Oregon Health Fund Board

Delivery Systems Committee Recommendations

Report to the Oregon Health Fund Board

May 2008

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Oregon Health Fund Board — Delivery Systems Committee Recommendations

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Section 1: Introduction and Summary of Recommendations

I. Executive Summary

Background

In June 2007, the Oregon Legislature passed the Healthy Oregon Act (Senate Bill 329, Chapter 697 Oregon Laws 2007). The Act called for the appointment of the seven-member Oregon Health Fund Board to develop 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 Healthy Oregon Act also established a set of committees to develop recommendations on specific aspects of the reform plan. One of these committees, the Delivery Systems Committee, was assigned the difficult task of providing the Board with policy recommendations to create high-performing health delivery systems in Oregon that produce optimal value through the provision of high quality, timely, efficient, effective, and safe health care.

While the Oregon Health Fund Board did not aim to limit the scope of the investigation and recommendations from the Delivery Systems Committee, the Committee's charter from the Board listed a number of priority areas of interest. These included: revitalizing primary care; managing chronic disease; developing new reimbursement models; increasing information transparency by collecting, measuring and reporting quality data; encouraging the diffusion of health information technology; ensuring the appropriate diffusion and utilization of clinical technology; strengthening public health and prevention; and improving end-of-life-care (See Appendix A for Delivery Systems Committee Charter).

Vision Statement

The Delivery Systems Committee has a bold vision for health care in Oregon: *World Class Health Care for Each Oregonian*. This includes world class physical, behavioral and oral health. The current delivery system is broken and unsustainable and world class care cannot be achieved within the existing framework. Achieving world class care requires a radical transformation, as part of larger comprehensive reform. This must include a revitalization of primary care and a focus on preventing and managing chronic diseases, while improving the quality of care across the health care system. The people and the economy of the state cannot wait any longer – transformation is needed now.

Delivery System Change as Part of Comprehensive Reform

The Committee developed a series of recommendations which the members believe will help to contain costs over the long term, while improving population health and improving patient experience with care. Many of these recommendations are aligned with the Board's priority areas, with some additional ideas drawn from health service research and experience in other states. The main recommendations are captured in the Committee's "Framework for Delivery System Reform" presented in Section V of this report. The Delivery System Committee recognizes that most of the recommendations put forth in this report represent long-term goals that cannot be accomplished in isolation and must be viewed as one piece of larger reform. In the short tem, many of the recommendations that follow will require an investment in sustainable change and the Health Fund Board must look for opportunities to reduce short-term spending in other parts of the system that can be reinvested in delivery system reform.

The recommendations presented below call for transformational change in the fundamental way things are done. The recommendations represent a significant cultural change in the organization and delivery of care and require strong public/private partnerships in the design, delivery, and monitoring of health care services. The Committee recognizes that there will be strong opposition to many of its proposals and challenges the Health Fund Board, the Oregon Legislature and the entire state to have the political will to push for the changes needed to move Oregon toward a world class health system.

Committee Recommendations

Primary Care and Chronic Disease Management/ Integrated Health Homes

Primary Care/Integrated Health Homes Recommendation 1: Oregon's primary health care delivery system must be radically transformed in an effort to improve individual and population health and wellness. This transformation should be guided by the concept of the integrated health home and must involve a revitalization of primary care, as well as other health and social services that are vital components of a system equipped to meet the health needs of the population. The state should take bold steps to partner with consumers, providers, purchasers and payers around the common goal and vision of providing every Oregonian with an integrated health home.

Primary Care/Integrated Health Homes Recommendation 2: Promote and support patient-centered integrated health homes to be available for all participants in the Oregon Health Fund Board Program, with eventual

statewide adoption to ensure integrated health homes are available to all Oregonians.

Primary Care/Integrated Health Homes Recommendation 3: Create and support interactive systems of care (real and virtual) which connect integrated health homes with community-based services, public health, behavioral health (including Employee Assistance Programs), oral health, and social services to improve population health.

Primary Care/Integrated Health Homes Recommendation 4: Provide Oregon's health care workforce with technical assistance, resources, training and support needed to transform practices into integrated health homes.

Primary Care/Integrated Health Homes Recommendation 5: Develop a plan to ensure that Oregon has a workforce able to meet population need, especially safety net providers and those serving vulnerable populations.

Primary Care/Integrated Health Homes Recommendation 6: Develop and evaluate strategies to empower consumers to become more involved in their own health and health care by partnering and engaging with integrated health homes.

Primary Care/Integrated Health Homes Recommendation 7: Develop funding, payment and incentivizing strategies that promote and sustain integrated health homes and other system of care partners.

Primary Care/Integrated Health Homes Recommendation 8: Recognize, strengthen and integrate the role of the safety net in delivering services to Oregon's vulnerable populations.

Improving Quality and Increasing Transparency

An Oregon Quality Institute

While there are numerous public and private efforts underway across the state to 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 Committee recommends the state establish and provide substantial, long-term funding for a publicly chartered Oregon Quality Institute (See Appendix C for full Quality Institute Work Group Recommendations).

Quality Institute (QI) Recommendation 1: An Oregon Quality Institute should be established as a publicly chartered public-private organization. The state should provide stable long-term funding to support the Institute.

QI Recommendation 2: 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. 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.

2. Convene public and private stakeholders to align all groups around common quality metrics for a range of health care services

3. Ensure providers have the ability to produce and access comparable and actionable information about quality, utilization of health care resources and patient outcomes that allows for comparison of performance and creation of data-driven provider and delivery system quality improvement initiatives.

4. Ensure the collection and timely dissemination of meaningful and accurate data about providers, health plans and patient experience. Set standards for what metrics are collected and reported and how data is collected and reported. Set performance benchmarks that can be adapted over time.

5. Advise the Governor and the Legislature on policy changes/regulations to improve quality and transparency.

QI Recommendation 3: 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:

- Participate in the development and assessment of new quality improvement strategies by championing, coordinating, funding and/or evaluating quality improvement demonstration and pilot projects.

- 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.

- Align with recommendations of the Governor's Health Information Infrastructure Advisory Committee (HIIAC) about a strategy for implementing a secure, interoperable computerized health network to connect patients and health care providers across Oregon. Support efforts to develop and facilitate the adoption of health information technology that builds on provider capacity to collect and report data and ensures that the right information is available at the right time to patients, providers, and payers.

- 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.

Financial Transparency

There needs to be greater transparency about health care costs and provider operating and financial data. While there are a number of state-sponsored projects working to increase financial transparency in Oregon, access to this type of information remains limited.

