently and collaboratively to develop concrete, realistic reforms that can be implemented over the next five years. The recommendations outlined in this report propose a road map for reform and act as a resource for the Governor, state legislators, state agencies, and other stakeholders during the implementation of Senate Bill 329 and beyond.

Vision

Provide all Oregonians affordable access to a high-value health care system that ensures positive outcomes and promotes healthy lives. A high-value health care system is one in which all Oregonians: participate in both the benefits and the costs of a reformed system; have access to affordable, coordinated, high quality health care; and are adequately protected against financial ruin associated with catastrophic medical expenses. A high-value health care system will ensure efficient, evidence-based care and support continuous improvement.

Why Reform Is Needed

The health care system we have now is inefficient, expensive and often fails to ensure good outcomes. Health care costs are high and continue to rise. Increasingly unaffordable health care jeopardizes Oregonians' health status and the state's economic future. In 2006, one in six Oregonians (576,000 people, including over 116,000 children) were uninsured. Low-income Oregonians are at increased risk, but many employed individuals also lack insurance coverage. The uninsured are less likely to get routine care and more likely to delay treatment, resulting in serious and costly conditions. In addition, many Oregonians lack both access to care and to information about costs and quality standards. Without good information, it is difficult for people to be active participants in their own care.

All Oregonians pay for system inefficiencies and services for the uninsured through higher medical bills and insurance premiums, increased consumer prices, and higher taxes. Providers treat uninsured patients, providing care for which they are not paid. To recoup their costs, providers must increase costs to insured patients through higher charges to insurers. Employers pay more for insurance for their employees and are hurt by work time lost to illness. In 2003, the Institute of Medicine estimated that the 41 million people without insurance in the United States cost an annual total of $65 billion to $130 billion.

The economic and human costs of these system inefficiencies must be addressed. To do this, the Commission started with the following guiding principles for health care reform.

OHPC Guiding Principles for Health Care System Reform

- Health care is a shared social responsibility. Everyone must take responsibility for reform.
- Oregon needs a plan that can be realistically implemented over the next five years by improving existing system structures and defining new ways to provide care more effectively.
- The health care system will be sustainable only if reforms address the relationship between access, cost containment, transparency, and quality.
- Resources will always be limited, so coverage decisions must be made through a rational process to achieve access for all Oregonians.
- Reforms must both increase insurance coverage and maintain a strong safety net that serves those who lack insurance.
- Delivery system reforms must improve service integration and align payment incentives to prioritize prevention, continuity of care, and care management.
- We must reduce health disparities based on race, ethnicity, geography, and income.
- Reforms must maximize available federal (especially Medicaid), state, and private financing.
- Coordination with other reform efforts in the state is essential to achieve concrete reforms.

Reform Recommendations

Create a high-value health care system through the following state policies:

- A Health Insurance Exchange, an entity that can bring individuals, affordable coverage options, employers, and public subsidies together in a new and more effective way;
- A requirement that every Oregonian obtain affordable health insurance;
- Publicly-financed coverage and insurance subsidies to ensure affordable coverage for lower-income Oregonians; and
- Sustainable system financing, including a broad-based employer contribution**.**

Create a high-value health care system by implementing both public and private delivery system changes including:

- Drive public-private collaboration on value-based purchasing, managing for quality, and making the system more transparent;
- Develop widespread and sharable electronic health records;
- Improve health care safety;
- Help all Oregonians establish a primary care home; and
- Support community-based innovations that align resources for more cost-effective, higher quality care.

The OHPC reform plan also underscores the need for a thoughtful evaluation plan to monitor the success of reforms.

Oregon Health Policy Commission Road Map for Health Care Reform

Overview of Recommendations

Vision: Provide all Oregonians affordable access to a high-value health care system that ensures positive outcomes and promotes healthy lives.

Recommendation 1: Establish universal health insurance coverage for children.

Lack of insurance affects 116,000 Oregon children; 12.6 percent of the state's children have no insurance. These children represent 20% of Oregon's total uninsured population. Providing affordable health care to all children is a concrete investment in Oregon's future. Proposals currently being discussed in the state would:

- Improve and expand access to Oregon's Medicaid and SCHIP programs;
- Expand health care coverage for children by giving parents with moderate family income (income above the current cut-off for federal program eligibility) the opportunity to buy affordable, state-subsidized group coverage for their children; and
- Continue to expand school-based health centers.

Recommendation 2: Create a Health Insurance Exchange to bring together individuals and employers with affordable coverage options and public subsidies.

The Exchange will operate as a central forum for individuals and small business to buy health insurance. It will be governed by an independent board that will use all of the tools currently available to purchasers, including plan design, to support value-based (quality and cost) purchasing and encourage individuals to manage their medical care and their health. Individuals will use the Exchange as a one stop shop for information and access to insurance options, including access to subsidies for private market coverage.

The Exchange will:

- Define an array of insurance plans available for purchase through this entity;
- Be a "smart buyer" for government and participating individuals and business, driving market change and delivery system reform through plan design, member education and incentives, quality reporting and incentives, cost controls, and other value-based purchasing;
- Define an "affordability standard," an assessment of how much Oregonians can be expected to spend for health care and still afford to pay for housing, food, and other necessities;
- Be utilized on a voluntary basis;

- Attract small employers by minimizing employer administrative burden and providing increased employee plan options;
- Drive quality by negotiating and collaborating with insurers and producers; and
- Act as a market organizer that can respond to and implement future state health care reforms.

Recommendation 3: Require all Oregonians to have health insurance to protect their health and financial security, spread health care costs over the whole community, and reduce the impact of uncompensated care.

All Oregonians will be required to have health insurance. Affordable access to insurance will be ensured through the Health Insurance Exchange, expanded publicly-funded coverage and subsidies, and concerted delivery system reforms. Universal coverage will reduce premiums for the currently insured. Currently, providers recoup the cost of caring for the uninsured by increasing what they charge insurers for their members. Higher charges to insurance companies are then translated into increased premium costs to individuals and employers. With everyone in the market, uncompensated care costs will decrease sharply. In addition, employer-based insurance offerings will increase as all Oregonians demand access to affordable insurance.

Recommendation 4: Offer low-income Oregonians publicly-financed subsidies to ensure insurance is affordable.

Publicly-financed insurance assistance will be made available on a sliding scale to Oregonians with income up to 300% of the federal poverty level (FPL). Preliminary analyses indicate that individuals and families can only begin to afford both necessary household expenses and health care between 250% and 300% FPL.[1] To support this effort, the state will request federal Medicaid matching funds to the highest income level possible.[2]

The OHPC recommends assistance in two forms: direct Medicaid coverage (the Oregon Health Plan) and premium subsidies. Medicaid coverage would be an option for all children with family income up to 200% FPL, and adults with income up to 200% FPL who lack access to employer sponsored insurance.[3] Adults with access to employer coverage and everyone with income over 200% FPL will have access to premium subsidies to purchase insurance. Premium subsidies can be used to purchase insurance in the employer or individual markets.

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[1] http://egov.oregon.gov/DAS/OHPPR/HPC/HealthReformResources.shtml

[2] Federal Medicaid funds provide approximately 60 cents on every dollar spent on federally approved insurance coverage. Recently, Massachusetts received approval from the federal Centers for Medicare and Medicaid Services for its Medicaid waiver amendment allowing federal matching funds up for premium subsidy expenditures paid on behalf of individuals with income up to 300% FPL. Until this approval it has been the policy of the Bush Administration to only approve federal matching funds for coverage expansions up to 200% FPL.

[3] The OHPC recommends maintaining Medicaid coverage currently available for populations that are "categorically" eligible under federal Medicaid law (including children, pregnant women, the elderly, and people with disabilities).

Publicly-financed coverage will be comprehensive and emphasize preventive services and care for chronic conditions. The Prioritized List of Health Services, including proposed changes to increase the List's prevention and chronic care focus, will provide guidance to public coverage decisions.

Recommendation 5: Drive public and private stakeholders to continuously improve quality, safety, and efficiency to reduce costs and improve health outcomes.

To ensure quality health care for all Oregonians, reform must both improve the delivery system and expand access. Access and delivery issues exist at the local as well as the state level. With this in mind, the OHPC recommends the following:

- Create an independent institute that will develop and promote methods for improving quality information collection, measurement, and reporting;
- Continue efforts to create a stronger, more coordinated statewide effort on value-based purchasing to improve the ability to measure, report, and improve the system.
- Provide leadership and support to further the development of widespread and shared electronic health records;
- Assure a workforce that can capitalize on health information technology;
- Encourage purchasers, providers, and state agencies to improve system transparency and public understanding of quality in health care;
- Support the Oregon Patient Safety Commission's efforts to increase collaboration and state leadership to improve health care safety; and
- Mobilize a coordinated effort among all state purchasers (PEBB, OMIP, Medicaid) and insurers to support new delivery models and new reimbursement strategies that are more effectively supporting infrastructure investments, integrated care, and improved health outcomes.

Recommendation 6: Support community efforts to improve health care access and delivery.

Reform efforts need to be flexible enough to provide local communities the ability to align available resources with the needs and characteristics of their communities. To support local innovation in health care delivery, the Commission recommends the following:

- Promote the primary care model;
- Support local access collaboratives; and
- Create pilot projects to demonstrate ways to realign payment incentives to improve health outcomes.

Recommendation 7: Establish sustainable and equitable financing for reform.

The OHPC proposes simultaneously working toward universal coverage and improved system efficiency. To fund a coverage expansion and premium subsidies for low-income uninsured Oregonians, the OHPC proposes up-front funding that can be phased out as system efficiencies take hold over the following years.

The financing needed to fund public coverage and premium subsidies is an investment that will make Oregonians healthier and produce savings throughout the state. This investment, implemented along with the delivery system initiatives outlined in this report, will lead to more productive employees, increased efficiency, and reduced system costs.

To implement the OHPC plan, a funding source will need to be identified. The OHPC recommends consideration of financing scenarios that are broad-based, stable, and ensure that everyone contributes to system reform. Financing sources involving employers should equalize the financial burden between employers that provide health coverage to employees and those that do not.

Recommendation 8: Design and implement evaluation of system reform.

The OHPC recommends developing a coherent, stable and coordinated evaluation infrastructure prior to reform implementation. To assess success and inform future policy decisions made by the Legislature and state officials, any reform plan should include a well-developed evaluation plan that includes assessment of changes from the pre- to post-reform period and the extent to which reform implementation matches program goals and intentions. The evaluation plan should include metrics for provider capacity, population demand, provider and consumer participation, utilization patterns, changes in health outcomes, health disparities and quality, financial impacts and special issues of concern such as crowd-out, use of technology, and transparency. Sustainable evaluation funding and a central evaluation entity must be identified in order to assure evaluation is coordinated with reform.

Oregon Health Policy Commission Road Map for Health Care Reform

Introduction

Background

Throughout 2006, public interest in solving the growing problems in Oregon's health care system has increased dramatically. There is widespread agreement that our health care system is too expensive, confusing, inefficient and inaccessible, and does not adequately promote health.

Since 2004, the Oregon Health Policy Commission (OHPC) has served as a forum for exploring broad health reform ideas and evaluating promising improvements to the state's health care system. In February 2006, Governor Kulongoski asked the Commission to develop recommendations for establishing a system of affordable health care that is accessible to all Oregonians. Throughout 2006, the Commission worked diligently and collaboratively to develop concrete, realistic reforms that Oregonians can implement over the next five years.

This report outlines the OHPC vision and provides a framework Oregon can use to move the health care system forward. The OHPC report is intended as a resource for the Governor, Legislature, state agencies and other interested stakeholders, providing information and recommendations on reform options and funding mechanisms. The Commission will use this document as it participates in reform discussions during and beyond the legislative session, providing information, participating in analysis and discussions, and encouraging action on comprehensive, meaningful reform at the state level.

Vision for a High-Value, Affordable Health Care System

The Commission presents reforms that would **provide all Oregonians affordable access to a high-value health care system that ensures positive outcomes and promotes healthy lives.** [4]

Affordable access requires:

> **Universal Participation.** A reformed health care system is a shared social responsibility. All Oregonians must participate in both the benefits and costs. Everyone must seek out affordable health insurance whether through a private or public option.

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[4] In developing its reform vision, the OHPC drew significantly on the Commission's 2004-2006 discussions and the vision statement of the Commonwealth Fund's Commission on a High Performance Health Care System. Additional sources included the Oregon Public Employees' Benefit Board 2007 Vision, SB 27 (1989 legislation that created the Oregon Health Plan), the Senate Interim Commission on Health Care Access and Affordability (2006), the Archimedes Movement, the Oregon Business Council's Healthcare Initiative and the federal Citizens Health Care Working Group (2006).

Universal participation also means everyone must accept the personal responsibility to seek preventive and disease management services in order to avoid later serious illness that negatively impact health and increase health care costs.

Affordable Health Care for Everyone. Every individual and family not only has affordable health insurance, but also insurance that provides access to affordable health care. Insurance that does not provide adequate access to providers or requires individuals to pay more out of pocket than they can reasonably afford does not provide access to affordable health care. A system with real access provides care in a way that reduces health disparities between population subgroups.

Adequate Financial Protection. A well-operating system will adequately shield individuals and families from the devastating debt that can occur from unexpected accidents and illness.

High-value health care is:

High Quality, Coordinated and Safe. The system should focus on improving quality and health outcomes. Everyone needs a primary care home where care is organized, coordinated, and integrated across providers and over the life of the individual. The care provided must be patient-centered, consciously involving patients as informed and active participants.

Efficient and Evidence-based. Our health care system must be an integrated system that gives consumers and providers the market incentives to provide the right care at the right time and in the right setting. Access to health care does not mean access to all available services. New technologies, procedures, and treatments must be evaluated for effectiveness and value. The health care system needs to use evidence-based medicine to maximize health and utilize dollars wisely.

Continuously Improving. Our health care system needs the tools to capitalize on innovation and integrate research findings into practice. We need system-wide transparency through available and understandable information about costs, outcomes, patient motivation, and other useful data. We need an information technology infrastructure that supports integration, transparency, and quality and is available when and where both patients and providers need information for decision-making. We must have a statewide strategy to address the critical needs for the health care workforce of the future.

Components of a High-Value, Affordable Health Care System

Symptoms of the Broken System We Have Now

Cost Increases Harm Oregon

Health care expenditures in the United States were almost $1.9 trillion in 2004, over two and a half times the 1990 spending and 16.0% of the Gross Domestic Product. Since 1998, health insurance premiums have risen substantially, outpacing inflation and impacting individuals, employers, and government. Rising costs jeopardize Oregonians' health status, make the state and nation less competitive, and make adequate investment in other crucial areas such as education more difficult.

System Impacted by Poor Quality of Care

The Institute of Medicine has documented the existence of a "quality chasm" in the United States.[5] Recent research indicates that Americans receive recommended care only about 55 percent of the time.[6] The IOM estimates that between 44,000 and 98,000 Americans die each year from preventable medical errors in hospitals. Almost one third of health care expenditures pay for care that is duplicative, fails to improve patient health, or may even make it worse.[7] A recent Commonwealth Fund study found the United States health care system less efficient than other countries, as measured by duplicated tests, repeated medical histories, and medical records not available at the time of the visit.[8]

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[5] A list of IOM reports on quality issues is available at http://www.iom.edu/CMS/8089.aspx.

[6] "Who Is at Greatest Risk for Receiving Poor-Quality Health Care?" Asch SM, et al., *New England Journal of Medicine*, Vol. 354, No. 11, March 16, 2006, pp. 1147-1156.

[7] "The Implications of Regional Variations in Medicare Spending. Part 1: The Content, Quality, and Accessibility of Care," Elliott S. Fisher, et al., Annals of Internal Medicine, February 2003; 138: 273 - 287.

[8] "Taking the Pulse of Health Care Systems: Experiences of Patients with Health Problems in Six Countries," Schoen, Cathy et al. *Health Affairs.* Nov 28, 2005.

Too Many Oregonians Lack Insurance

In 2006, 15.6% of Oregonians were uninsured.[9] Over 576,000 Oregonians, or one in six residents, were uninsured; 116,000 of those were children. Another 258,000 Oregonians experienced a gap in their health care coverage at some time during the year.

While 15.6% of Oregonians aged 19 to 64 are uninsured, 44% of poor adults lack coverage. In 2004, 21% of children in families with income under 100% of the Federal Poverty Level were uninsured, compared to 19% of all children in Oregon. Even when a parent has access to coverage, their children may be uninsured because family coverage is not offered or affordable. Many families do not know their children are eligible for Oregon Health Plan coverage; still others find it too difficult to enroll or prefer not to access a public program.

Employment Not a Guarantee of Coverage for Low and Moderate Income Oregonians

Contrary to what many believe, a high percentage of employed persons do not have insurance. Even those working for employers that offer insurance may not be able to afford the insurance offered. Seventeen percent of individuals in families with at least one full time worker lack health insurance, and 33% of those with part-time employment lack health insurance. 56% of uninsured Americans are not eligible for Medicaid or other public sector health programs and cannot afford to buy coverage on their own.[10]

Lack of Coverage Hurts Access to Cost-Effective Prevention, Health Maintenance

Although insurance coverage does not guarantee access to services, the uninsured are less likely to access cost-saving preventative services or to seek treatment for illness or injury until the problem is not manageable and the hospital emergency room seems the only option.

The uninsured are less likely to seek regular care, and they are four times less likely to have a regular source of care than are the insured.[11] Uninsured children are nearly three times less likely to have seen a physician in the past year than are children with insurance coverage.[12] Almost 40% of people who delay care cite lack of insurance and cost as the main reasons they did not see a provider.[13] Without treatment, chronic problems can become acute and require costly and avoidable emergency treatment.[14] Lack of insurance both shortens productive years of work and undermines the standard of living for families and individuals faced with large medical

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[9] *Profile of Oregon's Uninsured, 2006*, Office for Oregon Health Policy and Research. February 2007. Report is based on the 2006 Oregon Population Survey, a biennial statewide telephone survey of Oregon households. CPS data released in August 2006 indicates the national uninsurance rate was 15.9% in 2005.

[10] "The Uninsured and the Affordability of Health Insurance Coverage," Lisa Dubay, John Holahan, Allison Cook. *Health Affairs* 26, no. 1 (2007).

[11] "Demographic Characteristics of Persons Without a Regular Source of Medical Care – Selected States, 1995," Centers for Disease Control and Prevention, *Morbidity and Mortality Weekly Report*, 1998, 47: 277-79. For general statistics, see http://www.eoionline.org/HealthCareUninsuredDilemmaFS.pdf.

[12] *Health Insurance? Its Enough to Make You Sick.* Philadelphia: American College of Physicians-American Society of Internal Medicine, November 1999.

[13] "Entry Into Prenatal Care --- United States, 1989-1997," Centers for Disease Control and Prevention, *Morbidity and Mortality Weekly Report*, May 12, 2000, 49 (18): 393-8. Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm4918a1.htm.

[14] "Unmet Health Needs of Uninsured Adults in the United States," John Ayanian, et al., *Journal of the American Medical Association,* October 25, 2000, 284:2061.

expenditures. Nationally, the 41 million uninsured cause an estimated annual loss of $65 billion to $130 billion due to poorer health and earlier death.[15]

All Oregonians Impacted by the State's High Uninsurance Rate
The uninsured delay needed care, but can not avoid it entirely. When people without insurance get care in high cost settings such as emergency departments or hospitals, they can often not afford to pay for the services they have received. Providers that have cared for these individuals must make up for their expenses. For the most part, providers rely on the insured to help pay for services for the uninsured. Providers recoup the cost of caring for the uninsured by charging insurance carriers more for services rendered to carriers' members. Higher charges to insurance companies are then translated into increased premium costs to individuals and employers.