Financial Transparency Recommendation 1: Require health care providers, including but not limited to hospitals, ambulatory surgery and imaging centers to be more transparent and public about fiscal information.

Accountable Care Districts

Accountable care districts will act as a vehicle to foster shared accountability for quality and cost among all of the providers (including physicians, other health care professionals, hospitals, and other centers where health care is delivered) serving a defined population across the continuum of care.

Accountable Care District (ACD) Recommendation 1: Define accountable care districts within Oregon's delivery system. All health care quality and utilization data reported by the Oregon Quality Institute will be aggregated to allow for meaningful comparisons of quality and utilization across the state and across ACDs.

ACD Recommendation 2: Engage and incentivize communities at the onset, to use ACD data to inform health planning and resource utilization discussions.

Payment Reform Models

The current healthcare delivery system relies heavily on a fee-for-service (FFS) payment method in which a provider is paid a fee for rendering a specific service. This system rewards providers based on the volume of care delivered, without including incentives that encourage high-quality care and efficient resource utilization. New reimbursement models are needed that incentivize health care providers to be accountable for quality, efficiency and care coordination.

Payment Reform Recommendation 1: Health care providers (physicians, other health care professionals, hospitals, and other centers delivering care) should be accountable for quality, efficiency, health outcomes and care coordination. Payment reform should be designed to incentivize these desired outcomes, while holding global Oregon health care costs to Consumer Price Index as measured over a five year period.

Payment Reform Recommendation 2: New payment models should be tested within the infrastructure established by delivery system reform.

Comparative Effectiveness and Medical Technology Assessment

Comparative effectiveness research provides valuable information about the relative effectiveness and cost-effectiveness of alternative treatment options. This information can be used to develop standard clinical guidelines and inform benefit design to ensure that health resources are utilized in a manner that maximizes health gains. There are currently a number of comparative effectiveness and medical technology assessment initiatives in place in Oregon and across the nation, but no mechanism to facilitate collaboration across efforts or to ensure that coverage decisions across the state are informed by the best available research and data.

Comparative Effectiveness Recommendation 1: Streamline and strengthen efforts to support comparative effectiveness research and ensure policy decisions are informed by the best available evidence.

Comparative Effectiveness Recommendation 2: Endorse patient decision aids shown to increase the use of cost-effective care.

Comparative Effectiveness Recommendation 3: Develop standard sets of evidence-based guidelines for Oregon based on comparative effectiveness research.

Comparative Effectiveness Recommendation 4: Develop common policies across public and private health plans regarding the coverage of new and existing treatments, procedures and services based on comparative effectiveness research.

Shared Decision Making

In a world class health system that delivers patient-centered care, providers work with patients and their families to make health care decisions aligned with their values and goals. Decision support processes can help patients understand the likely outcome of various care options, think about what is personally important about the risks and benefits of each option and make decisions with the support of their care team.

Shared Decision Making Recommendation 1: The Oregon Health Fund Program (via the Quality Institute, HRC, HSC or other health commission) should develop or endorse evidence-based standardized decision support processes for integrated health homes and other care settings, which account for patients' cultural, ethnic, racial and language needs.

Shared Decision Making Recommendation 2: New payment methods should be used to encourage providers in state funded and private health programs to use decision making support processes and reimburse them for time spent engaged in tasks associated with these processes.

Shared Decision Making Recommendation 3: The state should partner with public and private stakeholders to develop and offer training courses to providers in facilitating shared decision making processes.

Shared Decision Making Recommendation 4: A statewide electronic Physician Orders for Life Sustaining Treatment (POLST) Registry should be created to ensure the availability of the POLST form at the time of need.

Public Health, Prevention and Wellness

Three in five deaths in Oregon are from heart disease, stroke, cancer, diabetes and chronic lower respiratory diseases and these diseases cost the state more than $1.4 billion every year. Chronic behavioral health conditions also account for a significant amount of morbidity and mortality and a large portion of health care spending. In 2006, the economic costs of substance abuse in Oregon were nearly $6 billion.[1] With better funded, evidence-based community efforts to detect and treat risk factors, a significant amount of chronic disease could be prevented, thus improving population health and reducing utilization of expensive and invasive acute treatments.

Public Health Recommendation 1: The state should partner with public and private stakeholders, employers, schools and community organizations to establish priorities and develop aggressive goals for the prevention of chronic disease and other physical, oral and behavioral health conditions and reduction of unhealthy behaviors that contribute most to the mortality of Oregonians.

Public Health Recommendation 2: The state should partner with local boards of health (including public and behavioral health), providers, employers, schools, community organizations and other stakeholders to develop a statewide strategic plan for achieving these goals and a process for evaluating progress toward these goals.

Public Health Recommendation 3: The state should establish and fund a Community-Centered Health Initiatives Fund (CCHI) to fund primary and secondary prevention activities.

Public Health Recommendation 4: All state agencies, in partnership with PEBB, should develop a strategic plan for creating a culture of health for state employees.

Administrative Simplification and Standardization

Administrative expenses account for a large percent of total health care spending and there are significant opportunities to contain costs by increasing administrative efficiency.

Administrative Simplification Recommendation 1: Increase transparency surrounding health plan and provider administrative spending.

[1] R. Whelan, A. Josephson, and J. Holocombe. 2008. The Economic Costs of Alcohol and Drug Abuse in Oregon in 2006. EcoNorthwest.

Administrative Simplification Recommendation 2: Develop standard formats and processes for eligibility, claims and payment and remittance transactions.

Administrative Simplification Recommendation 3: Simplify and streamline prescribing processes to reduce the administrative burden to providers of being required to prescribe from multiple formularies.

Reduced Pharmaceutical Spending

Pharmaceuticals account for eleven percent of total health care spending in Oregon.[2] Bulk purchasing arrangements established by purchasers and insurers can help reduce the cost of drugs and reduce overall health care spending.

Reduced Pharmaceutical Spending Recommendation 1: Utilize bulk purchasing arrangements to maximize savings in pharmaceutical spending.

[2] Office for Oregon Health Policy and Research. 2007. Trends in Oregon's Healthcare Market and the Oregon Health Plan: Report to the 74th Legislative Assembly. Available: http://www.oregon.gov/OHPPR/RSCH/docs/LegRpt2007_Final.pdf.

II. Vision Statement

The Delivery Systems Committee has a bold vision for health care in Oregon: *World Class Health Care for Each Oregonian*. This includes world class physical, behavioral and oral health. The current delivery system is broken and unsustainable and world class care cannot be achieved within the existing framework. Achieving world class care requires a radical transformation, as part of larger comprehensive reform. This must include a revitalization of primary care and a focus on preventing and managing chronic diseases, while improving the quality of care across the health care system. The people and the economy of the state cannot wait any longer – transformation is needed now.

A delivery system that provides world class care will meet the following goals:

- Within the Top 5 in world measures for:
  - Health status and outcomes, including the prevention and management of chronic disease
  - User Satisfaction
  - Low Cost
- Universal – delivers world class care to each person for all health needs, including physical, behavioral and oral.
- Provides high-quality care that is safe, efficient, patient-centered, effective, timely and equitable.[3]
- Payment system aligned with goals
- Transparent information about cost and quality and transparent public decision-making processes
- Utilizes interoperable health information technology to maximize health

Currently, the United States ranks well below most other industrial nations in measures of health status and health care quality. Within the United States, Oregon ranks 34th in state health system performance.[4] Over 19,000 people die a

[3] From the Institute of Medicine's Six Aims of a 21st Century Health System as proposed in Crossing the Quality Chasm. Available: http://books.nap.edu/openbook.php?record_id=10027&page=R1. See Appendix B for description.

[4] J. C. Cantor, C. Schoen, D. Belloff, S. K. H. How, and D. McCarthy. 2007. Aiming Higher: Results from a State Scorecard on Health System Performance. The Commonwealth Fund Commission on a High Performance Health System. Available: http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=494551

year in Oregon from chronic disease and chronic diseases cost the state more than $1.4 billion every year. [5] Oregon, as well as the rest of the nation, is struggling to remain globally competitive, with a health care system that provides lower quality care at a higher cost. There is a great deal that Oregon can learn from other states and nations with higher performing health care systems. In addition, Oregon can draw on its rich history of leading the nation with bold and innovative health reform. The Oregon Health Fund Board must use these lessons to transform Oregon's delivery system into a system that provides every Oregonian with world class care.

III. Committee Background

The Healthy Oregon Act

In June 2007, the Oregon Legislature passed the Healthy Oregon Act (Senate Bill 329, Chapter 697 Oregon Laws 2007). The Act called for the appointment of the seven-member Oregon Health Fund Board to develop 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 Healthy Oregon Act also established a set of committees to develop recommendations on specific aspects of the reform plan. One of these committees, the Delivery Systems Committee, was assigned the difficult task of providing the Board with policy recommendations to create high-performing health delivery systems in Oregon that produce optimal value through the provision of high quality, timely, efficient, effective, and safe health care.

Committee Process

The Delivery Systems Committee began their formal deliberations in October 2007. The nineteen members of the Delivery Systems Committee represent a wide range of stakeholders, including health plans, providers, business, labor, and consumers, including several members of Oregon's Health Policy Commission. Dick Stenson, President and CEO of Tuality Health Care, chairs the Committee, and Maribeth Healey, Director of Oregonians for Health Security, and Doug Walta, MD, Chief Physician Strategy Officer at Providence Health and Services, serve as vice-chairs (A complete list of Committee members is at the front of this report).

The Committee held a total of ten meetings, during which members developed a framework for delivery systems reform and recommendations to move Oregon

[5] Oregon Department of Human Services, Department of Public Health. 2007. Keeping Oregonians Healthy: Preventing Chronic Diseases by Reducing Tobacco Use, Improving Diet, and Promoting Physical Activity and Preventive Screenings. Available: http://www.oregon.gov/DHS/ph/hpcdp/docs/healthor.pdf.

toward a world class delivery system. The Committee invited a number of guests to present on specific topic areas including:

- Value-based purchasing: Jean Thorne, retired administrator of the Public Employees Benefits Board (PEBB) and Oregon Educators Benefits Board (OEBB).
- Integrated Health Homes: Dr. David Labby, CareOregon; Dr. Ralph Prows, Regence BlueCross BlueShield of Oregon; Dr. Thomas Hickey, Kaiser Permanente; Dr. David Dorr, OHSU; and Dr. Chuck Kilo, Greenfield Health and Better Health Initiative.
- Public Health: Dr. Grant Higginson, Public Health Division, Oregon Department of Human Services.
- Safety Net: Members of the Safety Net Advisory Council
- Accountable Care Districts: Dr. John McConnell, OHSU and Oregon Health Fund Board Economist.
- Oregon Hospitals: Kevin Earls, Association of Hospitals and Health Systems.
- End-of-Life Care: Susan Tolle, OHSU Center for Ethics in Health Care

The Committee also got public input during portions of each meeting from a variety of stakeholders and the public, including the Oregon Ambulatory Surgery Center Association, the American Heart Association, the American Lung Association of Oregon, the American Cancer Society, the Oregon Medical Association, the Oregon Primary Care Association and others.

Materials, presentations and recordings from the meetings are available from the Oregon Health Fund website at:
http://www.oregon.gov/OHPPR/HFB/Delivery_Systems_Committee.shtml.

The Committee also established a Quality Institute Work Group to create recommendations for the development of an entity to coordinate the creation, collection and reporting of cost and quality information to improve health care purchasing and delivery. The Work Group presented its recommendations and a full report to the Delivery Systems Committee on April 17. The Delivery Systems Committee had an in–depth discussion with members of the Work Group, endorsed the recommendations with minor additions, and integrated them into the overall recommendations included in this report. The full report from the Work Group, along with a cover letter which highlights related Committee discussion, can be found in Appendix C.

Developing a Framework For Delivery System Reform
Throughout its proceedings, Committee discussion was informed by related health service research and data, as well as information about reform initiatives across Oregon and the nation. In fulfilling its initial task of developing a

framework for reform, the Committee considered concepts outlined in the following resources: The Institute of Medicine's Crossing the Quality Chasm, The Institute for Healthcare Improvement's "Triple Aim" and the Federal Government's Four Cornerstones to Promote Quality and Efficient Health Care (Full citations and summaries of these documents can be found in Appendix B).

For additional reference, the Office for Oregon Health Policy and Research prepared two research briefs for the Committee, focusing on the integrated health home model and payment reform options. Both of these papers are available on the Oregon Health Fund Board website.