Lack of Information Is Endemic
In our current system, it is difficult for patients to get clear and comparable information about health care costs and standards of care. Individuals pay different amounts for the same procedures based on their insurance status. The lack of information makes it hard for patients and their families to be active participants in their own care. Without full information, patients can not make the best clinical and economic decisions.

Fragmented Service Delivery Does Not Support Quality
Most behavioral health providers and treatments operate separately from physical health care. The historic lack of parity in insurance coverage for behavioral health care exacerbates the difficulties many people have accessing mental health care and substance abuse treatment. While a mental health parity law took effect in Oregon on January 1, 2007, more must be done to ensure that those in need can have behavioral health issues effectively and responsively identified and treated. Another area of care that remains disconnected from acute care services is long term care. Although integration would improve patients' health, acute care providers are generally not given incentives or other support to coordinate with long term care providers.

A fragmented delivery system also makes it very difficult to design a reimbursement system with incentives that align for payers and providers. In the current system, it is too easy to push financial responsibility to other parts of the system, making the system less accountable for results. It is relatively easy for each piece of the system to maximize its reimbursement when no one takes responsibility for the big picture or the interrelationships.

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[15] "Covering the Uninsured: What is it Worth?", Wilhelmine Miller, et al. *Health Affairs – The Uninsured, Value of Coverage* Web exclusive. March 31, 2004. The Institute of Medicine, in its June 2003 report *Hidden Costs, Value Lost: Uninsurance in America*, estimated the value of improved health for a currently uninsured individual who gains coverage at between $1,645 and $3,280 a year.

OHPC Guiding Principles for System Reform

Recognize that assuring health care is a shared social responsibility. This includes both a public responsibility for the health and security of all Oregonians, and the responsibility of everyone to contribute. Individuals, employers, government, and providers are mutually responsible for creating, financing, and sustaining an affordable health care system.

Develop reform recommendations that can be implemented over the next five years. The OHPC recommendations primarily focus on what Oregon can do right now to achieve significant reform. The OHPC recognizes there are efforts underway to reform state and federal health policy to achieve broader reform. By outlining steps the state can take today, the OHPC recommendations are not inconsistent with these other reform efforts.

Support and improve current programs and structures that work, overhaul the ones that do not. To promote short-term reforms that help achieve the longer term vision of a high-value, affordable health care system, the reform plan needs to both utilize existing programs and define new ways for the uninsured to access care. Unnecessary complexity leads to confusion, cost, and errors. Both the delivery system and the administration of new and existing programs must be streamlined in order to be accessible and comprehensible. Changes must improve access and care for Oregon's vulnerable populations, including racial and ethnic minorities, individuals in geographically underserved areas, and low-income Oregonians.

Recognize that access, cost, transparency, and quality are intertwined. To develop a high-quality system, we must address problems such as an inefficient delivery system, medical errors, and uncontrolled cost growth. Access, cost containment and quality must all be valued in order to achieve a sustainable system. Quality care relies on patients, providers, and employers having transparent access to appropriate health care information.

Achieve access for all Oregonians through rational coverage decisions. To stay within budget constraints, it is better to promote access to primary and chronic care services rather than limiting services to emergency access. Services can be limited and directed in order to maximize the number of people who get both health insurance and real access to needed services. The Prioritized List of Health Services has been used successfully in Oregon's Medicaid program since 1989. The Commission believes the expansion of basic health care to all Oregonians should utilize the Prioritized List and prioritize health promotion, disease prevention and disease management.

Emphasize care that prevents and manages disease, engages patients in their own care, and protects families from catastrophic health care costs. Ten percent of our population is responsible for 69% of health care costs. In order to produce the greatest return on investment and control health care costs, health reform must emphasize health care services that seek to prevent and manage disease and must find more effective ways to engage patients in their own care. Additionally, as with car insurance, health insurance must provide protection against catastrophic losses. A recent Commonwealth Fund study found that 21 percent of adults surveyed (both insured and uninsured) said they are struggling to pay off medical debt.

Maintain a broad, strong safety net. Over the past few years, Oregon's safety net infrastructure has been stretched thin. We recognize that there will always be times of transition during which individuals are not eligible for available coverage. A meaningful coverage system requires a strong safety net to provide quality care and access to both patients without access to insurance coverage and those with insurance.

Encourage delivery system integration and alignment of payment incentives. Consumers and providers must have incentives and information to make health care decisions that drive quality and control cost. The state should take a clear leadership role through its public insurance programs. Additionally, state policy should recognize and support the many community efforts underway across Oregon to align resources and form partnerships to improve local health care delivery systems.

Maximize available financing. Coverage for all Oregonians can only be achieved by doing all that is possible to optimize available sources of revenue. As everyone in Oregon is sharing in the cost of the current inefficient system, we must identify, capture, and reinvest savings produced from successful reforms. Maximizing available federal Medicaid financing is paramount.

Coordinate with other reform efforts in the state. Many groups are working to develop policy reforms and garner support to move reforms forward. The OHPC will draw ideas from and seek connections between these efforts to the extent possible in order to help channel this energy into true change.

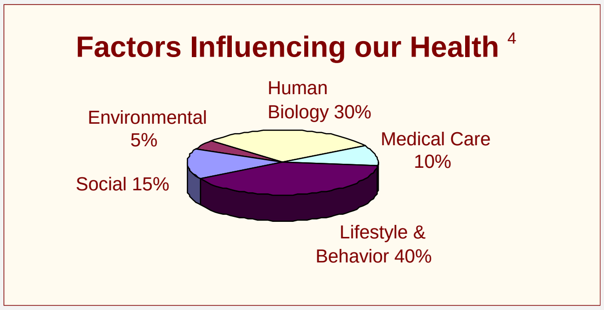
Public Health and Disease Prevention: Health Is More than Health Care

When it comes to our health, we leave the barn door open until the horses get out. In spite of the billions of dollars funneled into the U.S. health care system, we fail to capitalize on the profound and far-reaching impact that disease prevention and wellness programs can have in improving our quality of life and reducing the social and economic burden of avoidable acute and chronic diseases. We know that health is determined by far more than medical care.[1] Both Oregon and the nation are falling short of achieving the best health for our citizens when we focus most of our resources on acute care after our health is lost.

Invest in Health

Historically, public health interventions have had a greater effect on health outcomes that any medical interventions. Life expectancy has quadrupled in the last 150 years due to basic (though often controversial) measures such as municipal water treatment, hand washing, food safety measures, vaccination programs, and fortification of food staples such as bread and milk with essential vitamins and minerals. Yet for the first time in American history, a child born today has a shorter life expectancy than her parents.[5] Modern technology has created new obstacles to health in our society and we are again faced with changing our public environment to maintain and improve the public's health.

One third of deaths in Oregon can be attributed to just three unhealthy behaviors: tobacco use, lack of physical activity and poor eating habits. These behaviors often result in and exacerbate chronic disease. Heart disease, cancer, stroke, respiratory disease and diabetes account for two of every three deaths in Oregon.[2] Furthermore, one out of every three years of potential life lost before the age of 65 is due to a chronic disease.[3] These chronic diseases reduce the quality of life of individuals, burden families and friends, and are responsible for massive health care expenditures.



Invest in Knowledge

There is also a need for more public health research, particularly in the area of health disparities between racial and ethnic groups. Such disparities are reflected in stark differences in life expectancy; rates of disease; disability and death; disease severity; and access to treatment.

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[1] Oregon Vital Statistics Annual Report 2004, Vol. II, Chapter 6. Mortality.
[2] *Ibid*
[3] *Ibid*
[4] McGinnis J.M., Williams-Russo, P., Knickman, J.R. (2002). *Health Affairs,* 21(2), 83.
[5] "A Potential Decline in Life Expectancy in the United States in the 21st Century," S. Jay Olshansky, et al., *The New England Journal of Medicine*, March 17, 2005, Volume 352:1138-1145, Number 11.

What can be done?

Public/private partnerships - our public health interventions and health care systems can work together on disease prevention and effective care management, giving us a fighting chance to overcome the unhealthy behaviors and racial health disparities that we face today.

Make the healthy choice the easy choice - foster environments that encourage healthy lifestyle choices in our daily lives. That means making health a priority in schools, the workplace, community development, and in our homes.

Some of this work is already underway

This fall, Northwest Health Foundation and Community Health Partnership: Oregon's Public Health Institute were successful in bringing public and private health entities together around a common agenda for the 2007 legislative session.[1] Some needed policy changes supported by these groups, as well as the OHPC, include:

- More data collection that is targeted to relevant policy and spending decisions
- Community water fluoridation
- Statewide school nutrition standards

The Commission's report, *Promoting Physical Activity and Healthy Eating among Oregon's Children* provides public officials and the public at large with a detailed resource for attacking the trend of obesity and resulting illnesses in Oregon's children.[2] This report was assembled by a team of local and national experts from a variety of fields, including medicine, public health, education, and land-use planning.

Additionally, an exciting new partnership between the Northwest Health Foundation, the Oregon Public Health Division and the OHPC will make public health data accessible to policymakers and generate the community engagement vital for effective public health programs.

Solutions for the world we live in

We know intractable social issues like poverty and poor education have significant negative health impacts, yet there is much that can be done within the health care system to mitigate the impact of those larger problems. To begin:

1. Put high priority on prevention services, such as immunizations and health education, to avoid illness and injury in the first place. Public and private purchasers and insurers need to align payment incentives to encourage preventive care and chronic disease management.

2. Integrate public health and health care systems. Currently the public health system and the health care system operate separately and often in competition. Collaborative community efforts are underway in 19 counties across the state to coordinate local resources and improve the health of their communities[3]. These community partnership efforts are well positioned to help public health and health care systems begin to work in concert.

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[1] For more information, see http://www.communityhealthpartnership.org/images/pages/newsletters/dec_06.pdf.

[2] *Promoting Physical Activity and Healthy Eating among Oregon's Children: Draft Recommendations to the Oregon Health Policy Commission*, DHS Office of Family Health. October 2006.

[3] Community-Created Health Care Solutions in Oregon, Oregon Health Policy Commission, January 2006.

Oregon Health Policy Commission Road Map for Health Care Reform

Recommendations: Building a High-Value, Affordable Health Care System in Oregon

This section outlines the concrete reforms Oregon can implement to move the state toward realizing a high-value, affordable health care system over the next five years. Reform will only be sustainable if it is both short- and long-term focused. In the short term, Oregon needs to expand health care access to the growing number of uninsured. However, Oregon also needs to recognize that uninsurance is a symptom of a much deeper problem with how health care is delivered and financed. Over the long-term, we need to address these deeper systemic problems or our efforts to expand access will not be sustainable.

No one actor can make it happen. Reform is an effort that requires all of us – consumers, health care providers, insurance carriers, policymakers – to look beyond our immediate separate interests, to a future with a more equitable, higher quality, and efficient health care system for all. Reform cannot happen overnight. While there is no magic bullet, there are "pressure points" in the system that can be leveraged to achieve reform. The Oregon Health Policy Commission (OHPC) recommendations spotlight those pressure points, outlining how they can be enhanced and be more effective. These recommendations are a reference for health care reform discussions in the implementation of Senate Bill 329 and beyond.

Note on the OHPC Approach

Of the guiding principles upon which the OHPC recommendations were built, two form the backbone of the recommendations.

First, the Commission recognized that reforming the health care system is a shared responsibility. In order to ensure affordable access to health care for everyone, everyone must contribute. The OHPC recommendations operationalize this principle through an individual coverage requirement, publicly-financed subsidies, and a broad-based financing source that includes employers. The OHPC also recommends establishing a Health Insurance Exchange, an entity that can bring these pieces together in a new way to serve individuals and small business.

Second, the Commission sought to develop reforms that can be implemented in the near term in order to work toward reform now and over the next few years. This report recommends changes that do not require large-scale federal changes occur before reform can be implemented in Oregon. The Commission believes that changes to federal policy and funding mechanisms are needed but are not necessary for implementing the recommendations in this report. All of the reforms outlined in this report can be implemented over the next several years, and can be modified later to take advantage of federal policy changes.

Federal Policy Changes to Support Health Reform in Oregon

The Oregon Health Policy Commission's reform proposals seek to create a road map to affordable health care access, outlining reforms the state can implement within current federal constraints. The state should not wait until major policy changes are made at the federal level to push forward with reform. However, there are many federal policy changes that would give Oregon needed flexibility and institute greater equity and stability in the health care system. Some of OHPC's top federal priorities are outlined below.

Force a national dialogue on health care reform and federal health care financing: The OHPC supports comprehensive health reform at the federal level that rationalizes how federal funds are spent on health care.

Increase Medicare provider payment rates: Medicare provider payment rates in Oregon are among the lowest in the country, increasing the cost-shift to those insured through the private sector.

Adjust the Medicaid matching formula to avoid penalizing states during an economic recession: The current Medicaid federal medical assistance percentage (FMAP) formula does not adjust quickly enough to changes in states' economic conditions. The FMAP should be modified to account for periods of economic downturn to ensure that states are getting more federal funding when the demand for their programs is greatest.

Provide states with flexibility under ERISA: The Employer Retirement Income Security Act (ERISA) of 1974 preempts states' ability to regulate employer benefit offerings, including health insurance. This blanket preemption limits states' ability to develop reforms that establish minimum requirements for employer-sponsored insurance. In absence of federal reform, the OHPC supports instituting a waiver process that allows states to apply for waivers of ERISA in order to enact state-level reforms.

Change federal tax policy to support individual insurance purchase: While people who purchase health insurance through an employer can pay premiums with pre-tax dollars, individuals buying insurance in the individual market get no such benefit. To encourage insurance purchase by the self-employed and others without access to employer-sponsored insurance, the federal government should allow individual insurance purchase to be federally tax deductible.

Recommendation #1: Establish Universal Health Insurance for Children

Proposal Overview

Governor Kulongoski's 2007-2009 Recommended Budget included implementation of the Healthy Kids Plan.[16] The Oregon Health Policy Commission (OHPC) supports the funding and implementation of Healthy Kids, which will provide comprehensive health care (including medical, dental, vision, and mental health) to all of Oregon's uninsured children up to age 19. Building on existing programs, it will allow low-income families to enroll their children in public coverage or to use subsidies to purchase private coverage for their children. In addition, the program provides an opportunity for families not eligible for public programs or subsidies to buy affordable coverage through a separate program. The OHPC supports the Healthy Kids efforts to improve and expand access to comprehensive health insurance and continue expanding school-based health centers to increase access to care.

Programs for Children Based on Income, Access to Private Coverage

For children in families with income up to 200% of the federal poverty level (FPL), benefits will continue to be provided through the Oregon Health Plan, with dental, vision, and mental health care, no co-payments and no family premium share. Low-income families may also access the Family Health Insurance Assistance Program, which provides premium assistance allowing a family to purchase insurance through a parent's employer.

Children in families with income at 200% FPL and above with no access to employer-sponsored insurance will have access to comprehensive coverage through a private insurance product. Families will have assistance in choosing a plan and premium subsidies will be based on income. Health plans may compete to participate. Children in families with income above 350% FPL may still enroll in Healthy Kids but must pay the full cost of the coverage.

Cost to Families

The Healthy Kids program was designed based on conversations with Oregon families about what is affordable. Premium assistance will be income-based. Higher income families will pay affordable monthly premiums and co-payments.

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[16] The Governor's Healthy Kids Plan draws on recommendations from the Medicaid Advisory Committee and a series of public hearings. For more information, see: http://egov.oregon.gov/DAS/OHPPR/MAC/docs/HealthyKidsReport.pdf

Why Change Is Needed

In 2006, an estimated 116,000 Oregon children were without health insurance. About half of them qualify for state programs but are not enrolled. Many children in Oregon lack access to providers and basic health care services. Uninsured children face additional barriers to care. They are half as likely to get preventive care or see a doctor as those who are insured.[17] Children without insurance are more likely to use expensive emergency room for care and to be hospitalized. Poor health makes it harder for children to learn. Illness and chronic conditions lead to missed days of school and poorer performance. Keeping kids healthy also saves money.

More than half the uninsured children in Oregon have employed parents. Many families earning between $40,000 and $80,000 a year make too much for their kids to qualify for state programs but struggle to afford health insurance. Families lack coverage for their children for many reasons. Employer-sponsored coverage may not be available to the family or premiums for dependent coverage may be too expensive. In addition, enrollment barriers keep some families from enrolling their eligible children in public coverage. The OHP application process can pose difficulties to working families The requirement that eligibility be recertified every six months means that families must re-do paperwork twice a year. Some families are unaware that their children are eligible for OHP even when their parents are not.

Selected Implementation Considerations

To make Healthy Kids work, the state will partner with community organizations to reach out to uninsured children and help families enroll their children (and keep them enrolled). To facilitate enrollment and maintain eligibility, the state will utilize a shorter application, 12-month enrollment period, a reduced (two month) uninsurance requirement, and no asset test. To assist children where they are, school-based health centers (SBHC) will be expanded and supported. At least five new SBHCs will be funded in counties without existing health centers. At least five additional SBHCs will be funded in counties that already operate one or more SBHC.

Other Healthy Kids programs include the expansion of the dental sealant program that will seal the teeth of 50% of all 8-year-olds by 2010. This compares to 30% of uninsured children who currently have dental sealants. Additionally, a nurse advice line will provide families with access to information that will allow children to get the best care in the most appropriate setting.

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[17] *Children's Access Survey*, Jen DeVoe, Lisa Krois, Tina Edlund, Jeanene Smith. January 2006.

Recommendation #2: Establish a Health Insurance Exchange to Bring Together Individuals, Coverage Options, Employers, and Public Subsidies

Proposal Overview

The Oregon Health Insurance Exchange is a market organizer that helps purchasers to buy value. It acts as a central forum for individuals and businesses to purchase affordable health insurance.[18] The Exchange is also the mechanism through which individuals can access subsidies for private market coverage.

The Exchange will define an "affordability standard," which is a calculation of how much individuals and families can be expected to spend for health insurance and still afford to pay for housing, food, and other necessities. This affordability standard will be used to define both the insurance packages available through the Exchange and the public subsidies for coverage.

While the Exchange will exist in addition to existing purchasing venues, it should particularly appeal to small employers as an easy, reliable, cost effective insurance source for them and their employees.

The Exchange will be a vehicle for driving quality by negotiating or collaborating with the community of insurers and providers. It will work with insurers to develop packages that manage care, quality and cost. Quality will be built in, through contractually established expectations on insurance carriers, such as pay for performance requirements, including quality measures, prevention focus, self-management, and employee education.

As the Exchange grows, it can create a critical mass of customers who can influence providers and insurers. To ensure enrollment stability, the Exchange will require those insured through the Exchange stay in for a mandatory period.

The OHPC recommends establishing the Exchange as an independent organization. It should be shielded from politics and be responsive to stakeholders. The Exchange requires legal, actuarial, and negotiation expertise and must be explicitly given the power to conduct activities such as contracting for services.