Focusing on Cost Containment

In order to support the Committee's efforts to identify opportunities to contain costs within the health care delivery system, staff also created an inventory of initial options for cost containment strategies that were drawn from the literature and reform plans and proposals from other states. In developing its full set of recommendations, the Committee considered all of the options on the initial list, added additional options and discussed the potential for each to lead to reduced spending and more efficient use of resources (See Appendix D for the inventory of cost containment strategies considered by the Committee and a list of resources consulted in drafting the inventory). The Commonwealth Fund's report entitled *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending* was especially useful to the Committee and a summary of the cost saving options presented in this report can be found in Appendix E.

The Committee had numerous occasions to discuss each set of recommendations, both in the full committee and through multiple staff review panels, and in most cases was able to reach consensus on the overarching recommendations. The section below includes additional language in each section, which provides additional insight into Committee discussion and highlights potential policy options proposed by members. Places where full consensus was not achieved are highlighted in the discussion sections.

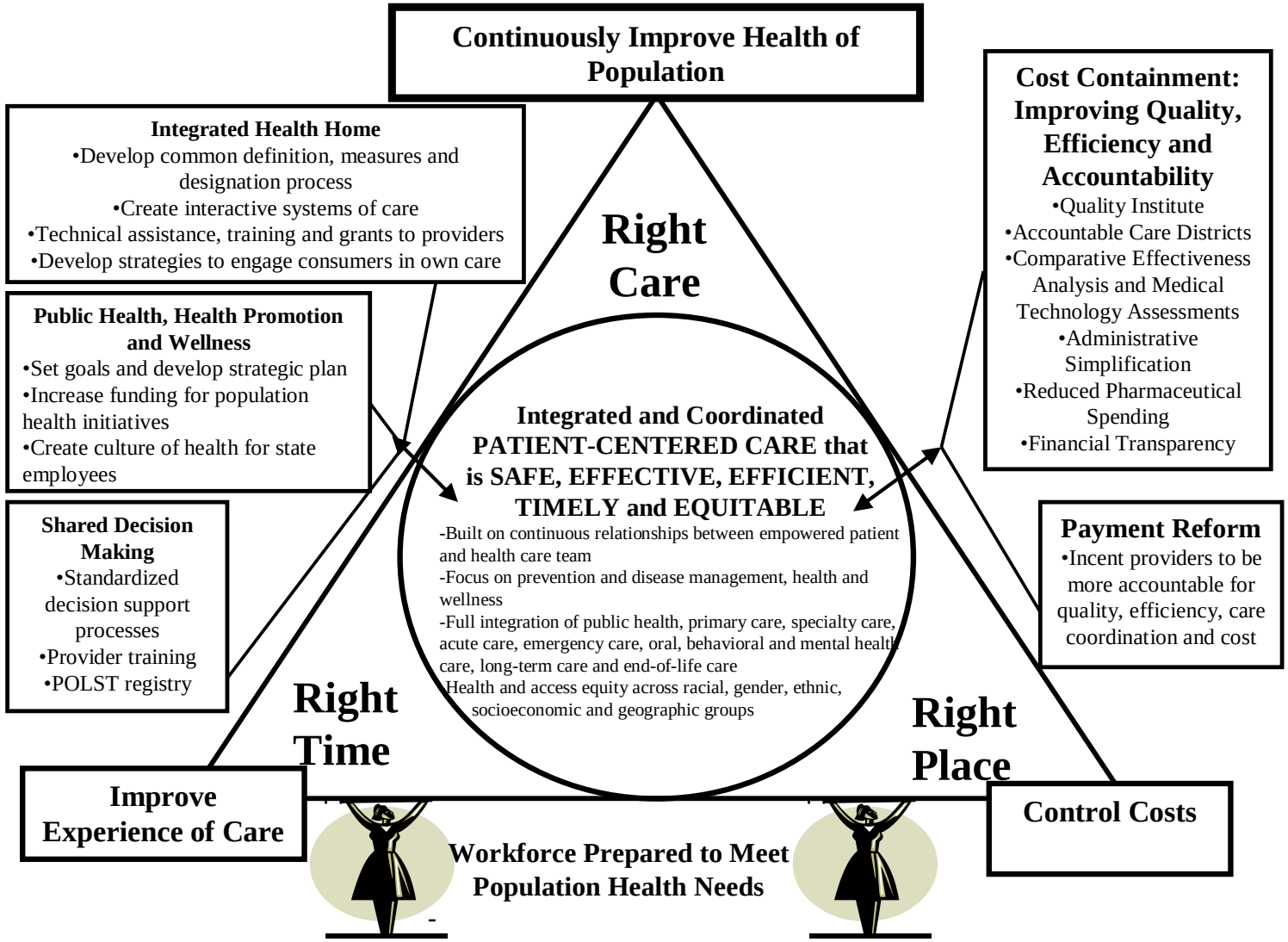
IV. Delivery System Change as Part of Comprehensive Reform

The Delivery System Committee recognizes that most of the recommendations put forth in this report represent long-term goals that cannot be accomplished in isolation and must be viewed as one piece of larger reform. The Committee believes that when implemented, the changes laid out in the recommendations will help transform Oregon's Delivery System into a world class health system; however, the Health Fund Board must realize that it will take significant time

before projected quality improvements and cost savings are realized. In the short tem, many of the recommendations that follow will require an investment in sustainable change and the Health Fund Board must look for opportunities to reduce short-term spending in other parts of the system that can be reinvested in delivery system reform. The Board will have to identify areas of excess spending for fiscal opportunities to redeploy funds in areas where evidence demonstrates positive effects on population health. In particular, the Committee recommends that the Health Fund Board work with the Benefits Committee to explore opportunities to use a public process to create a more cost-effective benefits package for Oregonians.

The recommendations presented below call for transformational change in the fundamental way things are done. The recommendations represent a significant cultural change in the organization and delivery of primary medical care, mental health and addictions treatment, oral health and public health services. They will challenge Oregon to build and educate a healthcare workforce that can work together to realize the integration suggested. They require strong public/private partnerships in the design, delivery, and monitoring of health care services inclusive of providers, insurers, patients, state government and local government including the functions of the local public and mental health authorities. The Committee recognizes that there will be strong opposition to many of its proposals and challenges the Health Fund Board, the Oregon Legislature and the entire state to have the political will to push for the changes needed to move Oregon towards a world class health system.

V. Framework for Delivery System Reform



Summaries of documents consulted in developing this framework can be found in Appendix B

Oregon Health Fund Board — Delivery Systems Committee Recommendations

Section 2: Detailed Recommendations and Discussion

The Delivery Systems Committee was assigned the difficult task of providing the Board with policy recommendations to create high-performing health delivery systems in Oregon that produce optimal value through the provision of high quality, timely, efficient, effective, and safe health care. While the Oregon Health Fund Board did not aim to limit the scope of the investigation and recommendations from the Delivery Systems Committee, the Committee's charter from the Board listed a number of priority areas of interest. These included: revitalizing primary care; managing chronic disease; developing new reimbursement models; increasing information transparency by collecting, measuring and reporting quality data; encouraging the diffusion of health information technology; ensuring the appropriate diffusion and utilization of clinical technology; strengthening public health and prevention; and improving end-of-life-care (See Appendix A – Delivery Systems Committee Charter). Using these priorities as a guide, the Committee developed the following recommendations, which the members believe will help to contain costs over the long term, while improving population health and improving patient experience with care. Members believe that the changes described below, will help transform Oregon's health care delivery system into a system that provides world class care.

VI. Primary Care and Chronic Disease Management/Integrated Health Homes

A revitalization of primary care must be an integral part of any comprehensive effort to reform the health care delivery system in Oregon. Research demonstrates better health outcomes, higher patient satisfaction and lower cost per capita in countries with strong primary care systems. However, the current delivery system in Oregon is not equipped to meet the longitudinal primary care health needs of the population. Care is fragmented and many Oregonians do not have regular and convenient access to a primary care provider that delivers preventative and chronic disease management services, as well as treats acute problems that arise. In many cases, people do not receive recommended care or receive duplicative services from many sources. Chronic diseases are not always optimally managed and largely preventable episodes result in severe illness and hospitalizations. This cycle is perpetuated by the current reimbursement structure, which is built on fee-for-service payments that reward providers based on the volume of services provided rather than on the effective and efficient use

of resources. Providers are incentivized to treat people once they are sick, rather than keeping them healthy.

The Delivery System Committee recommends the Health Fund Board seek opportunities to revitalize primary care across the state and re-design the health care delivery system to maximize individual and population health. Primary care infrastructure and reimbursement policies should be designed to encourage patient-centered, cost-efficient, longitudinal care and stress the importance of wellness, prevention and effective disease management rather than episodic, illness-oriented care. The Delivery Systems Committee believes the integrated health home model (referred to in other sources as the patient-centered primary care home, medical home, health home) can serve as a blueprint for this type of re-design and should guide primary care practice transformation across the state. The integrated health home builds strong provider-patient relationships which can improve overall health, empower individuals to better manage their own health, improve quality of care, increase efficiency through care coordination and better disease management and lead to savings across the system (A more comprehensive description of the integrated health home model and current state and national integrated health home pilots can be found in a research paper prepared by the Office for Oregon Health Policy and Research at http://www.oregon.gov/OHPPR/docs/The_Medical_Home_Model_Final.pdf).

Primary Care/Integrated Health Homes (IHH) Recommendation 1: Oregon's primary health care delivery system must be radically transformed in an effort to improve individual and population health and wellness. This transformation should be guided by the concept of the integrated health home and must involve a revitalization of primary care, as well as other health and social services that are vital components of a system equipped to meet the health needs of the population. The state should take bold steps to partner with consumers, providers, purchasers and payers around the common goal and vision of providing every Oregonian with an integrated health home.

Primary Care/Integrated Health Homes Recommendation 2: Promote and support patient-centered integrated health homes to be available for all participants in the Oregon Health Fund Board Program, with eventual statewide adoption to ensure integrated health homes are available to all Oregonians. Initial focus should be placed on providing integrated health homes for people with chronic conditions.

Timeline: Within 3 years, every member of the Oregon Health Fund Program should have access to an integrated health home. Within 5 years there should be widespread statewide adoption of the integrated health home model that ensures every Oregonian has access to an integrated health home.

Definition: A standard definition of integrated health home should be developed for Oregon that allows for innovation and encompasses a range of models. The Delivery System Committee recommends the following key elements be included in the definition. These elements are modified from the description of patient-centered medical home developed jointly by 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).

Key aspects to include are:

- *Personal connection with practice* – Every patient has available an established and continuous relationship with a provider or provider group working in a practice that meets all criteria of an integrated health home. This could be with a primary care physician, nurse practitioner or others trained to provide longitudinal health care services. These services can be provided within the care setting or through coordinated virtual networks.
- *Team-based Care* - A coherent team of providers working at the top of their licenses, who are collectively responsible for the patient's longitudinal health needs. Empowered patient and patient's family (when appropriate) play active and central role in team-based care. Roles within the team are assigned to maximize the efficient use of resources and responsiveness to patient needs.
- *Whole Person Orientation* – Integrated health homes assumes responsibility for providing culturally competent care for all of the patient's health care needs, including wellness, preventive care, disease management services, acute care and end of life. The integrated health home provides direct care when possible and arranges for appropriate referrals to other providers and other health and social services.
- *Coordinated and Integrated Care* - Care received from the integrated health 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, oral health, behavioral health, and behavioral health services, including Employee Assistance Programs. 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 integrated health home to establish and facilitate coordination.
- *Quality and Safety* – Integrated health homes focus on quality improvement and safety, through health care provider 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.

Primary Care/Integrated Health Homes Recommendation 3: Create and support interactive systems of care (real and virtual) which connect integrated health homes with community-based services, public health, behavioral health (including Employee Assistance Programs), oral health, and social services to improve population health. These systems should have the ability to provide feedback on population health statistics, population based outcomes measures and improvement across the delivery system. Systems should be established to coordinate and support each service provider, use resources efficiently and minimize duplication of efforts.

Further Discussion: A number of members stressed the importance of assuring that safety net providers are included in systems of care. In addition, a number of members expressed a desire to endorse the recommendations of the Safety Net Advisory Council and assure the on-going viability of the safety net by establishing a Safety Net Integrity Fund (See Appendix H for Safety Net Advisory Council Recommendations to the Oregon Health Fund Board Delivery Systems Committee and Recommendation 8 for further discussion of the safety net.)

Primary Care/Integrated Health Homes Recommendation 4: Provide Oregon's health care workforce with technical assistance, resources, training and support needed to transform practices into integrated health homes. This support must be provided to Oregon's primary care workforce, as well as other health care and social service personnel needed to provide individual and population health, coordination and management services vital to the integrated health home model. In addition, educational programs must be established to help institutions training health care professionals include the integrated health home model in their curriculum.