Funding for the Exchange should be sustainable and internally generated. Funding mechanisms could include a transaction fee on policies sold through the Exchange, a premium on policies, and a membership fee for insurance providers. Additional funding mechanisms include

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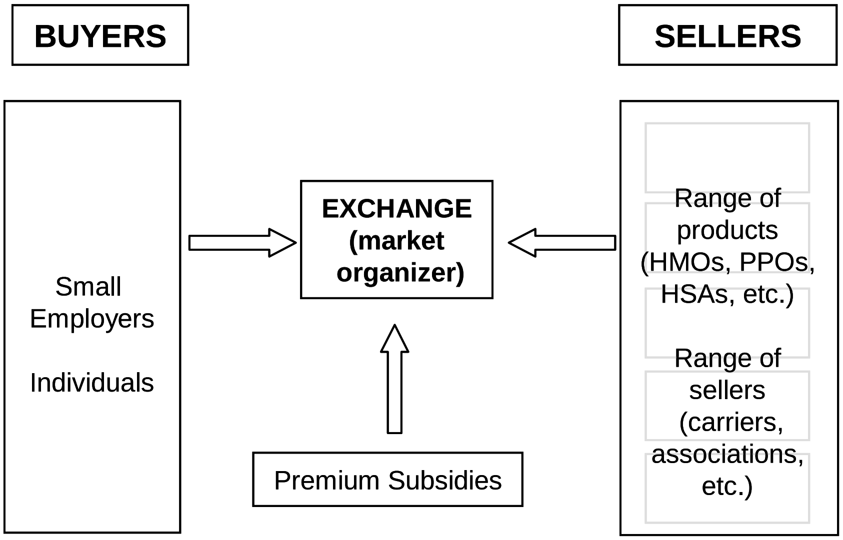
[18] The Health Insurance Exchange is similar to the Commonwealth Connector established by Massachusetts, and to the Trust Fund proposed by the Senate Interim Commission on Health Care Access and Affordability.

Medicaid administrative funds. To cover the initial costs, the state should provide the Exchange with start up funds to be repaid once the entity is on solid financial footing.

OVERVIEW OF THE HEALTH INSURANCE EXCHANGE



What Can An Exchange Do For Oregon?

- Act as a single, statewide, centralized exchange for buying and selling insurance in non-large group market
- Aggregate people to influence quality and efficiency of non-large group market
- Facilitate transactions among individuals, insurers, employers, and government
- Provide people with familiar feel of employer-group coverage, with added benefits of individual portability, choice and control

Why Change Is Needed

Employers

Researching insurance options is complex and time consuming, and often falls outside of an employer's expertise. Many small employers, even those who work with brokers, spend considerable effort and time researching available plans and weighing the financial impact of a given insurance product.

Small businesses that provide health insurance for their employees consistently get less for their money, suffering faster premium increases and steeper jumps in deductibles over time than large firms.[19] Small employers can often offer only one plan, which makes it harder to find a plan that fits the needs of all employees.

While small employers face special difficulties in researching and procuring health insurance for their employees, all employers regardless of size face challenges in choosing health coverage that is affordable for employer and employees. The Health insurance Exchange would provide a resource to help employers find quality, affordable coverage.

Individuals

Individuals who lack employer-sponsored health insurance (ESI) and who do not qualify for Medicaid must find their own health insurance. This can be a daunting task for an individual who must weigh costs, coverage limitations and lifetime caps. Information is often not comparable across products and insurers, and legal and medical language is confusing to the lay person.

How an Exchange Adds Value

The Exchange Benefits Employers

The Health Insurance Exchange will offer a variety of insurance product options, from traditional indemnity plans to managed care options and high-deductible health plans with affiliated Health Savings Accounts. This will allow employers to offer employees a range of insurance options - low cost, high coverage and in between. While this is of special interest to small employers that have traditionally been limited to offering a single plan that may not fit all employees' needs, all employers benefit from this function. The Exchange will develop an on-line decision support tool to assist employees, employers, and brokers to compare the benefits and cost of a variety of plans.

The Exchange will be a sustainable source over time for employers offering coverage to their employees. It will be available to employers on a voluntary basis; employers may continue to seek insurance as they currently do. However, the Exchange will be a favorable option for employers because it offers them increased choice and reduced administrative burden.

When working through the Exchange, the employer can allow employees to choose a plan that fits their finances and health needs. The Exchange acts as the pooling mechanism on the employer's behalf, giving employees increased options without increasing employer costs. By providing the employer services such as facilitated plan selection and streamlined access to employee premium subsidies, the employer will experience reduced administrative burden while still providing insurance to their employees.

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[19] *Risky Business: When Mom and Pop Buy Health Insurance for Their Employees*, Jon R. Gabel, M.A., and Jeremy D. Pickreign, M.S., The Commonwealth Fund, April 2004. Authors' analysis of Kaiser/HRET 2003 survey of employer sponsored health benefits.

Individuals with greater health needs are more likely to choose plans that are more comprehensive and expensive. Healthier people often value cost savings over more benefits. The Exchange will institute provisions to ensure that the existence of range of plans does not lead to adverse selection by workers with more care needs.

The Exchange Benefits Individuals

The Exchange provides individuals with affordable options. In addition to serving as the access point for eligible individuals' use of subsidies, the Exchange will offer a range of insurance packages, allowing individuals to choose plans that fit their health and financial needs. For example, plans featuring low premiums and streamlined benefits may appeal to young people who currently do not enter the market because they do not think they need insurance.

The Exchange will also allow employed individuals who purchase insurance on their own to use pre-tax dollars to pay health insurance premiums. While pre-tax funds can currently only be used for purchasing insurance when an individual gets insurance through an employer, a statutory change at the state level would allow the self-employed and others purchasing insurance outside of employer-sponsored plans to take advantage of this tax benefit.

For individuals, the Exchange increases insurance portability; the insurance is not tied to an employer or lost when employment changes. An individual whose employer utilizes the Exchange can choose to retain that same insurance through the Exchange even when the individual leaves that employer. This can help people avoid pre-existing condition limitations often associated with changing insurance providers.

The Exchange will offer people a source for coverage they can count on if they need it. Use of the Exchange will be optional with one exception. Individuals and families accessing publicly funded premium subsidies in the individual market will be required to purchase insurance through the Exchange.

Selected Implementation Considerations

Risk Adjustment Options for Consideration

Some insurance carriers may be concerned about unknown risk of a new consumer base. While the Exchange offers the chance for significant new business through the enrollment of previously uninsured populations given the individual mandate, insurers may worry that something unforeseen could cause one carrier to enroll a disproportionately higher number of sicker members. To address this risk selection concern, the state could engage in risk adjustment. Two possible risk adjustment strategies are retrospective smoothing of costs among carriers, and excess-loss claims subsidies to carriers.

Retrospective risk adjustment would involve the state looking back at the costs borne by insurers during a given period, and reimbursing a percentage of costs to carriers with above-average claims costs. With claims subsidies, the state helps pay claims costs for plan enrollees with costs above a set annual limit. Within the risk corridor, the state would pay a percentage of claims.

Realizing the Exchange's Potential Added Value: Areas for Further Research
One potential benefit of utilizing an Exchange for the purchase of health insurance is the expansion of tax benefits to employed individuals not insured through an employer. Currently, individuals purchasing insurance through an employer-sponsored plan can use pre-tax dollars to pay premiums. This effectively lowers the purchase price of the insurance for these individuals.

The Exchange faces additional tax issues upon implementation. Massachusetts (which recently implemented a "Connector" entity that acts like Oregon's proposed Exchange) is currently addressing tax issues related to the implementation of its program. The OHPC recognizes that additional work is needed to identify and respond to tax considerations raised by the goals of a fully functioning Exchange.

One added benefit for employed people that needs additional development is allowing an employee with multiple employers to have more than one employer contribute to the individual's premium. This is not currently available to individuals with more than one job, but could allow people with multiple employers to get help with insurance premiums from employers that may be unable or unwilling to individually contribute the full cost of coverage.

Recommendation #3: Require All Oregonians to Have Health Insurance

Proposal Overview

A central element of the Oregon Health Policy Commission's (OHPC) reform plan is universal health insurance coverage. The OHPC recommends requiring that all Oregonians obtain insurance. To ensure affordability for lower income Oregonians, this individual mandate must be coupled with sliding scale subsidies to help make health insurance premiums affordable (Recommendation #4). Low-income individuals without access to employer-sponsored insurance will be eligible for the Oregon Health Plan. A Health Insurance Exchange (Recommendation #2) will be established to provide a one-stop-shop to facilitate enrollment in a selection of plans and access to publicly-funded subsidies.

Why Change Is Needed

Everyone needs to be insured to protect their health and financial security, spread health care costs over the whole community, and reduce the amount of uncompensated care.

The uninsured who find themselves in a medical crisis have few alternatives to the emergency room. While emergency room care is needed in some situations, it is costly and can often be avoided by making prevention, primary care and chronic care services available and affordable. Making such services financially accessible reduces reliance on high intensity, high cost emergency care, and increases individuals' ability to obtain care in the most appropriate settings.

Bringing everyone into the market will do more than benefit the currently uninsured. It will also reduce the burden of uncompensated care in the system. Hospitals receive state and federal funds to offset some "uncompensated" care; they also pass much of these costs on to insurers. These added costs drive up claims costs which are then reflected in higher insurance premiums. This cost-shift for uncompensated care represents 10% percent of premium costs for insured persons.[20]

Some employees who are offered insurance do not enroll, either because they do not think they need it or because the cost is prohibitive. An individual mandate will require everyone to obtain insurance. This will encourage employees with access to employer-sponsored insurance to use it, capitalizing on the existing employer market.

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[20] Calculations by John McConnell, PhD, Oregon Health and Sciences University.

Selected Implementation Considerations

Affordability

The question of what is affordable has four components:

- What can people afford to spend on health care?
- What are the overall program costs (what can society afford to spend)?
- What subsidies are needed to make health care affordable for Oregonians?
- What benefit package can be afforded and sustained given the answers to the three questions above?

In order to calculate what families at different income levels can afford to spend on health care, the OHPC used the Economic Policy Institute's Family Budget Calculator to estimate necessary household expenses on housing, food, childcare, transportation, taxes and other necessities in Oregon.[21] The OHPC removed the health care costs and added 10% for savings. The goal was to estimate the cost of making essential health care affordable for lower income individuals and families in Oregon.

Based on this work, the OHPC proposes affordability levels that policymakers can use to guide reform discussions. The affordability levels presented below represent a maximum portion of family income to be spent on health care costs for a family of three up to 300% of the Federal Poverty Level.[22]

Family income (% of federal poverty level)	Family income (dollars per month)[23]	Maximum percent of income for health care	Maximum family spending on health care (per month)
0 - 149% FPL	$0 - $2,075	0%	$0
150 - 199% FPL	$2,075 - $2,766	5%	$104 - $138
200 - 249% FPL	$2,766 - $3,458	10%	$277 - $346
250 - 299% FPL	$3,458 - $4,149	15%	$519 - $622

Definition of Coverage

To mandate coverage, the state needs a general definition of a basic package of services. The OHPC recommends using Oregon's current broad definitions of insurance that will permit a wide range of insurance plans.

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[21] The Economic Policy Institute's Family Budget Calculator is located at: http://www.epi.org/content.cfm/datazone_fambud_budget.

[22] For more information on the affordability analysis used by the OHPC, please see our companion report, available on the OHPR web site at: http://www.oregon.gov/DAS/OHPPR/HPC/Reports.shtml.

[23] All dollar figures are shown for a family of three. Source: Federal Register, Vol. 71, No 15, January 24, 2006, pp.3848-3849.

For example, the definition of insurance used by Oregon's Family Health Insurance Assistance Program (FHIAP) is as follows:

> A "Health benefit plan" as a policy or certificate of group or individual health insurance that provides payment or reimbursement for hospital, medical and surgical expenses. Such a health benefit plan includes a health care service contractor or health maintenance organization subscriber contract, the Oregon Medical Insurance Pool and any plan provided by a less than fully insured multiple employer welfare arrangement or by another benefit arrangement defined in the federal Employee Retirement Income Security Act.
>
> A health benefit plan does have limitations, and does not include accident-only coverage, insurance limited to care for a specific disease or condition, limited parts of the body (vision only or dental only coverage), or for services within a particular setting (hospital-only, for example). Other excluded coverage types are credit, disability income, coverage of Medicare services pursuant to contracts with the federal government, Medicare supplement insurance, student accident and health insurance, long term care insurance, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, insurance under which the benefits are payable with or without regard to fault and that is legally required to be contained in any liability insurance policy or equivalent self-insurance or coverage obtained or provided in another state but not available in Oregon.[24]

Enforcement

Oregonians with access to affordable coverage who choose not to purchase it will face financial penalties. The OHPC proposes that non-participants lose their individual exemption on state taxes and perhaps forfeit their kicker. Implementation of enforcement measures must be carefully planned to provide adequate time for Oregonians to understand their new personal responsibility to seek out insurance and enroll in available plans.

Care for Remaining Uninsured

Although the goal is 100 percent coverage, the OHPC recognizes that individuals at times will lack coverage for a variety of reasons. Those entering and leaving the state, changing jobs or undergoing a variety of life changes may temporarily be without coverage. Some people, such as the mentally ill and chronically homeless, may not be in a position to obtain and utilize health insurance. In addition, uninsured visitors to the state may need emergency care.

To ensure access to care for the uninsured and vulnerable populations facing significant financial, geographic, language, cultural, and other barriers to care, we must continue to develop a strong safety net. Local providers serving low-income and uninsured individuals offer culturally appropriate, trusted services. Recommendation #7 outlines some ways that Oregon can support local efforts to deliver health care more effectively and efficiently to all a community's residents.

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[24] Oregon Revised Statutes 735.720.

Recommendation #4: Offer Low-Income Oregonians Publicly-Financed Support to Ensure Insurance Is Affordable

Proposal Overview

The Oregon Health Policy Commission (OHPC) recommends pairing an individual coverage mandate (Recommendation #3) with publicly-financed assistance that would make coverage affordable for individuals and families with incomes up to 300% of the Federal Poverty Level (FPL).[25] The goal is to ensure that everyone can afford the coverage that all Oregonians will be required to attain.

Publicly subsidized insurance would come in two forms: direct Medicaid coverage (the current Oregon Health Plan) and insurance premium assistance. The OHPC recommends a structure in which direct Medicaid coverage is an option for all children with family income up to 200% FPL, and adults up to 200% FPL who lack access to employer sponsored insurance. Adults with access to employer coverage and everyone with income between 200% and 300% FPL will utilize premium subsidies. These premium subsidies could be used to purchase insurance in the employer or individual markets.[26]

Subsidies will be graduated based on income and an affordability standard created by the Health Insurance Exchange (Recommendation #2), phasing out by 300% FPL. The Exchange would also act as a one-stop shop for Oregonians seeking out coverage options, serving as a connection point between individuals, coverage options, and public subsidies.

In order to most efficiently utilize state resources, the OHPC recommends maximizing federal Medicaid match to the highest income level that the federal government will approve. Under the Medicaid program, state dollars are matched with Federal funds, reimbursing the state 60 cents for every Medicaid dollar spent. Based on recent federal demonstration approvals for Massachusetts, Oregon should be able to receive federal Medicaid matching payments for much of the cost of a coverage expansion to 300% FPL.[27]

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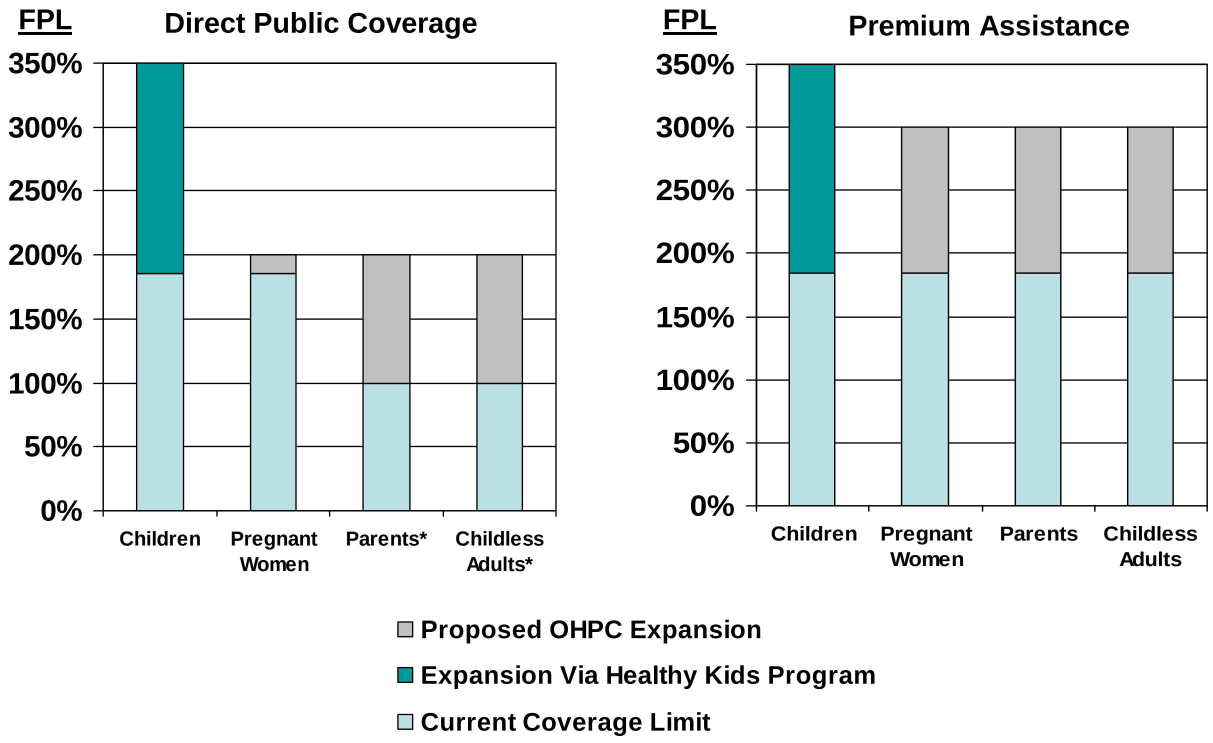
[25] In 2006, 300% of the Federal Poverty Level was $29,400 per year for an individual and $49,800 per year for a family of three.

[26] The OHPC recommends maintaining the coverage currently available for populations that are “categorically” eligible under federal Medicaid law, including children, pregnant women, elderly, and people with disabilities.

[27] Recent Medicaid waiver amendments approved by the federal Centers for Medicare and Medicaid Services for Massachusetts granted federal matching funds up to 300% FPL for premium subsidies for employer-based insurance. Up until this approval, it has been the policy of the Bush Administration to only approve federal matching funds for coverage expansions up to 200% FPL.

Overview of OHPC Proposed Expansion of Publicly-funded Coverage Options



*Note: Funding for OHP Standard currently limits enrollment to approximately 24,000 individuals.

Why Change Is Needed

An individual insurance mandate is only meaningful if all Oregonians have access to affordable coverage. In a survey of adults aged 18 and over, seventy percent of uninsured adults say the cost of insurance is the main reason they are without coverage, while only 6% say they are uninsured because they do not think they need it.[28] With 15.6% of Oregonians lacking health insurance coverage, insurance is prohibitively expensive for many in the state.[29]

The OHPC used the Economic Policy Institute's Family Budget Calculator which estimates necessary household expenses such as housing and food to develop recommendations on the income level at which people require assistance to make health insurance affordable. These data indicate that families do not begin to have discretionary income above necessary household expenses and household savings until they approach 250-300% of poverty. Based on this preliminary analysis, the OHPC recognizes that Oregonians up to 300% FPL require some assistance to make health care affordable.

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[28] The *USA Today*/Kaiser Family Foundation/Harvard School of Public Health, "Health Care Costs Survey" August 2005.

[29] 2006 Oregon Population Survey.

Although 60% of Oregon employers offer health insurance to their full-time employees, a significant number of working people are not offered employer-sponsored insurance or cannot afford to purchase it. This is a particular problem for low-income individuals, for whom health insurance is often not offered as compensation for part-time and low-skilled employment.

Selected Implementation Considerations

Potential Negative Market Effects of Public Coverage Expansions

Encouraging employers to financially contribute to their employees' health insurance is essential to an affordable system where everyone contributes to the costs. One often cited concern with public coverage expansions is that employers may drop coverage if their employees become eligible for public coverage. Conversely, employees may decline employer insurance if public coverage is available, increasing public subsidy costs. To mitigate such issues, efforts must be undertaken to maintain employer participation in health care. Oregon could learn from the experience of other states' efforts to address these concerns in their public coverage expansions.

Publicly-Subsidized Insurance Can Push for Quality Coverage

The state has a responsibility to ensure that public health care funds purchase high quality, cost effective health care to promote a healthy Oregon. To that end, the state is currently investigating changes to the OHP Prioritized List of Health Services that will emphasize prevention, primary care and the proper management of chronic care.[30]

Another way the state can use its payer role to be a smart buyer is to require subsidies be used to purchase quality health coverage that promotes access to primary care, prevention, and chronic care management. To that end, individuals who access state subsidies to offset premium costs will purchase insurance products that promote preventive and primary care services.

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[30] The Health Services Commission ranks health services by priority, from the most important to the least important, representing the comparative benefits of each service to the entire population to be served. In order to encourage effective and efficient medical evaluation and treatment, the Commission uses peer-reviewed medical literature to determine both the clinical effectiveness and cost-effectiveness of health services, and their relative importance. The Commission may also include clinical practice guidelines in its prioritized list of services.

Recommendation #5: Drive public and private stakeholders to continuously improve quality, safety, and efficiency to reduce costs and improve health outcomes

The Oregon Health Policy Commission believes that true reform is more than just assuring access to health care. It also requires the creation of a high-value health care system that:

- *Provides high quality, safe care* that is organized, coordinated, and integrated across providers and over the life of the individual;
- *Ensures evidence-based care* that provides the right care at the right time and setting in a cost-efficient manner; and
- *Supports continuous improvement* through information transparency, reliable health information exchange, adequate workforce development and a culture of improvement.

Everyone must participate to achieve change. To achieve a high-value health system, the OHPC, along with numerous national and state level policy organizations, supports bringing the state, providers, purchasers, and individuals together to push the system forward in some key areas:

- Improving information collection, reporting, and outcomes measurement;
- Improving the system's ability to manage for quality and become more transparent;
- Encouraging public-private collaboration on value-based purchasing;
- Developing widespread and shared electronic health records;
- Assuring a well-trained health care workforce; and
- Increasing health care safety.

This section outlines some concrete reforms Oregon can implement now to create a health care system that continually improves quality, safety, and efficiency to reduce costs and improve outcomes. The OHPC acknowledges the efforts of the Commission's Quality and Transparency Workgroup in developing these recommendations.

Overview of Proposals

Make targeted state investments

The OHPC supports the use of targeted state investments to achieve increases in health care quality, efficiency and value. The OHPC encourages the Governor and the Oregon Legislature to include such investments in the 2007-2009 state budget. A variety of organizations and efforts would benefit greatly from small investments in state staff and funding, as state involvement would help assure more rapid progress with the following:

- The success of the Oregon Patient Safety Commission's mission;
- The improvement of data available for managing the system;
- Increased transparency regarding health system performance; and

- The coordination of efforts to expand electronic health records and connect health information across providers.

Create the collaborative structure to improve quality information collection, measurement, and reporting

Building on current collaborations among private organizations and the Office for Oregon Health Policy and Research (OHPR), the OHPC recommends that the Oregon Legislature direct OHPR to work with stakeholders to develop a model for a public-private quality institute. The purpose of this institute would be to coordinate the creation, collection and reporting of quality information to improve health care purchasing and delivery. An independent public-private entity is critical for gaining the trust of all key stakeholders. The institute should be financially stable and make efficient use of available public and private funds. An organized, stable structure will help Oregon attract additional resources from federal and private funders.

Responsibilities of a quality institute would include:
- Collecting quality data and information in a central location;
- Coordinating reporting of quality information from numerous sources in a central location;
- Complementing individual stakeholder efforts;
- Supporting and encouraging collaboration between quality efforts in the state;
- Examining state regulations for opportunities to increase efficiency and reduce administrative complexity;
- Addressing issues of legal discovery and liability;
- Fostering provider capacity to collect and use data for improvement;
- Encouraging dissemination of data in formats that are useful to a broad range of audiences; and
- Engaging Oregonians to use available quality data when choosing health care providers.

Encourage all purchasers, providers, and state agencies to further develop data and tools to improve system transparency and quality

The OHPC encourages all purchasers, providers, and state agencies to support and expand on current public-private efforts to improve data and tools to manage quality and to improve data available to the providers and consumers:
- Hospital quality including: participation in efforts such as the Surgical Care Improvement Project (SCIP), the National Surgical Quality Improvement Program (NSQIP), 100,000 Lives, and Leapfrog reporting in addition to state and federal mandated reporting;
- Hospital cost reporting;
- Ambulatory care quality measures;
- Actual cost of service reporting, including cost of services provided in Oregon Health Plan Medicaid managed care plans;
- HEDIS and HEDIS-like quality measures; and

- Collaborative public/private strategies to make consumers more knowledgeable about quality and value in health care and the resources available to them.

Encourage increased public-private collaboration to create stronger, more coordinated statewide value-based purchasing

The State should strongly encourage value-based purchasing. Value-based purchasing strategies seek to influence the decisions or behavior of individuals (employees, patients) and health care entities (providers, health plans) to improve quality, efficiency, and outcomes. The Public Employees Benefit Board (PEBB) should have a strong role in such a coordinated effort, along with the Department of Human Services, the Oregon Medical Insurance Pool (OMIP), university health, the SAIF Corporation and the Department of Corrections. Collaboration with other private and public purchasers to develop a consistent value-based purchasing approach in the community is an important part of this effort.

Through this coordinated effort, state agencies should implement the following reforms:

- **Ensure state health care purchasers use purchasing standards that explicitly include quality measures in the criteria for selecting which health plan options to offer.** PEBB could provide leadership in this arena, as it currently does this in its biennial Request for Proposals to health plans.

- **Collect information on quality performance regularly and rigorously and distribute this information widely to help employees and their dependents make informed choices among health plans and providers.** PEBB has established a comprehensive set of performance measurements for its health plans and is participating in community efforts to identify common measures for evidence-based care.

- **Offer state employees information and incentives to choose high-value health plans and providers.** Medicaid should also consider how best to provide value information to its enrollees.

- **Reinstitute prior authorization to manage access to Medicaid pharmaceuticals.** Utilizing prior authorization to enforce the Prioritized List has great potential for cost savings.[31] This requires statutory change, as prior authorization for the Oregon Health Plan preferred drug list is currently prohibited by statute.

- **Improve the Oregon Health Plan's access to technology.** The Department of Human Services has the opportunity to manage the prudent use of technology in its Medicaid program. Line zero of the Prioritized List (the line that covers diagnostic services) can be managed by incorporating evidence-based reimbursement and/or prior authorization. At the

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[31] "An Evaluation of Oregon's Evidence-Based Practitioner-Managed Prescription Drug Plan," Daniel M. Hartung, et al., *Health Affairs*, 25, no. 5 (2006): 1423-1432**.**

printing of this report, this idea is under discussion by the Oregon Health Services Commission, the group that oversees the Prioritized List.

- **Expand disease management programs under the Oregon Health Plan.** Currently the OHP disease management program targets five key chronic conditions: asthma; chronic obstructive pulmonary disease; coronary artery disease; diabetes; and heart failure. This program helps individuals with chronic conditions manage their care by providing patients with the most cost effective services and health practices for their conditions.

- **Continue to maximize efforts to increase access to prescription drugs by the uninsured.** The state is currently seeking to access the power of bulk purchasing through the Oregon Prescription Drug Program (OPDP). The OPDP increases the uninsured's access to prescription drugs, and lowers state and city government costs while helping them stay within budgeted goals. The program can leverage the best prices on the most effective medicines by pooling prescription drug purchasing power, using evidence-based research to develop a preferred list of lowest cost drugs, and negotiating competitive discounts with pharmacies. In 2006, the OPDP and Washington's Prescription Drug Program formed the Northwest Prescription Drug Consortium. The Consortium has a potential enrollment pool of over five million members. That negotiating strength helped negotiate a new administrative contract with The ODS Companies that brings greater economic value, auditable transparency and financially guaranteed service levels for both group and uninsured members. This contract makes the OPDP and WPDP competitive in their markets for group participation and brings unprecedented value for their uninsured populations.

Develop widespread and shared electronic health records (EHR)

- **Increase coordination.** The state should fund a state coordinator of Health Information on a continuing basis with sufficient staff and funding support to carry out the assigned functions. The coordinator provides a strong state leadership role for health information exchange and EHR adoption, assures coordination of community efforts throughout Oregon, and assures that Oregon health records are compatible with emerging national standards and infrastructure. Among other things, the coordinator should conduct an ongoing assessment of the costs and benefits of implementing electronic health records and health information exchange for Oregon as a whole.

- **Create pilot programs for health information exchange.** The state should solicit CMS and other funding to support pilot projects that encourage health information exchange and reduce silos of personal health information. Examples of such projects are: (a) an Oregon Business Council funded Oregon Health Care Quality Corporation effort to develop a Portland metropolitan area pilot project for viewing and retrieval of lab results, image reports and hospital and emergency department summaries; and (b) a statewide master patient index to enhance the potential for information sharing.

- **Support efforts to improve privacy and security of electronic health records.** The state should support implementation and dissemination of the Health Information Security and Privacy Collaborative recommendations released in Spring 2007.[32] These recommendations outline several steps that foster the protection of patients' health information especially in an electronic exchange. The plan looks at the public and private sector roles with regard to identification, authentication and authorization of users, addressing medical identity theft, reviewing specially protected information laws, educating consumers, protecting health information held by non-covered entities, ensuring appropriate access for secondary use, and enforcing current law. The report suggests the need for funded coordination at the state level through a Health Information Privacy Coordinator, as well as technical assistance to organizations for comprehensive adoption of appropriate privacy and security practices. In phase two of the project, the Collaborative intends to develop a "communication toolkit" to improve consumer education on health information exchange.

- **Monitor and promote widespread adoption of electronic health records.** The state should perform an annual assessment of EHR adoption to guide policy and identify areas where targeted assistance is needed. To the extent that small practices and safety net clinics are unable to finance timely EHR implementation, the state should help them secure other funding to do so, including federal sources such as CMS. Coordinated value-based purchasing activities should promote the creation of incentives for EHR adoption, including payment scenarios that allow some financial benefit to accrue to a provider investing in EHR.

- **Promote claims processing efficiencies.** The state should continue its efforts to create a simplified and standardized claims processing system throughout Oregon, using its influence as a purchaser and as the regulator of many of the key players. This would reduce the impact of inefficient claims processing and high transaction costs on the costs of health care, allowing funds to be better spent elsewhere. It is likely that this claims processing system can be integrated over time with EHRs and HIEs, such that health information is fully integrated.

Assure a workforce that can capitalize on health information technology

Sufficient provider capacity is necessary for successful system reform. Creative efforts will have to be undertaken to expand capacity and increase provider education in order to meet a range of patient needs and to successfully use information technology in health care settings.

It is important to train current and new providers in electronic record keeping. The OHPC recommends the Workforce Institute train practitioners who can capitalize on new information technology. Increased use of technology will result in improved, better coordinated care that will minimize duplication and errors. For advances in health information technology to be meaningfully translated into improved patient care, providers must both understand the value of

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[32] The implementation plan of the Health Information Security and Privacy Collaborative *Privacy and Security Solutions for Interoperable Health Information Exchange* can be found at: http://www.q-corp.org/q-corp/images/public/pdfs/final_implementation_plan_report.pdf

using technology (such as electronic medical records) and be comfortable using the technology. As technology changes, health care staff from nurses and physicians to medical office and hospital staff need training to remain current in their knowledge.

Increase collaboration and state leadership to improve health care safety

The OHPC recommends further developing the work of the Oregon Patient Safety Commission in order to:

- Encourage the participation of all hospitals, nursing homes, ambulatory surgery centers, retail pharmacies and other health care facilities in the Oregon Patient Safety Commission's voluntary reporting program of serious adverse events.
- Incorporate a surgical events reporting program (specifically, the National Surgical Quality Improvement Program) within the Patient Safety Commission to encourage cross-institutional sharing and learning. The OHPC recognizes that implementation of this recommendation requires finding a way for rural hospitals to be financially able to participate. Direct OHPR to establish public reporting of quality measures at the institutional level.
- Provide state financial support for the Oregon Patient Safety Commission's work in order to give the Commission the means to build awareness of and to develop strategies to reduce serious adverse events and their costs.

Why These Reforms Are Needed

Information, Measurement, Collaboration Are Key to Quality Care
Numerous public and private efforts are underway to push for improvements in quality, transparency, and coordination of care. Many of these efforts will be more effective if accomplished collaboratively between public and private entities. Involving more provider and payer organizations in the data collection process improves the quality of information provided and increases providers' and insurers' interest in using the information collected to improve care quality and efficiency.

For example, quality information on evidence-based care becomes more valid and useful to providers when data is consolidated across the community rather than by individual health plan. An excellent example of the power of a collaborative public-private approach is the recent Oregon Health Care Quality Corporation's leadership in developing common measures of ambulatory care and the strategic plan for market-driven change supported by a Robert Wood Johnson Foundation grant. This grant is, however, only a three year project, leaving the funding for continuation and enhancement unknown at this time.

There is a need for a stable model to continue such efforts into the future and consolidate a variety of information beyond the limited scope of the Robert Wood Johnson grant. Public and private interests should explore the model most likely to provide stability for the critical function of providing a range of quality information to a range of users. The answer could come in strengthening existing organizations, new collaborations, or new institutions meeting basic functions detailed in the recommendation.

Information Transparency Will Improve the System's Ability to Manage for Quality
The OHPC continues to recognize and support the need for performance information to guide purchasers, providers, and consumers in their efforts to make wise decisions, spend resources wisely and perhaps most importantly, improve performance. Experience has shown that publicly available information can result in both improved performance and in more focused attention to quality improvement efforts. Providers need to benchmark their performance, purchasers need ways to identify and reward quality performance, and consumers need information to help them make critical decisions.

Much of the value of public information to date has been to promote quality in the provider community itself. Consumers need to be more aware of why they need to care about health care quality and information that will help them make wise personal health decisions. Major health plans are becoming both more concerned and in many cases are making significant investments to offer more tools to consumers and employers. Consumer organizations are increasingly interested in promoting a more active and aware consumer. The state should participate in collaborative efforts such as the Robert Wood Johnson Foundation Grant program linking public and private organizations (including consumer organizations) in an effort to inform consumers about quality variations and to improve the tools available to help consumers seek quality in the delivery of their health care.

There are many efforts currently at the national and state level to improve quality information and to make information transparent. Often, however, these efforts are not coordinated. One of the positive national trends is for the major federal purchasers (Centers for Medicare and Medicaid Services) and quality organizations (Agency for Healthcare Research and Quality) to collaborate with important professional organizations (such as the College of Surgeons and the Joint Commission for the Accreditation of Health Organizations) and private non-profit entities such as the Institute for Healthcare Improvement and the Leapfrog Group for Patient Safety. This has resulted in new programs and strategies such as the Surgical Care Improvement Program, the 100,000 Lives Initiative, the National Surgery Quality Improvement Program, and payment increases being tied to increased quality reporting by hospitals to CMS. Many of these efforts improve data transparency. For example, the CMS Hospital Compare program or the State of Oregon website that provides mortality data for 8 procedures and volume data for 7. Some efforts are not fully transparent, but are associated with significant quality improvement tools designed to help organizations address the issues that data identifies such as NSQIP and 100,000 Lives.

Public/Private Collaboration Is Needed to Promote Value-Based Purchasing
The OHPC supports an expansion of purchasing practices aimed at improving the value of health care services, where value is a function of both quality and cost. Value-based purchasing strategies seek to influence the decisions or behavior of individuals (employees, patients) or health care entities (providers, health plans).

The state can and should take a strong lead in pushing health care purchasers to develop value-based purchasing strategies statewide. The Public Employees Benefit Board (PEBB) is a leader in value-based purchasing in Oregon. PEBB designs, contracts and administers a range of insurance products and flexible spending accounts for state employees and their dependents. It also offers health insurance options to retirees not yet eligible for Medicare and individuals in other participating groups. PEBB's total membership is approximately 120,000 individuals.

There is great potential for value-based purchasing strategies within Oregon's Medicaid program, which has over 270,000 enrollees in managed care and approximately 70,000 others in fee-for-service or primary care case management. This enrollment gives Medicaid both leverage and opportunity to influence the quality of care for its enrollees and the broader community. It also represents a large portion of the state's budget, giving efforts to improve service efficiency and quality broad implications.

Widespread, Shared Electronic Health Records Will Improve Care Quality and Efficiency

Good health information is key to the development of a high-value health care system. Reliable health information exchange (HIE) makes patient information available when and where it is needed to all who are authorized to access it. A recent study by the Commonwealth Fund ranked the United States last compared to four other developed countries with regard to the availability of health records when needed and regarding redundant medical testing. A robust system of interoperable electronic health records (EHR) can reduce duplicative medical tests by 15-20%. Evidence shows that EHRs that include tools such as clinical decision support, reminders and registries helps better manage patient care and improves quality.

Investments in EHR and HIE have substantial economic benefits to society as a whole, measured by improved outcomes, fewer mistakes, more effective, efficient and timely treatment, and reduced transaction costs. Among other things, EHRs can reduce billing errors and prevent fraud through improved documentation and administrative checklists, benefiting both providers and society.

The costs are sometimes cited as a reason providers are hesitant to invest in EHR, but recent research suggests that the costs of implementation are quickly recovered. Researchers at the University of California, San Francisco conducted case studies of solo and small primary care practices using EHR.[33] They found average start up costs of $44,000 per provider, with practices recouping the investment costs in two and a half years. The average annual efficiency savings and benefits of increased provider productivity was $15,800 per provider per year.

In a March 2005 Report to the 73rd Oregon Legislative Assembly, a subcommittee of the Oregon Health Policy Commission recommended that the state take reasonable steps to promote the rapid and widespread adoption of health information technology including electronic health records and health information exchanges. It is now 2007, and the reasons for bringing modern information technology to Oregon health care are still compelling. While some progress has been made since the 2005 report, there is much yet to be done.

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[33] "The Value of Electronic Health records in Solo or Small Group Practices" Robert. H. Miller, et al., *Health Affairs,* September/October 2005, 24 (5): 1127–3.

Widespread adoption of compatible and shareable information technology is essential for improving the quality and safety of care and reducing waste and costs. A functioning EHR system:

- Provides improved manageability of health data;
- Offers support for provider decisions at the point of care, such as reminders and alerts about drug interactions;
- Allows for electronic prescribing and order entry by providers, thus reducing mistakes secondary to legibility, improving communication, providing interaction checking and increasing efficiency of the refill process and formulary adherence
- Facilitates patient population reporting and management;
- Can improve the productivity of health care staff over time;
- Facilitates the delivery of evidence-based health care; and
- Improves the coordination of care for the chronically ill (the highest users of health care.)

Oregon Needs a Well-Trained Health Care Workforce

The OHPC sees the newly formed Oregon Health Care Workforce Institute as an integral component of health care system reform. The Institute is a private-public partnership charged with developing a coordinated statewide response to critical needs in the health care workforce. The Institute will provide consistent and reliable research about health care workforce shortages and develop policies and resources to resolve the shortage. To minimize duplication and errors, it is critical that workforce training focus on building the understanding and skills to capitalize on new information technology that will result in improved, better coordinated care.