Options to consider:

- Forum for those participating/funding demonstration projects to come together to share best practices and discuss challenges.
- Learning opportunities that give providers and other stakeholders the chance to partner with public health to facilitate the use of data to improve individual and population health.
- Funds for demonstration projects, especially in rural and underserved areas. While the focus will often be on primary care provider models, funding for demonstration projects where a specialist (e.g. endocrinologist for patient

with diabetes, behavioral health professional for patient with mental illness, dentist) serves as the integrated health home should also be considered.
- Grants to practices to build HIT infrastructure, disease registries, etc.
- Ongoing funding for practices dedicated to making the transformation into integrated health homes to support the development and completion of transition plans.
- System improvement training and other technical assistance.

Primary Care/Integrated Health Homes Recommendation 5: Develop a plan to ensure that Oregon has a workforce able to meet population need, especially safety net providers and those serving vulnerable populations.

Further Discussion: The Committee acknowledged that there is a significant need for coordinated and collaborative efforts to increase the capacity of Oregon's entire workforce, including integrated health home providers. The Committee discussed efforts of the Senate Interim Commerce and Labor Subcommittee on Health Care Reform to work with the Oregon Healthcare Workforce Institute to develop a clear assessment of Oregon's current workforce. The Committee suggested that the state build on these efforts and use the data collected by the Workforce Institute to identify gaps in the current workforce that will need to be filled in order to provide Oregonians with integrated health homes and develop a strategic plan to fill these gaps. In efforts to strengthen Oregon's rural workforce, the Health Fund Board should look to expand and strengthen existing efforts of the Office for Rural Health to support primary care provider teams and rural communities. Special attention should be paid to the workforce needs of the safety net (See Appendix H for Safety Net Advisory Council recommendations to the Delivery Systems Committee).

Primary Care/Integrated Health Homes Recommendation 6: Develop and evaluate strategies to empower consumers to become more involved in their own health and health care by partnering and engaging with integrated health homes.

Options to consider:
- Pilot and evaluate strategies to provide rewards/incentives for Oregon Health Fund Program participants who enroll with integrated health homes, seek preventative and wellness services, practice healthy behaviors, effectively manage chronic disease with support from health homes, etc.
- Develop tools and provide training to help providers more effectively communicate with patients and to provide culturally appropriate care.
- Educate public about benefits of enrolling with integrated health homes.

- Explore opportunities to integrate shared decision making tools into care of Oregon Health Fund Program enrollees, as well as other Oregonians (See Shared Decision Making Recommendations).
- Assure opportunities for consumer involvement on advisory committees monitoring the performance of integrated health homes.

Primary Care/Integrated Health Homes Recommendation 7: Develop funding, payment and incentivizing strategies that promote and sustain integrated health homes and other system of care partners. The Committee recommends the following four strategies:

1) Acknowledge and support initial pilots underway across the state and use the lessons and best practices from these pilots to design, promote and/or fund a larger scale continuous rollout of the integrated health home model. This rollout should aim to develop new integrated health home models, as well as new models of reimbursement that adequately compensate and support providers and other associated workforce personnel for delivering integrated health home services.

2) Develop standard policies that tie reimbursement to requirements to report on common measures of integrated health home process and performance and system performance measures.
   - The common set of measures should be developed via the Quality Institute (See Quality Institute Recommendations below), which should be responsible for coordinating the collection of baseline data and ongoing performance data. Measurements should build on national standards and current efforts to measure quality, cost, and efficiency in Oregon. Measures should include process and outcomes measures, be designed to measure longitudinal clinical outcomes for individuals as well as provider panels, and include measures of population health. A process should be developed to ensure that measurement processes are fluid and regularly updated.
   - Common measures should allow for comparative analysis of integrated health homes to improve individual and population health, as well as patient and provider experience.

3) Design a simple and standard process to designate health care practices as integrated health homes. The designation process should be based on measurements included in the common set of measures (see #2 above).
   - Designation process must be simple and tiered to acknowledge various levels of progress toward evolution into fully integrated health homes.
   - Designation process should be built on common measures to minimize burden of reporting requirements on providers.

- Payment for integrated health homes (see #4 below) should be based on a tiered designation process.

4) Develop long-term sustainable payment policies that appropriately compensate providers and other partners involved in integrated health home systems of care. Compensation should be provided for developing capacity to provide integrated health home services and for providing these services to Oregonians in a high-quality and high-value manner. New payment strategies should be tested and evaluated to determine the potential to improve patient outcomes and experience, as well as provider experience. These new payment strategies should be part of a comprehensive payment reform strategy.
   - A mixed model of reimbursement will have to be developed, which includes fee for service payments for certain procedures and risk-adjusted bundled payments for providing integrated health home services
   - Payment should be tied to reporting requirements of common measures (see #2 above) and an auditing process will have to be developed.

Primary Care/Integrated Health Homes Recommendation 8: Recognize, strengthen and integrate the role of the safety net in delivering services to Oregon's vulnerable populations.

Further Discussion: Members of the Safety Net Advisory Council presented recommendations to the Delivery Systems Committee on two occasions and the Committee discussed the role of the safety net in a reformed system where coverage is available to all. A number of members expressed a desire to preserve the basic integrity of the safety net throughout the reform process, acknowledging that safety net providers are trained to deliver many of the services vital to providing patient-centered, culturally appropriate care. Other members stressed that while the safety net is extremely important and needs to be robustly funded in the short term, the role of the safety net will likely change as coverage is expanded. Some members expressed the opinion that a safety net may not be needed once universal access was achieved, but acknowledged that the system would still need to be "fail safe" and provide services to those who slip through the cracks (See Appendix H for Safety Net Advisory Council Recommendations to the Oregon Health Fund Board Delivery Systems Committee).

VII. Improving Quality and Increasing Transparency

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.[6] 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.[7]

One of the major problems with the current health care system is that comparable information about provider performance and costs is not widely available. Providers need better information to benchmark their performance, identify opportunities for quality improvement and design effective quality improvement initiatives that allow for better health outcomes at a lower cost. 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 and communities need information about health spending and resource utilization so that health planning decisions can be made to maximize population health. Any effort to contain costs within the health care system will rely on the availability of clear information that allows for the identification of delivery practices that improve individual and population health while reducing costs.

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.[8] 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.[9] The availability of clear and transparent information must be seen as one of the keystones to a sustainable delivery health care system that provides world class care and must be a central focus of any health care reform plan.

Recommendations from the Delivery Systems Committee to improve quality and increase transparency fall into three major areas: the establishment of an Oregon Quality Institute, increased transparency and public reporting of provider fiscal information, and the utilization of accountable care districts to foster local accountability for the quality and costs of care.

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[6] 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.