Improving Health Care Safety Will Decrease Costs and Improve Health Outcomes

Health care leaders agree that medical errors represent an epidemic that is beatable. The Institute of Medicine found that 44,000 to 98,000 people die in hospitals each year as the result of such events. The federal Veterans Administration system reports that about 180,000 deaths occur each year in the United States from “errors in medical care” across all health care settings. Other studies place the number of deaths even higher. In addition to deaths, many adverse events lead to serious, but non-fatal injuries. A recent survey of physicians and of the public offers a different perspective but with similar intent—35 percent of practicing physicians and 42 percent of the public have experienced a preventable medical error either personally or within their families. In Oregon, even with a health care system continually working to improve quality, more people probably die as the result of adverse events than from diabetes, Alzheimer’s, or pneumonia. Research findings consistently indicate that 50 to 70 percent of errors are preventable—if systems issues are identified and corrected.

The Oregon Patient Safety Commission was created during the 2003 legislative session to reduce the risk of adverse events and to encourage a culture of safety in Oregon’s health care system. The Commission brings a much needed independent view to quality issues and patient safety remedies. And while this Commission has made great strides in 2006 – 52 hospitals in Oregon are voluntarily reporting adverse events – currently the Commission is funded solely through fees from the hospitals. State financial support is needed in order to expand the Commission’s role and impact.

Recommendation #6: Support Community Efforts to Improve Health Care Access and Delivery

The Oregon Health Policy Commission (OHPC) recognizes that no one service delivery model will assure access for all people, communities, or providers. Health care delivery is local. Reform approaches need to be flexible enough to provide local communities the ability to tailor their local systems to the needs and characteristics of their community. There are two community responses to local health care needs that the Commission believes requires the urgent attention and involvement of the state, businesses, insurers, and community members alike – the health care safety net and local community health care access collaboratives.

The following are recommendations submitted to the Commission from the Safety Net Advisory Council and the OHPC Local Delivery System workgroup that the Commission supports to further local innovation in health care delivery.[34]

Overview of Proposals

Promote the primary care home model

The OHPC recommends creating a pilot grant program to support community efforts to provide Oregonians with a primary care medical "home" where they can receive timely, affordable, and comprehensive care. The OHPC believes this will enhance quality and reduce cost for vulnerable Oregonians.

Successful applicants will need to demonstrate a measurable short-term impact on cost and health outcomes, particularly for patients with chronic conditions, and a longer-term impact on patient health through preventive services. Successful applicants will have a demonstrated commitment to serve uninsured and Medicaid patients and collaborate with the broader healthcare system. Primary care home components to be supported through grants would include building the provider-patient relationships, comprehensive and integrated care, and assist patients with health system navigation and coordination.

Support local access collaboratives

The OHPC supports legislation establishing a state matching grant program to support development of local access collaboratives. The Community must demonstrate that the project is collaborative (public/private partnerships). Possible parameters for projects include:

- Increasing capacity and/or access;
- Coordinating the process of delivering comprehensive health care services;

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[34] See Appendix A for a list of Safety Net Advisory Council and Delivery System Workgroup members.

- Aligning available resources and leveraging financial commitments from stakeholders;
- Engaging multiple, diverse, public and private stakeholders;
- Sharing the risks and rewards across stakeholders;
- Offering significant stability to the local health care system;
- Reducing health disparities and increasing efficiencies and savings;
- Promoting the development of information technology infrastructure; and
- Promoting a continuum of care.

Include safety net providers and local community collaboratives in initiatives to realign payment incentives

The OHPC believes that reforming how our health care system pays for services is key to system reform. The OHPC will to embark on a thoughtful planning process to develop a collaborative initiative which will drive reimbursement reform forward in Oregon (See Section on "Priority Policies for Further Development by OHPC"). Payment reform must provide incentives for cost-effective care that improves health outcomes, as well as fuel the development of electronic health records, data sharing, and reporting systems. Safety net providers and the local community collaboratives should be at the table for this discussion to ensure that reforms support local innovation in providing high-value health care.

Why These Reforms Are Needed

The Health Care Safety Net

The health care safety net is a community's response to the needs of people who experience barriers to appropriate, timely, affordable and continuous health services. Health care safety net providers include a broad range of local non-profit organizations, government agencies, hospitals, and individual providers. Core safety net providers are a subset of the larger safety net and are especially adept at serving people who experience significant barriers to care, including homelessness, cultural and language barriers, geographic and social isolation, mental illness, substance abuse, cognitive impairment, decreased functional status, health literacy barriers, financial barriers, lack of insurance or undersinsurnace and other barriers. . These providers have a mission or mandate to deliver services to persons who experience barriers to accessing the services they need.

The Health Care Safety Net Advisory Council (SNAC) was created in 2005 as an advisory body that promotes understanding and support for safety net patients and providers in Oregon. SNAC provides the Governor and the Oregon Health Policy Commission with specific policy recommendations for safety net providers in order to ensure the provision of needed health services to vulnerable Oregonians.

Community Health Care Access Collaboratives

Throughout 2005 and 2006, the Commission convened the Local Delivery Systems Workgroup to bring together experts from throughout Oregon to investigate what can be done to support local or "community-created" solutions to improving access to health care within Oregon communities. Nineteen of Oregon's 36 counties are designing and implementing local solutions that ensure access to timely, quality, and affordable services delivered in an effective, efficient and sustainable manner. In order to promote the health of an entire community, these local health system collaborative efforts are working to:

- Coordinate comprehensive health services;
- Offer stability and accountability;
- Leverage existing dollars;
- Involve multiple, diverse, public and private sector stakeholders;
- Require local leadership or champions;
- Share risks and rewards.

The Commission released a report prepared by the workgroup in January 2006 highlighting ways the state could support these community efforts including recognizing the importance of the efforts, facilitating information sharing between communities, and creating flexible state policies to permit local delivery system redesign.[35]

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[35] The OHPC Local Delivery Systems Workgroup report on community collaboratives is on the OHPC website at: http://www.oregon.gov/DAS/OHPPR/HPC/docs/2006/SurveyofCommunityCreatedHealthcareSolutionsinOregon06.pdf

Recommendation #7: Establish Sustainable and Equitable Financing for Reform

Proposal Overview

Health care reform requires improvements on multiple fronts: the uninsured must gain coverage and the provision of services must be made more efficient and less costly. While many people agree that there are sufficient resources in the system to fund care for everyone, the difficult part is capturing and distributing the funding where it is needed. Rather than waiting for system reforms to be implemented before bringing the uninsured into the system, the Oregon Health Policy Commission (OHPC) proposes working toward both universal coverage and improved system efficiency simultaneously. To fund coverage expansion and premium subsidies for low-income uninsured Oregonians, the OHPC proposes up-front funding that will be phased out as system efficiencies take hold over the following years.

Preliminary pricing of the OHPC reform plan indicate that approximately $550 million per year is needed initially to finance the public coverage and premium subsidies structure proposed in this report.[36] This upfront investment in Oregonians' health will produce savings throughout the state. This investment, to be implemented along with delivery system and other reforms, will lead to more productive employees, improved outcomes, and reductions in system costs.

The OHPC recognizes that to implement the OHPC plan, a funding source will need to be identified. The OHPC recommends consideration of financing scenarios that are broad-based, stable, and ensure that everyone contributes to system reform. The OHPC also recognizes that many employers currently provide insurance to their employees. These employers are already subsidizing the system and should be rewarded for their ongoing contribution. To recognize this participation, financing sources involving employers should equalize the financial burden between employers that provide health coverage to employees and those that do not.

Table 1 includes initial estimates of various payroll tax and employer fee scenarios that could fund the necessary revenue of $550 million per year; and Table 2 provides some other revenue sources that may be proposed during reform discussions.

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[36] "Covering the Uninsured: The Cost to Oregon", John McConnell, et al., 2007. This companion report to the OHPC recommendation report is available at: http://www.oregon.gov/DAS/OHPPR/HPC/Reports.shtml.
The actual cost may be less or more, depending on a number of factors included in the modeling, such as whether an asset test or waiting period are required for public coverage and subsidies, and extent of crowd out into public programs.

Why This Change Is Needed

Universal Coverage Reduces Burden of Cost Shift

The current system funds care for the uninsured primarily through higher premiums for the insured. Providers pass the costs of caring for the uninsured on to insurers. The insured and employers that offer insurance pay more, as insurers pass on their increased costs to members. With universal health insurance in Oregon, providers will experience great reductions in "uncompensated" care. This will allow them to charge the insured for the actual cost of their care. Premiums should be adjusted in response. The insured will pay premiums that reflect a truer cost of providing care.

An Initial Investment Will Pay Off in the Future

Oregon bears a heavy cost for having a large uninsured population. The estimated cost of hospital uncompensated care was $299 million in 2004, and that number continues to increase. Researchers estimate that total uncompensated care (hospital, physician and out of hospital care) will be $534 million in 2008.[37] Both state government and the insured pay for this care. Uncompensated care accounts for ten percent of the cost of insurance premiums.

As the Institute of Medicine noted in its 2003 report, these costs are not just due to the costs of providing free health services to persons without insurance coverage.[38] Much of the cost is due to the poorer health experienced by the uninsured, who receive too little care. The economic value of better health outcomes that would accrue from continuous health insurance coverage (and appropriate health care use) for all Americans is between $65 and $130 billion a year.[39] The savings include higher expected lifetime earnings and educational and developmental outcomes.

System savings will accrue through reductions in uncompensated care costs and improvements that ensure people are getting the right care at the right time. However, as outlined in this report, to reap the benefits of an insurance market that covers everyone in the state, Oregon must implement a system of publicly financed subsidies that facilitate access to affordable insurance.

An investment in universal insurance coverage will reap the greatest gains if change is paired with delivery system reforms that make the system more efficient and accountable. The following are a few delivery system improvements that can control costs and improve care.

- Small practices that implement electronic health records recoup their initial investments in technology and training in an average of 30 months.[40]
- Reducing hospital acquired infections could reduce the rate of increase in insurance premiums and help make coverage more affordable. The average hospital stay was $32,000 higher when the patient experienced a hospital acquired infection (HAI).[41]

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[37] "Covering the Uninsured: The Cost to Oregon", John McConnell, et al., 2007. This companion report to the OHPC recommendation report is available at http://www.oregon.gov/DAS/OHPPR/HPC/Reports.shtml.

[38] *Hidden Costs, Value Lost: Uninsurance in America*, Institute of Medicine Committee on the Consequences of Uninsurance. 2003.

[39] Wilhelmine Miller, et al., op cit.

[40] H. Miller, et al., op cit.

- Medication errors are expensive and can be costly in terms of health outcomes. The Institute of Medicine estimated there are 7,000 deaths annually due to medication errors.[42] Each preventable adverse drug event added $2,000 to the cost of hospitalization, totaling $2 billion nationally in hospital care costs. The cost of medication errors is likely even higher, as drug errors and other problems arising from lack of medication reconciliation exist in other settings, including at nursing facilities, physician offices and medical clinics.

Everyone Must Contribute to Reform

Health care is a shared social responsibility and that everyone should contribute to health insurance coverage. Many employers are doing their share and more, subsidizing care for the uninsured through higher premium payments. New financing considerations should recognize these contributions and help equalize the burden of health insurance costs across employers.

Sustainable Reform Requires Sustainable Financing

Reform requires a stable funding source. A broad-based employment payroll assessment is one sustainable funding option that can be used to finance public coverage. Whether such a tax or fee is paid only by employers or is shared by employers and employees, such a source would ensure a stable funding base to which everyone contributes.

Implementation Consideration

ERISA and the Structure of an Employer Assessment

Table 1 outlines various options for a payroll assessment. If a payroll tax or fee is considered, the OHPC recommends a structure where employers who offer insurance are allowed to recoup all or a portion of the assessment paid.

The OHPC does not recommend a specified level of coverage in order for an employer to be eligible for a tax benefit provision. Any such requirement would likely face legal challenge under the Employee Retirement Income Security Act (ERISA). ERISA substantially limits states' ability to regulate employee benefit plans, including health insurance. While a state employer health insurance mandate has not received full legal vetting, recent court rulings indicate that states might be vulnerable to legal challenges if they attempt to require employers to provide a certain level of health insurance.[43] ERISA poses a serious implementation issue that must be considered in the design of a reform plan. Appendix D includes some guidelines provided by the National Academy for State Health Policy.

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[41] "Infections Due to medical Care in Oregon Hospitals, 2003-2005" Research Brief by Office for Oregon Health Policy & Research. November 2006. Available at http://www.oregon.gov/DAS/OHPPR/RSCH/.

[42] "To Err Is Human: Building a Safer Health System," Linda T. Kohn, Janet M. Corrigan, and Molla S. Donaldson, Editors, Institute o f Medicine. National Academy Press, 2000.

[43] On July 19, 2006, U.S. District Judge J. Frederick Motz overturned Maryland's Fair Share Health Care law, which had required large employers to spend at least 8 percent of their payroll on health care for employees or pay the equivalent in fees to the state. The judge's decision noted that the federal ERISA law preempted the Maryland law. .Judge Motz's rule is available at <http://www.mdd.uscourts.gov/Opinions152/Opinions/Walmartopinion.pdf>.

Table 1. Various Payroll Assessment Scenarios to Fund OHPC Proposed Public Coverage Expansion
Estimated Initial Direct Public Investment: $550 million per year

INITIAL ESTIMATES - FOR ILLUSTRATION ONLY

	Assessment Scenario	**Approx. Assessment % required to raise revenue**		**Average Annual Payment Per Employee**			
				2007	**2008**	**2009**	**2010**
a)	• Employer financed payroll assessment • No employer credit for offering insurance	0.8%	Employer share	$320	$320	$330	$350
b)	• Employer & employee financed payroll assessment (50/50) • No employer credit for offering insurance	0.8%	Employer share	$160	$160	$165	$175
			Employee share	$160	$160	$165	$175
c)	• Employer financed payroll assessment • Full employer credit for offering insurance	2.8%	Employer share (if offers insurance)	$0	$0	$0	$0
			Employer share (if no insurance offered)	$1,040	$1,040	$1,090	$1,150
d)	• Employer financed payroll assessment • Partial employer credit for offering insurance (50%)	1.25%	Employer share (please see table notes)	$1,070	$1,060	$1,120	$1,180
e)	• Employer financed payroll assessment • No employer credit for offering insurance • Additional surcharge per employee ($300/year) • Full credit for surcharge for employers offering insurance	0.6% + $300/yr if not offering insurance	Employer share (if offers insurance	$240	$240	$250	$260
			Employer share if (if no insurance offered)	$540	$540	$550	$560

Source: Preliminary revenue estimates, OHPC, January 2006. Based on public and private payroll estimates (see reference below).

Notes: Option B is included as illustration that assessments could be split between employers and employees. Options c, d, and e could also be jointly financed by employers and employees. Option D provides an estimate of the average payment per employee for all employers. Employers who provide insurance would pay less per employee as they would be eligible for the 50% tax credit. Employers who do not would pay more per employee.

REFERENCE:	**2007**	**2008**	**2009**	**2010**
Total Oregon Public & Private Payroll ($ in billions)	67.6	71.1	74.8	78.7
Total Number of Oregon Workers ($ in millions)	1.7	1.8	1.8	1.8

Source: Payroll and employment estimates, December 2004 Oregon Economic Forecast

Table 2. Additional Funding Options for Discussion

The following are some other funding sources that could be considered to finance the cost of proposed public insurance expansions.

Funding Source (in millions)[44]	**FY 2007-08**	**FY 2008-09**	**Broad Tax**	**Targeted Tax**
Broad Retail Sales Tax – 1% Rate (exempts shelter and groceries)	$860.2	$910.9	✓	
Restricted Retail Sales Tax – 1% rate (exempts shelter, groceries, public transport, health care, education, personal insurance, utilities, gasoline, tobacco products)	$607.2	$642.7	✓	✓
Increase Tobacco Tax – Increase Cigarette Tax by 84 cents per Pack[45]	$180-190	TBD	✓	✓
Increase Beer Tax – Increase Beer Tax by $1 per barrel	$2.6	$2.6		✓
Increase Wine Tax – Increase Wine Tax by 25 cents per gallon	$2.4	$2.4		✓
Medical luxury tax – Ex. 1% on cosmetic surgery not resulting from trauma or medical condition	TBD	TBD		✓
Provider Tax – Amount of tax depends on scope of provider types included	TBD	TBD		✓

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[44] Information from 2006 Oregon Public Finance: Basic Facts, Research Report #1-06. Legislative Revenue Office. February 24, 2006. http://www.leg.state.or.us/comm/lro/home.htm.

[45] Tobacco tax data (per pack amount and total revenue for the 2007-2009 biennium) are from the Governor's recommended budget.

Recommendation #8: Design and Implement System Reform Evaluation

Health Care Reform Demands a Strong Evaluation Component

The Health Policy Commission recognizes evaluation is an integral component of any successful health reform package. The purpose of evaluation is to measure health care capacity and access and to determine whether policy changes are having the intended impact on access, quality, and health outcomes. The OHPC recommends that a coherent, stable and coordinated evaluation infrastructure be developed prior to implementation to assess success and inform future policy decisions. Oregon's research infrastructure can be formalized and expanded to evaluate any global reform efforts. Building on this infrastructure is cost-efficient and timely.

Components of the Evaluation Infrastructure

- A well-designed baseline evaluation plan, capturing the data necessary to demonstrate 'pre-post' changes and attribute changes to specific reform policies;
- An evaluation of reform implementation, ensuring that implemented programs and practices are in line with the intention of policies;
- Identified sustainable funding for on-going evaluation identified during passage of any reform legislation;
- A central entity responsible for:
    - Collecting statewide and community level data, with the authority to collect data from providers and other entities that is integral to successful reform evaluation;
    - Coordinating existing state and community resources to develop shared units of measurement and metrics of change;
    - Developing a dissemination protocol that would ensure policymakers receive evaluation results in a timely manner and understandable format in order to be useful;
    - Developing and maintaining an integrative and interactive website where communities and policymakers could access relevant local and state data to inform their programmatic, practice, and local policy approaches.

Recommended Metrics of Change

A health reform evaluation plan would develop metrics from the outcomes described below. Some of the metrics outlined below can be extracted from current national and state surveys. However, several metrics are not currently collected in a manner that would be representative of all demographic subsets of Oregonians, such as race/ethnicity and geographic location. An Oregon population survey related to health care would be needed and health care providers would need to begin providing capacity data by insurance type, provider type, FTE, and clinic location.

- Provider and Consumer participation
  - Managed care participation
  - Use and usefulness of Health Insurance Exchange
  - Insurance status rates across demographic variables
- Provider capacity
  - By primary care and by specialty care
  - By clinic location
  - By provider type
  - By insurance type (e.g. Medicare, Medicaid)
- Population demand by age subgroups (e.g. pediatric care) and by disease subsets (e.g. chronic diseases)
- Utilization patterns that emphasize on preventative care and chronic disease management
  - Access to the appropriate level of care in a timely fashion:
    - Emergency Department visits by IC-9 codes
    - Number of primary care visits by age/demographic subsets
    - Appropriate use of diagnostic and specialty care
  - By insurance type (to assess impacts of co-pays and high-deductible plans)
- Changes in health outcomes and disparities, particularly members of vulnerable subgroups
- Health care quality measures
- Financial impacts that reflect affordability for the state, providers, employers, individuals and families
- Special concerns such as "crowd-out", effective and efficient use of technology and transparency

Infrastructure

This necessary evaluation component will build on current infrastructure at the State:

- The Office for Oregon Health Policy and Research (OHPR), Research Unit: The OHPR Research & Data Unit has extensive experience developing comprehensive evaluation plans, creating data collection instruments, managing evaluation contracts, and analyzing data from state-wide surveys.
- The Health Indicators Project (HIP): Under the HIP project, leaders in state-wide community access organizations: 1) define a common unit of analysis across the urban and rural areas of the state, termed Primary Care Service Areas (PCSA); 2) identify shared metrics of access to allow communities within PCSAs to compare themselves locally, state-wide, and nationally; and 3) develop a "tool-kit" for local access organizations to tap into existing data resources to answer their community-specific questions in a cost-efficient manner.
- The Oregon Health Research and Evaluation Collaborative (OHREC): OHREC supports evidence-based decision-making by collaborating with health researchers from Oregon's universities, state agencies, advocacy organizations, local community health-care access

initiatives, and a variety of other stakeholders. OHREC is committed to creating a bridge between health-care decision-makers and the research community; thus creating a feedback loop of rapid-cycle research findings that informs policy.

Oregon Health Policy Commission Road Map for Health Care Reform

Sequencing Reforms: A Five-Year Plan

The goal of the Commission's reform work is to develop a five year reform plan that would create a health care system in Oregon in which everyone has access to affordable health care. This section outlines a recommended approach to implementation.

Getting Started in the 2007 Legislative Session

- Pass universal health coverage for children. Ensuring coverage for children is a strong first step in ensuring affordable coverage to all Oregonians.

- Pass legislation outlining the major components of full scale reform, providing guidance to public and private cooperative work throughout 2007-2009.

Years 1 and 2

- Implementation of universal health care for children will occur in Year 1.

- Implementation planning for the Health Insurance Exchange, the publicly-financed coverage expansion, and an employer assessment or fee will take place throughout Year 1 into Year 2.
    - This provides over a year for the Exchange to be created carefully by establishing an independent oversight board, promulgating operating regulations, developing initial benefit packages for individuals and small businesses, and developing affordability standards and the subsidy structure.
    - Also during this time, the state will negotiate the terms of the needed Medicaid waiver amendments to implement the publicly-financed subsidy structure.
    - Implementation of the Exchange, the publicly-funded subsidy structure, and the employer fee will occur by the middle of Year 2.

- Also during the second year, the Office for Oregon Health Policy and Research (OHPR), in partnership with other state agencies, the Oregon Health Research and Evaluation Collaborative (OHREC), policymakers, and national experts, will develop a comprehensive five-year plan for evaluating the reform implementation and initial outcomes.

Years 3, 4, & 5

Individuals have from the passage of the enacting legislation until Year 3 to seek out available coverage. The child coverage expansion, the publicly-funded subsidy structure, and the Health Insurance Exchange are all in place to assist individuals in finding affordable options. Only after the beginning of Year 3 will individuals be subject to penalties if affordable insurance is available per the Exchange affordability standard.

During the legislative session and emergency boards during years 3 through 5, the Governor and Legislature will review implementation progress to date and assess whether any mid-course legislative corrections are required.

Evaluating the Success of Reforms

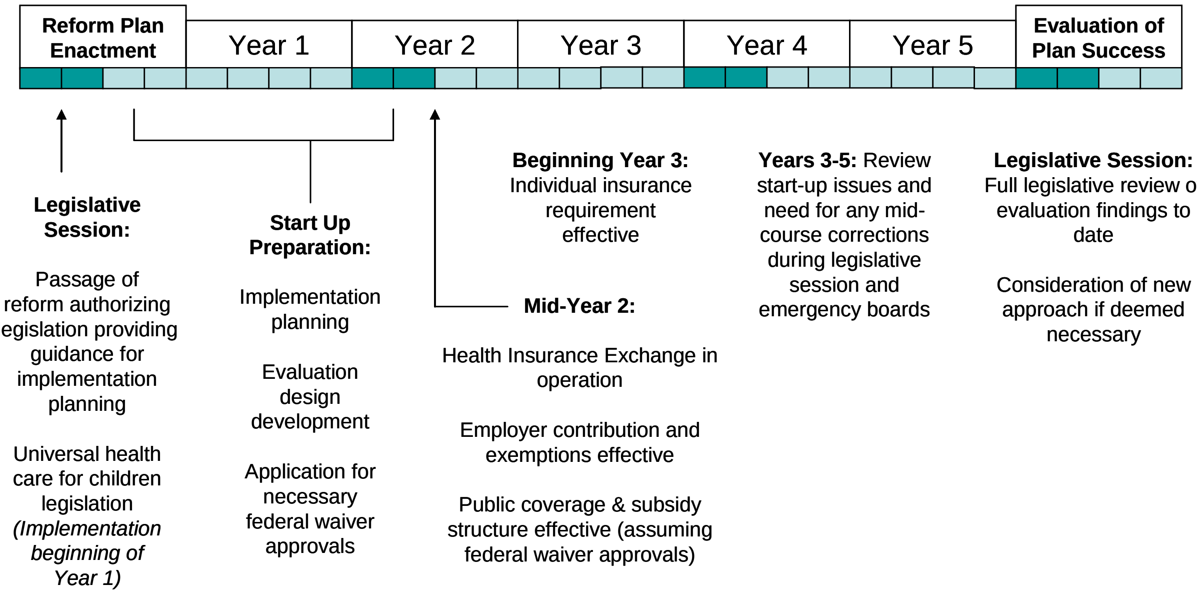
Upon completion of year 5, the Governor and the Legislature will conduct a public review of progress to date through:

- Preliminary results for review through initial evaluation findings from OHPR and other researchers;
- Feedback from constituents, advocates, providers, insurers, and other stakeholders; and
- Any updated recommendations from the OHPC and other advisory bodies.

Both minor adjustments and full scale direction changes should be on the table for discussion at this point.

OHPC Proposed Health Reform Plan

Timeline for creating a high value, affordable system in five years



Legislative Session:

Passage of reform authorizing legislation providing guidance for implementation planning

Universal health care for children legislation *(Implementation beginning of Year 1)*

Start Up Preparation:

Implementation planning

Evaluation design development

Application for necessary federal waiver approvals

Mid-Year 2:

Health Insurance Exchange in operation

Employer contribution and exemptions effective

Public coverage & subsidy structure effective (assuming federal waiver approvals)

Beginning Year 3: Individual insurance requirement effective

Years 3-5: Review start-up issues and need for any mid-course corrections during legislative session and emergency boards

Legislative Session: Full legislative review of evaluation findings to date

Consideration of new approach if deemed necessary

Oregon Health Policy Commission Road Map for Health Care Reform

Priority Policies for Further Development by OHPC

Implementing Senate Bill 329

Senate Bill 329, which outlines a work plan to design comprehensive reform in Oregon, was passed in June 2007. Signed into law by Governor Kulongoski, the bill's goal is the completion of a comprehensive plan by late 2008, followed by reform implementation legislation for consideration in the 2009 session.

The bill includes a detailed timeline for fleshing out a full-scale reform plan in the 2008 legislative session. Under SB 329, the Oregon Health Fund Board, a newly created governmental entity will oversee the development of a comprehensive reform plan and implementation proposal. Five subcommittees will develop recommendations for the Board focused on: 1) financing, 2) delivery system reform, 3) benefit definition (based on Oregon's Prioritized List of Health Services), 4) eligibility and enrollment policies, and 5) federal policy impacts and opportunities. To facilitate the work of the Board and its subcommittees, existing state commissions and committees will form the backbone of the subcommittees.

The Oregon Health Policy Commission is tasked with forming the backbone of the financing subcommittee. As such, the Commission will spend the majority of the remaining time in 2007 researching options for financing the Oregon Health Fund program, and developing recommendations for the Oregon Health Fund Board. Several of the issues the Commission will tackle in this capacity include:

- Developing an implementation plan for a health insurance exchange by February 2008;
- Collecting and pooling employer, employee and individual health care premium contributions; and,
- Developing a model for a Quality Institute to improve how health care information is collected and utilized.

During the public comment period, the Commission received input that reform plans should include consideration of end-of-life care, medical liability, and other topics not covered by this report. The Commission opted to not add these topics in this final report as many of them are listed as topics to consider in implementation of SB 329.

Delivery System Reform

While much of the focus of health care reform is on insurance coverage, real reform must also change our delivery system to ensure that everyone has access to quality and affordable care provided in the most appropriate setting. In our current system, care is often fragmented, with services such as behavioral health and long-term care not well integrated with physical health care. This is in part due to the way services are paid for, and is exacerbated by a system that does not reward provider collaboration.

The OHPC believes that reforming how our health care system pays for services is key to system reform. As discussed under Recommendation #5 in this report, there are numerous entities in the state and nationally focused on reforming how health care is financed and reimbursed. The OHPC will continue to focus on furthering delivery system reform in Oregon. Some key areas of OHPC's work will include:

- Encouraging the most effective care in the most appropriate setting. Our payment incentives should place a particular emphasis on promotion of preventive care, chronic care management, and coordinating care for patients over their lifetime in a continuous way rather than episodically.
- Motivating health care providers to utilize health information technology to improve quality, safety, and transparency by permitting patient information to be available at the point of decision making by both providers and patients. Building the capacity for such infrastructure development in safety net providers and small physician practices should be a focus.
- Ensuring adequate provider capacity to ensure the demand for needed health care is met throughout the state.
- Integrating cost-containment in the system in a way that levels out growth and makes the system more sustainable. Ideally, mechanism for "capturing" savings can be created in order to demonstrate the effect of system reforms.

Appendix A: Acknowledgements

The Oregon Health Policy Commission recognizes the valuable contributions of the following individuals:

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Appendix B: Reference on designing the employer contribution to reform in compliance with ERISA

Excerpt From: "Revisiting Pay or Play: How States Could Expand Employer-Based Coverage Within ERISA Constraints." Patricia A. Butler, JD, Dr.P.H. for National Academy for State Health Policy, May 2002.

Do not require employers to offer health coverage to their workers. Such employer mandates would be preempted under the precedent of the case that invalidated Hawaii's law.

Establish a universal coverage program funded in part with employer taxes. The state's legislative objective should be to establish a publicly-financed health coverage program that is funded partially with taxes on all types of employers. Neither the law nor its sponsors should refer to objectives such as assuring that employers cover their workers.

Do not refer to ERISA plans. State laws are easily invalidated if they refer specifically to private-sector employer-sponsored (i.e., ERISA) health plans. The pay or play tax should be imposed on *employers* not on the employer-sponsored plan and the law should not refer to such plans.

Remain neutral regarding whether employers offer health coverage or pay the tax. If the state's objective is to assure universal coverage, it should be neutral with respect to whether an employer pays the tax or covers its workers. The justification for a tax credit is to permit employers to cover workers, but the law and its sponsors should not express a preference for either option.

Impose no conditions on employer coverage to qualify for the tax credit. Despite the state's concerns about adequacy of benefits packages, cost sharing, employer premium contributions, or other employer plan design features, conditioning the tax credit on meeting certain state qualifications will affect ERISA plan benefits and structure and therefore raise preemption problems. Like the Massachusetts Health Security Act (designed carefully to avoid these pitfalls), state laws that impose no standards on qualification for the tax credit stand the best chance of overcoming a preemption challenge.

Minimize administrative impacts on ERISA plans. States cannot tax ERISA plans directly; the pay or play tax must be imposed on the employer. While the state law does provide an incentive for the employer (in its capacity as ERISA plan administrator) to assess whether it is more preferable (from cost, management, and employee relations perspectives) to pay the tax or cover workers, this burden alone should not compel ERISA preemption. Designing the pay or play program like other state tax laws (e.g., for remitting unemployment compensation taxes or withholding employee income taxes) can overcome arguments that the state law interferes with interstate employer benefits design and administration, because employers already are subject to varying state tax systems.

Governor's Racial and Ethnic Health Task Force

FINAL REPORT

Submitted to:

Governor John A. Kitzhaber, M.D.

November 2000

STATE OF OREGON
1859

Governor's Racial and Ethnic Health Task Force

Department of Human Services
Oregon Health Division
Office of Multicultural Health

Department of Administrative Services
Office for Oregon Health Plan Policy & Research

SPECIAL DEDICATION

On October 30, 2000, the Task Force on Racial and Ethnic Health voted to dedicate their report to the memory of Josiah Hill, III, a community leader and activist who left this world too soon but whose life made a big difference for Oregon. His tireless work to end health disparities served as an inspiration to the people he touched with his healing hands, and a heart filled with compassion and courage. His spirit lives on.

May his legacy continue in the hearts and minds of Oregonians who work to end racial and ethnic health disparities. He helped us realize that Oregon may be that special place where his dream to end health disparities has become more than a dream and will be achieved.

> *"Power is not in who or what you know, it is in what you do with your passion."*
>
> *~ Author Unknown*

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State Senator Susan Castillo
District 20, Eugene

State Senator Lenn Hannon
District 26, Ashland

Ruby Haughton
CareOregon, Inc.

Matt Hennessee
QuikTrak, Inc.

Dave Houghton
Multnomah County Health Department

Tom Janisse
Kaiser Permanente
Representing: Oregon Medical Association

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RACIAL & ETHNIC HEALTH TASK FORCE (continued)

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African American Health Coalition
Representing: Commission on Black Affairs

Jackie Mercer
Native American Rehabilitation Association
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State Senator David Nelson
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INTRODUCTION

The Task Force on Racial and Ethnic Health is pleased to present its report for consideration in the 2001-03 budget and legislative process. This report reflects the leadership of Governor John Kitzhaber and the commitment of racial and ethnic community members throughout Oregon to a shared mission of ending health disparities. Racial and ethnic communities in Oregon are disproportionately impacted by health concerns that are not adequately addressed by the current health systems in Oregon or nationally.

The Task Force recognizes that this as an opportunity to proactively remedy persistent and emerging health disparities, and to reconstitute a collective approach – public, private, medical and community together – to the health and well-being of ALL Oregonians. Together, we must strive for quality, affordable and culturally competent health services for every member of every community in Oregon.

There are reasons to be hopeful. Oregon is a leader in many areas of health and health care. The Oregon Health Plan has lowered the percent of Oregonians without health insurance from 18 percent in 1994 to 10 percent in 2000. Oregon is a leader and innovator in moving toward universal access. In spite of this progress, one out of ten Oregonians, or, more than 300,000 people, are still without health insurance coverage – more than 85,000 are children. Eighteen percent of the total uninsured population is made up of people of color, despite there being only nine percent of the total state population.

In addition, the incidence of many chronic diseases, lead poisoning in children and alcohol or drug abuse continue to escalate in communities of color. For example, diabetes is at least two times more common in the African American, American Indian, Hispanic, Asian and Pacific Islander communities, and people of color are also more likely than whites to have undiagnosed diabetes. This points to the need for making quality outreach, education and treatment available, accessible and culturally appropriate for all racial and ethnic communities.

The Governor's and Legislature's responses to the findings of the Task Force will begin to solidify a role for state government in ending health disparities in Oregon. The challenge is significant and will require partnerships that go beyond current efforts. The solutions will involve finding new resources, redirecting existing programs and services, or establishing new policy directions. The ultimate goal is for all Oregonians to live in a state where equity in health programs is a basic and important human right that works effectively to end health disparities.

BACKGROUND

The Racial and Ethnic Health Task Force is the result of several years' committed work by a group of dedicated people. The motivation for creating the Task Force was the recognition that persistent and significant health problems weaken Oregon's racial and ethnic communities much more than these same problems affect the population as a whole. Over the course of the 1990s, it had become evident that government health programs were not satisfactorily addressing many of these health problems plaguing Oregon's racial and ethnic communities. Despite ongoing efforts in several State agencies (notably the Oregon Health Division - OHD and Oregon Medical Assistance Programs - OMAP) to improve responsiveness, and despite improvements in some areas, there was continuing dissatisfaction with the slow improvement in critical health outcome measures.

Beginning in 1997, Carla Freeman (a health researcher, past/present member of the African American Health Coalition and longtime advocate for better programs targeting health issues for communities of color) began raising this issue with leaders and advocates committed to improving the health of Oregon's racial and ethnic communities. In numerous settings, including meetings with the Governor's Office, key Legislators, and community representatives, she argued for stronger and more structured efforts to address these debilitating disparities. At a planning retreat for the Oregon Health Council that summer, she suggested that a commission modeled on the Ohio Minority Health Commission be created in this state. In 1998, a workgroup was formed to evaluate the feasibility of establishing such a commission or task force in Oregon.

The workgroup was co-chaired by State Senator Avel Gordly and Mark Gibson, the Governor's Senior Advisor on Health, Human Services and Labor. Other members included, State Senator Susan Castillo, State Representative JoAnn Bowman, Carla Freeman, Barbara Taylor, Ruth Ascher, and state program representatives including Elinor Hall and Suganya Sockalingam of OHD, and advocates representing the concerns and interests of the following racial and ethnic communities: African American, American Indian/Alaska Native, Asian/Pacific American, Hispanic/Latino.

Over the following year, the workgroup further investigated the Ohio Minority Health Commission and other standing bodies designed to improve health outcomes for racial and ethnic communities in other states. Closer to home, the workgroup also began a study of State programs addressing health issues for communities of color and identified the need for a more thorough inventory of these programs and of the funds allocated to them. In the discussions that followed these investigations, three important points became clear. First, there is a wide range of relevant issues that might benefit to some extent from additional attention and resources. Second, the greatest net benefit would most likely result from concentrated efforts focused on a small number of high priority issues. Third, each year or two, findings and recommendations should be reported to the Governor and Legislature, and a new set of high priority issues should be selected for the next round.

The workgroup identified two basic criteria for selecting these high priority issues: a.) each issue must substantially and persistently undermine the well-being of one or more racial or ethnic communities; b.) the issue must not already be receiving heightened attention and increased funding. The workgroup further realized that once the first set of priority issues had been identified and addressed, a second set would be identified, and so on. This iterative process could then continue to address ongoing and emerging issues of importance to racial and ethnic communities, and therefore of importance to Oregon as a whole. The proposed commission would set new priorities based on the best available information on health disparities and their effects on racial and ethnic communities. On this basis, six critical health issues (see below) were selected as the first to be addressed.

The work group also considered the composition of the commission it would propose. To maximize effectiveness, it would be important to include representation from the executive and legislative branches of state government, from local government health officials, from providers of health care, and of course from the various communities themselves. Only with all bases covered could the work group expect substantial improvement in health outcomes related to the six priority issues.

In early 1999, the concepts developed by the workgroup were written into Executive Order NO. EO-99-07. This Executive Order both created the Racial and Ethnic Health Task Force and identified its role and responsibilities as well as its first year's priorities. These six priorities for 1999/2000 are:

1. Adequate access to treatment for Oregonians with physical and mental health coverage, with adequate access being defined as medically appropriate care provided when necessary by culturally competent providers in a suitable setting;
2. HIV/AIDS
3. Diabetes
4. Asthma
5. Lead poisoning
6. Alcohol and drug abuse

Executive Order NO. EO-99-07 also set the Task Force membership at 21, and specified that it would include representation as follows: six members from the

Legislative Assembly; one member each from the Commission on Asian Affairs, the Commission on Black Affairs, the Commission on Hispanic Affairs, the Legislative Committee on Indian Services, the Oregon Medical Association, the Conference of Local Health Officials, the Oregon Association of Hospitals and Health Systems, and the Governor's Office; and seven additional members representing racial and ethnic communities. The Governor's Office then worked with leadership from the work group that had designed the Task Force to select and appoint the 21 members (attached to this report as page i – ii).