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

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

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

A. An Oregon Quality Institute

While there are numerous public and private efforts underway across the state to 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 Committee recommends the state establish and provide substantial, long-term funding for a publicly chartered Oregon Quality Institute (See Appendix C for full Quality Institute Work Group Recommendations).

Quality Institute (QI) Recommendation 1: An Oregon Quality Institute should be established as a publicly chartered public-private organization. The state should provide stable long-term funding to support the Institute.

This proposed structure will 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 must provide the same protections to information submitted by other organizations.

The Committee 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 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 for full budget). 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.

Further Discussion: As noted in the cover letter from the Delivery Systems Committee that accompanies the Quality Institute Work Group Recommendations (See Appendix C), some members of the Committee advocated that the Board should revisit this proposed structure after a comprehensive plan for reform is developed. Members questioned whether there would be a need for a separate and distinct Quality Institute along with all of the entities created through reform. Members also suggested that the Board assess the role of private stakeholders in the public-private structure and suggested that these stakeholders provide specific testimony as to how a Quality Institute could enhance current efforts.

QI Recommendation 2: 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. 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 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.

When developing a system and methods for public disclosure of performance information, the Quality Institute should consider the following criteria[10]:

- Measures and methodology should be transparent and understandable;
- 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.

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.

QI Recommendation 3: As the budget of the Quality Institute allows, the Quality Institute Board of Directors should use data and evidence to identify opportunities to improve quality and transparency. The Quality Institute Board of Directors should consider the following activities (either directly carried out by the Quality Institute or in partnership with other stakeholder groups):

[10] 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.

- 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.

- 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.

Further Discussion: As noted in the cover letter from the Delivery Systems Committee that accompanies the Quality Institute Work Group

Recommendations (See Appendix C), members of the Committee stressed that greater transparency around cost is vital to reform and cost containment efforts. While the Committee did not necessarily recommend that the Quality Institute should take a more significant role in reporting data associated with costs than was recommended by the Work Group, but suggested that cost transparency needs to be addressed throughout the reform process.

B. Financial Transparency

The availability of understandable, easily accessible and comparable information about quality and resource utilization will help bring Oregon much closer to delivering world class care. At the same time, however, there needs to be greater transparency about health care costs and provider operating and financial data. There have been some initiatives in the state that have had some success in increasing financial transparency, such as the Compare Hospital Costs initiative, lead by the Office for Oregon Health Policy and Research (OHPR) and the Department for Consumer and Business Services,[11] OHPR's public report on capacity, utilization and financial trends in acute care hospitals[12] and the Oregon Association of Hospitals and Health Systems PricePoint system.[13] However, access to this type of information remains limited.

Financial Transparency Recommendation 1: Require health care providers, including but not limited to hospitals, ambulatory surgery and imaging centers to be more transparent and public about fiscal information. Public disclosure must occur in a timely manner so that data can be used to make resource utilization and health planning decisions.

Further Discussion: One option proposed by Committee members, but not officially endorsed by the full Committee, would require providers to file financial transparency and accountability reports with the Office for Oregon Health Policy and Research and the five largest commercial insurers either served or expected to be served by the facility or project. These reports would include:

- Capital Project Reporting: Any capital project by any provider of more than $1 million would be reported to the state one year before operation for new services or 6 months in advance for replacement services. The report would detail the entire cost of the project, the analysis of the need

[11] http://www.oregon.gov/OHPPR/RSCH/comparehospitalcosts.shtml
[12] Office for Oregon Health Policy and Research. 2007. Oregon's Acute Care Hospitals: Capacity, Utilization and Financial Trends. Available: http://www.oregon.gov/OHPPR/RSCH/docs/HospRpt_2007.pdf.
[13] http://www.orpricepoint.org/

for the project, the expected charges, expenses, and operating margins for the service(s) for 5 years, as well as the expected impact on total health care spending per capita in the accountable care district (See Accountable Care Districts Recommendations below) to which the provider belongs.

- Profit Margin Reporting: All providers with annual operating income margins in excess of 5% would be required to file a report with the state explaining how the additional funds will be used to benefit patients in Oregon, what the impact on services would be of reducing future operating margins below 5%, the impact of each additional percent above 5% on the total cost of care per capita in the accountable care district, and what steps, if any will be taken to reduce future operating margins below 5%.
- Commercial Reimbursement Reporting: All providers are required to annually report to the state the lowest reimbursement paid the previous year by commercial insurers for the top 20% of their services that account for majority of their commercial income. The lowest reimbursement payment per service may be reported as a dollar amount or percentage of Medicare, or per DRG, APG, or other bundled service unit.

All Committee members agreed that providers have an important role to play in controlling spending growth and that greater transparency and public reporting will lead to increased accountability. Some members, however, expressed concern that these measures would not do enough to contain costs and suggested the state enforce tighter fiscal regulations on providers, such as limits on profits and/or reserves. In particular, these members expressed specific concern that there are no checks in the system to maximize the community benefit from non-profit hospitals and other providers benefiting from non-profit tax status. While a few members pushed for recommendations that included new fiscal regulations, the majority of the Committee believed that this type of regulation would be difficult to administer and would not be more effective in containing costs.

C. Accountable Care Districts

The Committee's recommendations on accountable care districts (ACDs) are based on the concept of accountable care organizations developed by researchers at Dartmouth College. Accountable care districts will act as a vehicle to foster shared accountability for quality and cost among all of the providers (including physicians, other health care professionals, hospitals, and other centers where health care is delivered) serving a defined population across the continuum of care. Accountable care districts do not require new financial relationships to be created between providers, but empirically define local delivery systems large enough to support comprehensive performance measurement and to provide or

effectively manage the full continuum of patient care. According to Fisher, et al., there are three main benefits of creating such a framework for shared accountability for quality and cost[14]:

- Performance measurement - Performance and cost data can be aggregated to reflect population-based measures, as well as individuals' longitudinal experience with the health care system (including measures of health outcomes and per capita costs). This includes measures which account for the efficiency and coordination between various providers serving a defined community. [15]
- Fostering local accountability - Data from the Dartmouth Atlas demonstrates significant unwarranted regional variation in health resource utilization, reflected in differences in both quality and cost of care. Higher spending has been largely attributed to higher use of "supply-sensitive" services, where the supply of a particular service in a community has influence on the utilization rate (e.g. more hospital beds in a community lead to higher number of hospital admissions). A greater supply of such services has been found to lead to more intensive practice patterns that do not necessarily translate into better health outcomes.[16] Aggregating data about cost and quality by accountable care districts will allow for the identification of areas with high utilization rates and per capita spending, as well as districts that are able to more efficiently use resources to improve population health. Publicizing this data can foster local accountability and encourage providers to more effectively utilize health resources in ways that improve population health and contain costs.
- Intervening to improve quality and cost - Accountable care districts are more likely than individual practices to have the capacity to invest in measures to improve quality and efficiency. In addition, they can serve as a framework within which new payment methods that reward efficiency and quality can be tested. [17]

Accountable care districts are compatible with the integrated health home model. Districts with integrated health homes should be able to provide higher quality care at lower per capita costs.