The Task Force began meeting in the summer of 1999, and set to work immediately on gathering information and hearing testimony from State officials and community representatives. At the Multicultural Health Conference held in April 2000, the Task Force conducted a series of round-table discussions on the six priority issues listed above. These discussions were facilitated to encourage free expression by all participants, and were open to all who attended the Conference. As had been hoped, participation was inclusive of all communities represented at the Conference, and discussion was sophisticated and on point.

In July 2000, a design team was convened to identify findings and possible recommendations for the report from the Task Force to the Governor and Legislature. The design team had both plenary sessions and targeted work groups on each of the six priority issues. The first plenary session reviewed the work of the Task Force to that point, including its meetings and the round table discussions at the Multicultural Health Conference. The six work groups, with each group addressing one of the six priority issues, followed this plenary. Each work group included presentations from experts on the priority issue in question, as well as candid discussion by Task Force members, community advocates, staff from community-based programs, and state and county officials responsible for programs addressing the issue. During this discussion, a scribe made note of findings and possible recommendations.

The design team meeting concluded with a plenary session during which a representative of each of the six work groups presented findings and possible recommendations. When candidate recommendations from all work groups had been posted on the walls of the meeting room, participants prioritized the recommendations by distributing 20 "vote dots" according to the importance they attached to the various recommendations that had proposed by the work groups.

Following the design team meeting, Task Force staff tabulated the results of the priority setting exercise and developed a matrix arraying the recommendations according to those results. The recommendations in this matrix represent the remedies to health disparities underlying the six issues identified in Executive Order-99-07. The presentation, explanation, and implementation of these recommendations are the purpose of this report to the Governor and Legislature.

RECOMMENDATION OVERVIEW

It is clear that Oregon is well positioned to begin the process of closing the health disparities gaps that continue to impact racial and ethnic communities in Oregon. This report represents a major step along the path. Success will depend on state government, communities and policy makers acting as a catalyst for change. The recommendations address the need for change on three different fronts; making better use of existing resources, changing policy directions and finding new resources to address important issues.

In the process of developing recommendations in the six priority areas, it was clear that several "cross-cutting" issues were seen as overarching issues. As a result, the report has two sections. The first section is a set of recommendations relating to the "cross-cutting" issues. The second section represents recommendations in each of the six priority areas assigned to the Task Force in the Executive Order.

The matrix used to present the Task Force Recommendations is intended to provide complete information and serve as a summary of several months of work and interactions with community, providers and policy makers. Additional information on the meetings and presentations that led to this report are included in the Appendix. The following is an explanation of the information contained on the matrix:

First Column: "Action Items"

These initiatives or action items are being recommended by the Task Force for the Governor's consideration. The format has been designed to present a menu of choices for follow-up action by Governor Kitzhaber. It is envisioned that the Governor will select his priorities from the Action Items offered as recommendations. Once selected for implementation, the State agency, department or division designated as the “lead” (see "Responsible" description below) will develop an implementation plan.

Second Set of Columns: "Policy - Budget - Legislation"

Each “Action Item” has been marked to designate whether the full implementation of the concept will require state government to: make policy changes; introduce new legislation or finance with new budget resources.

Third Column: "Responsible"

The first agency, department or division listed in this column and designated as "lead" is identified as the one responsible for facilitating development of the recommended action if approved by the Governor. This box also lists any other state departments, divisions, or offices needing to be involved in the planning and implementation process. The listing does not include other government agencies, private sector or community partners at this point. However, they will be added if the initiative is selected for further concept development.

Recommendations on Overarching Issues

This section consolidates recommendations that cut across several priority areas. These solutions address two or more of the priority areas in this report but do not replace the recommendations detailed in the sections that follow.

I. Data

A. The availability of sufficient data on racial and ethnic communities is key to positioning the state to compete for new sources of funding and determine a level of priority in decision-making processes. The Governor's Office is requested to charge the Department of Human Services with the responsibility to form a Racial & Ethnic Health Data Group that includes state and local government and community partners. The Data Group shall reflect the racial and ethnic diversity of the state. Additional funding will enable the Oregon Health Division to conduct enhanced data collection utilizing culturally appropriate methods. The focus shall be on collecting data that will support the State's efforts to eliminate health disparities in Oregon.

II. Establishing Deliverables for Eliminating Racial and Ethnic Health Disparities

A. The State of Oregon must adopt a common set of expectations and deliverables for State departments, local government agencies and private and public sector contractors to meet when state funds are being utilized. These expectations can best be developed by a work group led by the Department of Human Services in cooperation with the Racial and Ethnic Health Task Force. At a minimum, the standards shall address: access to services, language interpretation, diversity in planning and decision-making, training, workforce diversity (hiring, retention, cultural support systems for people of color and strategies for developing future workers).

POLICY	BUDGET	LEGISLATIVE	RESPONSIBLE
X	X	X	Oregon Health Plan Policy & Research (lead agency), Dept of Human Services, Oregon Health Division, Oregon Medical Assistance Program, Oregon Progress Board
X	X	X	Dept of Human Services (lead department), Dept of Administrative Services, Oregon Health Plan Policy & Research, Oregon Progress Board

III. The Changing Face of State Government

A. Diversity will be fully embraced by organizations when the make-up of the workforce at all levels and decision-making groups reflect the communities and individuals being served by state and local government. In order to achieve this goal, State government must make sure there is a pipeline for future talent that includes people of color and bi-lingual workers. In addition, state government must implement retention practices reflect this priority and provide support systems to ensure the success of people of color in the workplace. All decision-making and advisory bodies must reflect the many aspects of diversity that are representative of Oregon. The Governor must hold state departments and divisions accountable for progress in this area.

IV. Meeting the Needs of Under-served Communities in Oregon

A. People of color are over-represented in the populations faced with the greatest barriers to good health. The needs of migrant seasonal farm workers (documented and undocumented), new immigrants, individuals and families who are homeless, individuals served by the adult and juvenile criminal justice system, the dependent elderly, and people with physical and mental disabilities are often discriminated against as well as under-served by state systems. It is recommended that the Department of Human Services develop an inventory of programs on an annual basis with activity reports that describe activities specifically relating to the involvement and outcomes for people of color and other under-served populations.

POLICY	BUDGET	LEGISLATIVE	RESPONSIBLE
X			Governor's Affirmative Action Office (lead office) Dept of Administrative Services, Dept of Human Services, Oregon Health Division, Oregon University System, Dept of Community Colleges & Workforce Development, Oregon Health Sciences University
X			Dept of Human Services (lead department), Dept of Administrative Services, Dept of Employment, Oregon Health Division, Mental Health & Developmental Disability Services Division, Senior & Disabled Services Division, Vocational Rehabilitation Division, Office of Alcohol & Drug Abuse Programs, Dept of Corrections, Oregon Youth Authority, Adult & Family Services Division, Services to Children & Families Division

V. Office of Multicultural Health

The Office of Multicultural Health must be adequately funded, staffed and organizationally positioned to lead the State of Oregon's agenda to eliminate racial and ethnic health disparities. The Office must report to the Governor and have responsibility for overseeing the implementation of the adopted recommendations of the Racial and Ethnic Health Task Force and serving as a resource for programs serving racial and ethnic communities at the state, local and community levels.

A. Create a quasi-governmental Office of Multicultural Health that reports to the Governor. The office must have; a full staff; access to state resources and office space funded through the state; and provide on-going private, state and federal grant funding through a not-for-profit foundation staffed by an experienced grant writer.

B. The office will be accountable to a newly appointed Board of Directors, comprised of the directors of the State's cultural affairs offices, bipartisan representation from both houses of the legislature, the administrator of the Oregon Health division and representatives from the private sector. The Office of Multicultural Health will be granted authority to implement the work of the Racial and Ethnic Health Task Force.

POLICY	**BUDGET**	**LEGISLATIVE**	RESPONSIBLE
	X	**X**	Governor's Office (lead agency), Racial and Ethnic Health Task Force, Dept of Human Services
X	**X**	**X**	Governor's Office (lead agency), Racial and Ethnic Health Task Force, Dept of Human Services

Issue Area (1):

Access to treatment for Oregonians with physical and mental health coverage, with adequate access being defined as medically appropriate care provided when necessary by culturally competent sensitive in a suitable setting.

I. Goal Statement: Improve the availability of culturally relevant health and mental health services to persons from diverse racial and ethnic backgrounds. Provide persons with Limited English Proficiency with access to health care by ensuring certification and standards of interpreting and translation services. (Include all languages).

Action Items:

A. Establish an Interpreter and Translator Task Force. Establish policies and procedures that will effectively enable limited English speaking persons access to interpreter services. Establish a forum that will include representation from a broad spectrum of groups who are affected by interpreter services. Ensure that consumers of interpreter services are included in developing policies and practices that will assist the community at large.

B. Develop a set of common standards for interpreter services and assist in the implementation of standards for state departments. Establish policies and procedures that will ensure that the August 2000 "Guidance Memorandum" from the Office of Civil Rights and the 1978 Patients Bill of Rights of the American Hospital Association is upheld at a statewide level (including public and private sectors) for limited English speaking patients.

C. Establish funding sources for appropriate oversight of interpreter services statewide. The state oversight would include development and oversight of examinations, qualifications, curriculum, competency policies and consumer reports. Funding sources should be established to assist public and private sectors in qualified interpreting and translating services.

POLICY	BUDGET	LEGISLATIVE	RESPONSIBLE
X			Dept of Human Services (lead department), Mental Health & Developmental Disability Services Division, Oregon Health Division, Senior & Disabled Services Division, Oregon Medical Assistance Program, Insurance Pool Governing Board, Office of Alcohol & Drug Abuse Programs
X	X	X	Dept of Human Services (lead department), Mental Health & Developmental Disability Services Division, Oregon Health Division, Senior & Disabled Services Division, Oregon Medical Assistance Program, Insurance Pool Governing Board, Office of Alcohol & Drug Abuse Programs, Dept of Administrative Services, Dept of Consumer & Business Services, Dept of Corrections, Oregon Youth Authority, Dept of Justice
X	X	X	Department of Human Services (lead department), OHD-Office of Multicultural Health

II. Goal Statement: Develop and implement a common plan and expectations related to culturally competent services that apply to all DHS divisions and programs and their contractors at the local level. Improve access to culturally relevant health and mental health services to persons from diverse racial and ethnic backgrounds.

Action Items:	POLICY	BUDGET	LEGISLATIVE	RESPONSIBLE
A. Develop a Community Cultural Competency Plan. Ensure this is a community-driven process that involves DHS clients, divisions, community partners, local experts on diversity dynamics and contractors in the planning process. Adopt a common set of definitions, expectations, deliverables and standards for performance measurement for state and local programs and services funded by the state. The Plan should also address how performance will be monitored for effectiveness.	X	X		Dept of Human Services (lead department), Mental Health & Developmental Disability Services Division, Oregon Health Division, Senior & Disabled Services Division, Oregon Medical Assistance Program, Adult & Family Services, Services to Children & Families, Office of Alcohol & Drug Abuse Programs
B. Conduct a shared learning between DHS divisions and local partners on the delivery and accessibility of culturally competent services.	X	X		Dept of Human Services (lead department)
C. Create an oversight group made up of racial and ethnic community groups and consumers to assess if local health departments are providing culturally appropriate services. Move accountability for culturally appropriate service delivery to departments or divisions working closest to the actual customer of state funded services.	X	X		Dept of Human Services (lead department), OHD-Office of Multicultural Health
D. Expand access to traditional medical practices. Develop specialized programs for persons who require identifiable cultural approaches in appropriate settings.	X	X		Dept of Human Services (lead department)
E. Achieve a productive government-to-government relationship between the State of Oregon and Oregon Tribes to improve the delivery of health services on reservations. This should be reflected in the relationship and funding between Oregon Tribes and DHS and each of its divisions.	X	X		Dept of Human Services (lead department)

III. **Goal Statement:** Increase the representation of people of color and bi-lingual/bi-cultural staff trained in health care, medicine and health policy. Consistently include individuals who represent diverse perspectives and backgrounds in the policy and decision-making bodies created by state government.

Action Items:

	POLICY	BUDGET	LEGISLATIVE	RESPONSIBLE
A. Submit quarterly DHS reports on efforts to meet affirmative action goals to the Governor's Task Force on Racial and Ethnic Health.	X			Dept of Human Services (lead department)
B. Develop partnerships with higher education to recruit and train bilingual/bicultural and people of color in health fields. Encourage state departments and divisions to participate in school-to-work programs that expose students of color to health-related careers. Provide resources to ensure the retention and skill development of existing employees.	X			Oregon University System (lead department), Dept of Community Colleges & Workforce Development, Dept of Administrative Services, Oregon Health Sciences University, Oregon Student Assistance Program, Scholarship Commission
C. Utilize lay workers to provide health services and provide appropriate training and oversight.	X			OHD-Office of Multicultural Health (lead division), Oregon Health-related Licensing Boards,
D. Develop partnerships with professional licensing boards and organizations to increase diversity in professions where people of color and bi-lingual/bi-cultural individuals are under-represented. Introduce legislation to require health licensing boards to increase the representation of people of color and bilingual licensees and report bi-annually to the Legislature.	X	X		Governor's Affirmative Action Office (lead office), Oregon Health-related Licensing Boards
E. Direct state department directors and division administrators to ensure, when appointing a policy-making and/or advisory body, that the appointments reflect the population that is being served.	X			Dept of Administrative Services (lead agency), Oregon Health Plan Policy & Research

IV. **Goal Statement:** Improve the availability of relevant health data regarding people of color in the state.

<u>Action Items:</u>

A. Develop a plan and secure funding to increase collection of health-related data for people of color and other under-represented populations. Funding is needed to implement new techniques for collecting data that are culturally sensitive and more effective. (Refer to page 7, item I.A.)

B. Develop and adopt a common set of definitions and agreement on how data will be collected and made available to other departments, divisions, community organizations and the public.

C. Involve communities of color in planning and administering quantitative and qualitative methods of data collection. The Task Force and community partners shall be involved in prioritizing data needs to support the work of the Governor's Task Force.

POLICY	BUDGET	LEGISLATIVE	RESPONSIBLE
X	X	X	Dept of Human Services (lead department), Oregon Health Division, Oregon Health Plan Policy & Research, Oregon Progress Board
X			Oregon Progress Board (lead agency) Oregon Health Division, Dept of Human Services, Oregon Health Plan Policy & Research
X			Dept of Human Services (lead department), Oregon Health Division, Oregon Health Plan Policy & Research, Oregon Progress Board

V. **Goal Statement:** Address resource, access and financial barriers that prevent quality health care. Reduce the high rate of uninsured and under-insured among racial and ethnic populations.

<u>Action Items:</u>

A. Explore new sources of revenue (e.g., beer and wine tax) to address health care needs in communities of color. Areas of focus include newly arrived immigrant groups and migrant seasonal farm workers.

B. Increase community funding and/or redirect funds for outreach to target populations in order to increase access to state supported programs and services. Outreach is needed in order to increase enrollment for racial and ethnic communities in the Children's Health Insurance Program (CHIP) and the Family Health Insurance Assistance Program (FHIAP).

C. Develop a plan to address the need for more culturally competent health care providers in rural areas to serve Oregon Health Plan clients; especially primary care, language interpreters, and technology resources. Identify incentives for providers in areas where services are not available or difficult to access because of language barriers, transportation problems or shortage of qualified service providers.

D. Remove barriers that currently prevent health care providers such as physicians assistants within the state from providing culturally sensitive health care to racial and ethnic communities.

POLICY	BUDGET	LEGISLATIVE	RESPONSIBLE
	X		Dept of Human Services (lead department), Oregon Health Division, Oregon Health Plan Policy & Research
X	X		Dept of Human Services (lead department), Oregon Health Division, Insurance Pool Governing Board
X	X		Oregon Health Division (lead division), Oregon Health Plan Policy & Research, Dept of Human Services, Oregon Medical Assistance Program, Office of Rural Health
X	X	X	*Pacific University (lead agency)*[1]

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[1] Non-State Partner

VI. **Goal Statement:** Support and provide technical assistance for community advocacy groups in order to assist with health education activities and advocacy.

	POLICY	BUDGET	LEGISLATIVE	RESPONSIBLE
<u>Action Items:</u>				
A. Provide education on emerging health-related issues like long-term care needs and involve community voices in the planning of new programs and services.	X	X		Dept of Human Services (lead department), Oregon Health Division, Oregon Medical Assistance Program, Senior & Disabled Services Division
B. Develop new outreach strategies to reach communities of color and involve community members in community health promotion for the individual, family members, work place and community. Develop partnerships between private and public sector partners to implement a community specific wellness movement. (Refer to page 7, item II.A.)	X			Oregon Health Division (lead division), Senior and Disabled Services Division

Issue Area (2):

Alcohol, Tobacco and Other Drug Abuse Prevention and Treatment

I. **Goal Statement:** The needs and voices of communities of color should be represented at every stage of the fight against alcohol, tobacco and other drug abuse.

Action Items:

A. Change norms in communities of color toward the importance of prevention and treatment of substance abuse and mental health treatment through community education and outreach.

B. Close information gaps by collecting quantitative and qualitative data on alcohol and drug use and abuse in communities of color. (Refer to page 7, item I.A.)

C. Require state divisions to involve more people of color in the provision and administration of prevention services and treatment to communities of color through contractual provisions between DHS and counties.

D. Develop model processes and shared standards among DHS divisions that are based on community needs in order to implement culturally appropriate services. Areas to include: male role models of color, language interpretation services, sign language, treatment modalities for addressing alcohol and substance abuse issues.

E. Work directly with Tribes and urban Indian programs to develop culturally appropriate models for prevention and treatment.

POLICY	BUDGET	LEGISLATIVE	RESPONSIBLE
X	X		Office of Alcohol & Drug Abuse Programs (lead division), Senior & Disabled Service Division
X	X		Office of Alcohol & Drug Abuse Programs (lead division), Oregon Health Plan Policy & Research, Oregon Medical Assistance Program, Oregon Progress Board
X			Office of Alcohol & Drug Abuse Programs (lead division)
X	X	X	Dept of Human Services (lead department), Office of Alcohol & Drug Abuse Programs, Senior & Disabled Services Division, Mental Health & Developmental Disability Services Division
X			Dept of Human Services (lead department), Office of Alcohol & Drug Abuse Programs

II. **Goal Statement:** Take steps to prevent alcohol, tobacco and other drug abuse from beginning and intervene early and effectively in cases of substance abuse.

Action Items:

A. Advocate for changes in business and advertising practices that target people of color. For example, explore methods to get the liquor industry to fund advertising to discourage underage drinking in communities of color.

B. Through contractual provisions between DHS and counties, add prevention dollars to alcohol, tobacco and other drug services in communities of color. Conduct community outreach to inform community members about the availability of treatment and prevention resources. Implement "drug free" housing programs and utilize mentors as a prevention strategy.

C. Educate medical providers to identify alcohol, tobacco and other drug abuse as a health issue of importance to racial and ethnic communities and make culturally appropriate referrals. DHS shall require any contract between the department and health plan organizations and managed care organizations to educate their medical providers to be culturally sensitive and make sure they subcontract with providers that represent communities of color.

D. Target community programs to address youth perceptions of alcohol, tobacco and other drugs, and integrate substance abuse education with youth violence initiatives.

POLICY	BUDGET	LEGISLATIVE	RESPONSIBLE
X	X	X	Office of Alcohol & Drug Abuse Programs (lead division), Oregon Housing and Community Services, Oregon Liquor Control Commission, *Grocers Association*[1]
X	X	X	Office of Alcohol & Drug Abuse Programs (lead division), Oregon Liquor Control Commission
X		X	Office of Alcohol & Drug Abuse Programs (lead division), Oregon University System, Dept of Community Colleges & Workforce Development, *Oregon Medical Association*[2]
X	X		Office of Alcohol & Drug Abuse Programs (lead division), Oregon Youth Authority

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[1] Non-State Partner

[2] Non-State Partner

III. **Goal Statement:** Ensure that substance abuse treatment services adequately serve the needs of racial and ethnic communities.

Action Items:

	POLICY	BUDGET	LEGISLATIVE	RESPONSIBLE
A. Expand the availability of quality residential services for communities of color in community-based, minority-operated settings. Address the gaps in residential treatment facilities that compromise the care of adults with older children, seniors and youth.	X	X		Office of Alcohol & Drug Abuse Programs (lead division)
B. Require treatment facilities to address the needs of families of individuals with alcohol and/or drug problems as a part of the treatment plan. Provide family counseling, drug-free housing and other support services.	X			Office of Alcohol & Drug Abuse Programs (lead division), Mental Health & Developmental Disability Services Division
C. Require that treatment dollars are used in the most effective manner and evaluated to meet community needs based on appropriate, identified outcomes. Identify best practices and fund treatment programs that provide the most effective and culturally specific services.	X			Office of Alcohol & Drug Abuse Programs (lead division)
D. Provide treatment for alcohol and drug abusers before they enter the adult and/or juvenile justice systems to avoid using the correctional facilities as treatment programs.	X			Office of Alcohol & Drug Abuse Programs (lead division), Dept of Corrections, Oregon Youth Authority, Oregon Medical Assistance Program, Insurance Pool Governing Board
E. Address the discontinuity in insurance coverage and health care that follows incarceration for many released prisoners.	X			Dept of Corrections (lead department), Oregon Youth Authority, Office of Alcohol & Drug Abuse Programs, DCBS-Insurance Pool, Oregon Medical Assistance Program

Issue Area (3):

Reduce the disproportionate impact of asthma on communities of color

I. **Goal Statement:** Improve coordination of asthma control efforts to improve outcomes for communities of color in Oregon.

<u>Action Items:</u>

	POLICY	BUDGET	LEGISLATIVE	RESPONSIBLE
A. Require that the Statewide Asthma Network is well represented by diverse community representatives and interests. Create a linkage between the Network and the Governor's Task Force on Racial and Ethnic Health and the Office of Multicultural Health.	X			OHD-Asthma Program (lead division), Office of Multicultural Health
B. Establish agreements with the Oregon Medical Association, Oregon Academy of Pediatrics, and other professional associations to cooperate with the activities of the Governor's Task Force on Racial and Ethnic Health on asthma outreach, education and treatment.	X			Oregon Health Division (lead division), Office of Multicultural Health
C. Require that the Oregon Asthma Program involve communities of color to reduce the burden of asthma in racial and ethnic communities. Utilize culturally specific strategies to obtain input from racial and ethnic communities, include making meetings accessible through their location, language interpretation, and facilitation.	X			OHD-Asthma Program (lead division)
D. Increase resources for asthma prevention and care. Explore new and sustainable resources to increase services in communities of color, including asthma education, asthma clinics, and asthma management resources.	X	X	X	Dept of Human Services (lead department), Dept of Motor Vehicles, OHD-Tobacco Program, Oregon Medical Assistance Program

Action Items:

	POLICY	BUDGET	LEGISLATIVE	RESPONSIBLE
E. Acquire funding to support statewide and local public health surveillance for use in the development of appropriate interventions, evaluation, and new data resources. Refer to page 7, item I.A.)	X	X	X	OHD-Asthma Program (lead division), OHD-Vital Statistics (BRFSS)
F. Research and implement national and local programs/initiatives that mobilize individual and community support for lifestyle changes that can prevent asthma attacks. Identify best practices and involve and support racial and ethnic communities in creating programs to meet their needs in a culturally relevant manner.		X		Oregon Health Division (lead division)
G. Work directly with Tribes and urban Indian programs to develop culturally appropriate models for prevention and treatment.	X			Dept. of Human Service (lead department), Oregon Health Division

II. **Goal Statement:** Conduct asthma education and outreach in communities of color.

Action Items:

	POLICY	BUDGET	LEGISLATIVE	RESPONSIBLE
A. Develop and implement a targeted outreach and education effort to reach communities of color. Partner with the public and private sectors to increase outreach and leverage new resources. Develop strong and effective community partnerships with childcare providers, employers, schools, medical providers, faith organizations and business community members to support asthma education, treatment, and prevention.	X	X		OHD-Asthma Program (lead division), Oregon Youth Authority, Dept of Education
B. Provide culturally relevant early detection and "living with asthma" classes. Involve racial and ethnic communities, health care providers, partner associations and private sector resources to provide information and possible subsidies for the purchase of peak flow meters, other treatments, and tools for self-management and education.	X	X		OHD-Asthma Program (lead division)
C. Utilize national and local education efforts targeted at every age group and designed to teach the community about the triggers of asthma. Address topics such as indoor and outdoor air quality, second-hand smoke, dust mites, roaches, and pesticides as triggers. Educate communities of color concerning the behavioral and psychological aspects of asthma to enable individuals to live well with the disease.	X	X		OHD-Asthma Program (lead division), Dept of Environmental Quality, OHD-Tobacco Program, OHD-0ccupational Health

Issue Area (4):

Reduce the disproportionate impact of diabetes on racial and ethnic communities.

I. **Goal Statement:** Initiate and support targeted health awareness and prevention campaigns and increase screening to identify undiagnosed cases of diabetes with the support and involvement of impacted communities.

Action Items:

A. Utilize national and local education efforts targeted at every age group and designed to teach the community about the warning signs. Educate communities about diabetes risk factors, symptoms, positive and negative outcomes and encourage early screening and treatment.

B. Research and implement national and local programs / initiatives that mobilize individual and community support for lifestyle changes that can delay or prevent the onset of diabetes. Focus efforts on diet, exercise and elimination of smoking at a community level. Identify best practices, and involve and support racial and ethnic communities in creating programs to meet their needs in a culturally relevant manner.

POLICY	BUDGET	LEGISLATIVE	RESPONSIBLE
X	X		OHD-Diabetes Program (lead division), Dept of Education, Oregon Youth Authority, Dept of Corrections, Senior & Disabled Services Division, Oregon Medical Assistance Program
X			OHD-Diabetes Program (lead division),

II. **Goal Statement:** Coordinate health care providers and organizations to deliver effective, holistic and culturally relevant treatment to diabetes patients and their families/support network.

Action Items:

A. Require that the health care system make timely and appropriate referrals to specialists for diabetes management especially in the early stages of the disease. Provide information to communities on treatment options and how to access the best care available.

B. Increase the number of diabetes educators of color and bilingual educators available to serve communities by providing educational grants, scholarships, and low interest loans. Recruit Certified Diabetes Educators (CDE's) from other states and provide incentives to relocate.

C. Fund new and existing programs to teach culturally relevant self-management skills to people with diabetes.

D. Provide psychological and psychiatric support for individuals diagnosed with diabetes. Educate medical providers to listen to diabetes patients' questions and needs, make referrals to service providers and teach patients to articulate their needs to providers.

E. Develop strong and effective community partnerships among divisions, organizations, people living with diabetes, service organizations, community media, public departments and schools, grassroots organizations, insurers, pharmaceutical companies, faith organizations, business community and funding organizations to support diabetes education and outreach efforts.

F. Utilize physicians and insurers to provide information to patients about accessing resources available in the community.

G. Track diagnosed patients and provide continuing care by providing information and access. Inform them of "best practices", education and tools in the community.

POLICY	BUDGET	LEGISLATIVE	RESPONSIBLE
X	X	X	Oregon Health Plan Policy & Research (lead agency), Oregon Medical Assistance Program
X	X	X	Oregon Health Division (lead division), Oregon Medical Assistance Program, Oregon University System, Dept of Community Colleges & Workforce Development
X	X		OHD-Diabetes Program (lead division)
X	X		Mental Health & Developmental Disability Services Division (lead division)
X	X		OHD-Diabetes Program (lead division), Senior and Disabled Services Division, Dept of Corrections, OR Youth Authority, Oregon Medical Assistance Program, Insurance Pool Governing Board
X			Oregon Medical Assistance Program (lead division), Insurance Pool Governing Board, *Oregon Medical Association*[1]
X	X	X	Oregon Medical Assistance Program (lead division), Insurance Pool Governing Board

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[1] Non-State Partner

III. **Goal Statement:** Improve data collection measures on racial and ethnic communities on the prevalence of diagnosed and undiagnosed people with diabetes as well as barriers to screening and care.

Action Items:

A. Collect improved data on all ethnic/racial populations using model methods for data collection. Current data is especially lacking in Asian/Pacific Islander and Russian populations. Refer to page 7, item I.A.)

B. Identify and reduce barriers to self-management and treatment faced by racial and ethnic populations living with diabetes including the problems caused by the increased financial burdens of people living with diabetes. Quantify results of improved self-management and better access to care.

POLICY	BUDGET	LEGISLATIVE	RESPONSIBLE
X	X		OHD-Diabetes Program (lead division), OHD-Vital Statistics, Oregon Progress Board
X	X		OHD-Diabetes Program (lead division), Oregon Medical Assistance Program, Senior & Disabled Services Division, Oregon Progress Board

IV. **Goal Statement:** Introduce, improve and or strengthen existing legislation and budgets that will improve diabetes prevention and treatment for racial and ethnic communities.

Action Items:	POLICY	BUDGET	LEGISLATIVE	RESPONSIBLE
A. Research and adopt "best practices" developed nationwide to use in developing new programs, legislation, and budgets for communities of color. Conduct reviews, and share information with community based programs on "state of the art" programs that have been successful in other parts of the country.	X	X	X	OHD-Office of Multicultural Health (lead division), OHD-Diabetes Program
B. Introduce and/or support legislation to provide funding and insurance reimbursement for diabetes education taught by certified diabetes educators or qualified health professionals with training on diabetes education. Increase the use of lay health educators to provide services. Negotiate the addition of an associate-level CDE lay-educator class.		X	X	Dept of Human Services (lead department), Dept of Consumer & Business Services, Dept of Community Colleges & Workforce Development
C. Generate state and local government funding to match federal funds for addressing diabetes and related complications. Seek potential funding, in-kind support, marketing resources and partnership opportunities with foundations and other public and private sector organizations.		X		OHD-Office of Multicultural Health (lead division), OHD-Diabetes Program
D. Work directly with Tribes and urban Indian programs to develop culturally appropriate models for prevention and treatment.	X			Dept of Human Services (lead department), Oregon Health Division

Issue Area (5):

HIV/AIDS

I. **Goal Statement:** Ensure that the needs of racial and ethnic communities are accounted for in the allocation of resources for HIV/AIDS prevention and treatment.

Action Items:

A. Fund capacity-building infrastructure needs of community-based organizations, as identified by those institutions, in order to empower those organizations to diversify funding streams to serve communities of color. Implement a system that allows for more opportunities for directly funding community-based organizations. Develop a solid infrastructure for board development, successful grant applications and stabilized financial systems and staffing.

B. Require representation for people of color on HIV prevention and services planning committees and advisory groups at the state and local levels. Require that the involvement of new members is meaningful and inclusive of individuals from many backgrounds, interests and perspectives. Require that the needs of people of color from rural areas and non-English speaking communities are not overlooked in statewide planning efforts.

C. Fund improved qualitative and quantitative HIV data collection for communities of color. Include people of color from racial and ethnic communities in the outreach efforts, and the analysis of the findings of both qualitative and quantitative data collection. Require data sharing between the Oregon Health Division and Oregon Medical Assistance Program.

POLICY	BUDGET	LEGISLATIVE	RESPONSIBLE
X	X		OHD-HIV/STD/TB Program (lead division), OHD-Office of Multicultural Health
X			OHD-HIV/STD/TB Program (lead division), OHD-Office of Multicultural Health, OHD-Community Partnerships
X	X	X	OHD-HIV/STD/TB Program (lead division), OHD-Vital Statistics, OHD-Office of Multicultural Health, Oregon Medical Assistance Program, Oregon Progress Board

	POLICY	BUDGET	LEGISLATIVE	RESPONSIBLE
D. Review and report to the Task Force on the new guidelines for HIV case managers issued in July 2000 for consistency and impact on communities of color. The new guidelines must help to assure that communities of color receive adequate resource levels, staffing, and services that meet the needs of individual racial and ethnic communities.	X			OHD-HIV/STD/TB Program (lead division), OHD-Office of Multicultural Health, Dept of Human Services
E. HIV prevention and treatment activities must reflect community needs.	X	X		OHD-HIV/STD/TB Program (lead division)
F. Work directly with Tribes and urban Indian programs to develop culturally appropriate models for prevention and treatment.	X			Dept of Human Service (lead department), Oregon Health Division

II. **Goal Statement:** Ensure that people of color living with HIV/AIDS are able to access culturally competent and affordable care.

Action Items:

	POLICY	BUDGET	LEGISLATIVE	RESPONSIBLE
A. Provide incentives to physicians who treat HIV patients in rural and under-served areas. There is a barrier in finding culturally competent clinicians willing to accept patients and administer treatments. Clinicians serving HIV patients are difficult to find in rural areas.	X	X		Oregon Medical Assistance Program (lead division), Insurance Pool Governing Board, Office of Rural Health
B. Establish cultural and linguistic competency as a requirement for HIV/AIDS educators and service providers.	X	X	X	OHD-HIV/STD/TB Program (lead division), OHD-Office of Multicultural Health, Oregon Medical Assistance Program
C. Fund the Needle Exchange Program as a prevention strategy for high-risk HIV populations.	X	X	X	Oregon Health Division (lead division)

III. **Goal Statement:** Expand efforts to educate and involve the community outside of the current HIV/AIDS system to the need for prevention, education and improvement of treatment services.

Action Items:

A. Maximize the benefit from mandated HIV education programs by holding state and local education departments accountable for increasing the quality and quantity of educational programs in schools.

B. Involve the public and private sector departments and employers in creating programs to return HIV positive individuals to the workforce. Model programs exist (e.g. Welfare-to-Work, Better People Program) to serve as examples. Explore the need for legislative changes to ensure employee rights to adequate insurance coverage and employment rights.

C. Establish cooperative agreements between the Oregon Health Division, Oregon Medical Assistance Program, managed care plans and community partners on prevention efforts at the individual and community level.

D. Assure access to education and screening in communities of color.

POLICY	BUDGET	LEGISLATIVE	RESPONSIBLE
X	X		Dept of Education (lead department), OHD-HIV/STD/TB Program, Oregon University System, Dept of Community Colleges & Workforce Development, Oregon Youth Authority, Dept of Corrections
X	X		Dept of Human Services (lead department), Vocational Rehabilitation Division, Oregon Health Division, Oregon Medical Assistance Program, Adult and Family Services, Dept of Corrections
X			OHD-HIV/STD/TB Program (lead division), Oregon Medical Assistance Program, Insurance Pool Governing Board
X	X		OHD-HIV/STD/TB Program (lead division)

Issue Area (6):

Lead Poisoning

I. **Goal Statement:** To prevent lead exposure to children from racial and ethnic communities, and to assure access to screening for those children who are potentially at risk for exposure.

<u>Action Items:</u>

	POLICY	BUDGET	LEGISLATIVE	RESPONSIBLE
A. Develop new funding streams to support lead poisoning prevention efforts. Create new partnerships with State divisions and organizations in the public and private sector. Explore legislative changes that would generate new revenue through collecting fees on certain types of real estate transactions to fund prevention efforts such as repainting older, high-risk houses.	X	X	X	OHD-Lead Program (lead division)
B. Assure that funding for Local Health Departments (LHD's) is sufficient for funded collaborations/contracts with community-based organizations that are organized to serve racial and ethnic communities. Fund health promoters through LHD's. Fund community-based organizations to build infrastructure and capacity to provide culturally appropriate lead poisoning prevention and education services. Assure that community-based organizations can pay a living wage in order to recruit and retain qualified employees.	X	X	X	Oregon Health Division (lead division)
C. Work with Oregon Health Division's Lead Program and the Office of Multicultural Health to develop assurances with the Conference of Local Health Officials (CHLO) to assure that testing and investigation services are culturally and linguistically competent.	X			OHD-Lead Program (lead division), OHD-Office of Multicultural Health
D. Convene a subcommittee of the Task Force to review the findings of the OHP Pilot Lead Screening Project among children living in high-risk communities. The subcommittee shall make recommendations based on the report regarding future screening protocols for OHP Children. The recommendations shall also take into consideration the HCFA and CDC guidelines for lead testing of children.	X		X	OHD-Lead Program (lead division), Oregon Medical Assistance Program

II. **Goal Statement:** Improve the information available on the scope and impact of lead poisoning on communities of color in Oregon.

Action Items:

	POLICY	BUDGET	LEGISLATIVE	RESPONSIBLE
A. Fund studies of the prevalence of lead paint in pre-1978 housing throughout the state. The Multnomah County studies provide a framework for conducting other studies.		X		Oregon Health Division (lead division), Oregon Housing & Community Services
B. Monitor lead screening data and utilize information in reviewing current policies and making changes as necessary in the policies of DHS and other state departments and divisions (i.e. Oregon Housing and Community Services Department).	X			OHD-Lead Program (lead division), Oregon Housing & Community Services
C. Fund testing for uninsured/underinsured children, follow-up investigation and mitigation education for any child with elevated blood lead levels, and referral to care when indicated.	X	X		Oregon Health Division (lead division)
D. Utilize strategies that assure efficient service delivery to populations at risk for lead poisoning by integrating blood-lead screening services into community immunization clinics, health fairs, and community-based testing clinics. Use health promoters who come from the community in order for them to outreach to communities of color that naturally congregate in places such as churches, Migrant Head Start clinics, etc.		X		Oregon Health Division (lead division)

III. **Goal Statement:** Increase targeted outreach and education strategies through the use of traditional and non-traditional activities to prevent lead poisoning.

Action Items:

	POLICY	BUDGET	LEGISLATIVE	RESPONSIBLE
A. Initiate a cooperative educational program with state and local education departments and local health departments to increase the knowledge level of special education programs and teachers on the prevention of lead poisoning.	X			OHD-Lead Program (lead division), Dept of Education, Dept of Human Services
B. Provide culturally appropriate information to racial and ethnic communities on the risks created by exposure to pottery with lead-containing glazes. Work with community groups and retailers to reduce lead poisoning caused by exposure to pottery.	X			OHD-Lead Program (lead division)
C. Develop a program to test rental houses and apartments for lead and require that those with unhealthy levels of lead be repainted.	X	X		OHD-Lead Program (lead division), Dept of Consumer & Business Development

IV. **Goals Statement:** Fund development of rural and urban models for comprehensive pilot intervention programs in targeted geographic areas (e.g. large neighborhoods or small communities) where the prevalence of older housing and poverty indicate potential risk to children from racial and ethnic communities.

<u>**Action Items:**</u>	**POLICY**	**BUDGET**	**LEGISLATIVE**	**RESPONSIBLE**
A. Provide funding to develop the capacity for community involvement in the development of the prevention efforts and include resources for full process and outcome evaluation. For example: structure components to include an intensive community awareness/mobilization strategy; household risk assessment; on-site testing; referral to care as needed; education and tools necessary for household lead exposure reduction (e.g. CLEARCorp Resident Intervention Model); referral to low-income lead remediation programs; follow-up with parents/guardians. Move or expand the pilot interventions into additional areas at risk if the program is successful.	X	X		OHD-Lead Program (lead division)
B. Work directly with Tribes and urban Indian programs to develop culturally appropriate models for prevention and treatment.	X			Dept of Human Services (lead department), Oregon Health Division