Accountable Care District (ACD) Recommendation 1: Define accountable care districts within Oregon's delivery system. All health care quality and utilization data reported by the Oregon Quality Institute will be aggregated to

[14] E. Fisher, et al. 2006. *Creating Accountable Care Organizations: The Extended Hospital Medical Staff. Health Affair*. Web Exclusive: w44-w57.
[15] E. Fisher, et al. 2006.
[16] J. Wennberg, et al. 2007. Tracking the Care of Patients with Severe Chronic Illness: The Dartmouth Atlas of Health Care 2008. The Dartmouth Institute for Health Policy and Clinical Practice Center for Health Policy Research. Available: http://www.dartmouthatlas.org/atlases/2008_Chronic_Care_Atlas.pdf
[17] E. Fisher, et al. 2006.

allow for meaningful comparisons of quality and utilization across the state and across ACDs.

The state will empirically define ACDs within Oregon's health care delivery system. ACDs will allow for appropriate data aggregation to account for the quality and cost of providing the entire spectrum of care for defined populations. ACDs do not necessarily require new financial relationships between providers and hospitals and could be identified in a number of ways. Options for identifying ACDs include:

- Defined empirically through claims data
- Large multi-specialty group practices with own hospitals
- Physician-Hospital Organizations
- Hospitals that own physician groups
- Extended Hospital Medical Staff (virtual or multi-specialty group practice directly or indirectly affiliated with a single hospital)
- Geographic area (e.g. county or education service district)

To the extent possible, all datasets aggregated by ACDs should include data about the safety net.

Further Discussion: Members agreed that using the accountable care district to aggregate cost and quality data will provide important insight into resource utilization around the state; however, a few expressed concern that data reporting on its own will do little to prompt changes that improve the efficiency of the delivery system. The Committee discussed longer term opportunities to engage community collaboratives in using accountable care district data to make health planning and resource utilization decisions (See ACD Recommendation 2). In developing shorter term strategies, members discussed opportunities to use payment reform to incentivize providers in accountable care districts to work together to provide integrated and coordinated high-quality care (See Payment Reform Models Recommendation 2). Members agreed that economic incentives are needed to drive change in the fundamental way things are done.

ACD Recommendation 2: Engage and incentivize communities at the onset, to use ACD data to inform health planning and resource utilization discussions.

Further Discussion: A number of Committee members cautioned that ACDs are a new concept and the state should focus efforts on developing meaningful comparative data at this time. Other members, however, believed that data aggregated by ACDs would only drive change if a community-based structure is developed to use the data to inform health planning and resource utilization discussions. The group considered requiring every ACD to create a community collaboration to take on this task, but ultimately decided not to be so

prescriptive. The group recognized that every community would have different players and should be given the opportunity to decide how to best translate the data into action and drive change at the community level. The group was clear that these community collaborations would have to go beyond just providers, to include purchasers, consumer, health plans, local and state government, the safety net and others serving vulnerable populations, public health and community organizations. The state might consider giving a small number of grants to communities ready to create collaboration among stakeholders to use ACD data to inform health planning and resource utilization decisions.

VIII. Payment Reform Models

The current healthcare delivery system relies heavily on a fee-for-service (FFS) payment method in which a provider is paid a fee for rendering a specific service. This system rewards providers based on the volume of care delivered, without including incentives that encourage high-quality care and efficient resource utilization. In addition, current reimbursement policies do not reflect the value of preventative and primary care services and do not adequately reimburse providers for care coordination services. If Oregon is to move toward a world class health system, new reimbursement models are needed that incentivize health care providers to be accountable for quality, efficiency and care coordination. A great deal can be learned from payment reform pilot projects already underway, such as the Medicare Physician Group Practice Demonstration project, which have demonstrated some early success in using payment reform to improve quality and slow health expenditure growth.[18] Other states, such as Vermont, are currently engaged in payment reform efforts that will produce important lessons for Oregon (A more comprehensive discussion of the current payment system, options for reform and descriptions of state and national pilot projects can be found in a research paper produced by the Office for Oregon Health Policy and Research available at http://www.oregon.gov/OHPPR/HFB/Delivery/Reports/Payment_Reform_Provider_Reimbursement_Paper_OHFB_Final.pdf**).**

Payment Reform Recommendation 1: Health care providers (physicians, other health care professionals, hospitals, and other centers delivering care) should be accountable for quality, efficiency, health outcomes and care coordination. Payment reform should be designed to incentivize these desired outcomes, while holding global Oregon health care costs to Consumer Price Index as measured over a five year period. A payment reform council should be established within the Oregon Health Fund Board, Quality Institute or a state

[18] M. Trisolini, G. Pope, J. Kautter, and J. Aggarwal. 2006. Medicare Physician Group Practices: Innovations in Quality and Efficiency. The Commonwealth Fund.

agency, to develop specific recommendations for comprehensive payment reform guided by the goals below. By January 2011, the council will establish initial rules for a payment system that is aligned with the goals of the Quality Institute and other entities created through reform and links levels of payment to quality, efficiency, health outcomes and care coordination. This new payment system will apply broadly to the entire delivery system, with specific features to promote and support the integrated health home model. The council will publicize and promote the new payment system, monitor the progress of public and private payment entities in adopting the payment system, provide technical assistance to entities adopting the payment system and continuously update the system. In addition, the council should partner with the Quality Institute to evaluate the effects of payment reform on health care delivery and spending.

The goals of a new payment system should be to:

- Improve population health and patient experience with care;
- Incentivize providers to be accountable to patients, purchasers and payers for delivering high-quality, efficient care; and
- Control costs.

Further Discussion: The Committee considered developing a specific design for payment reform, but ultimately decided that not enough was known about the long-term effects of any new payment methods to put forth a detailed proposal. The Committee was concerned that doing so would stifle innovation and commit the state to a strategy that might end up having significant unintended consequences. Members developed a list of goals and principles to guide payment reform, but decided that a longer process would be needed to develop and pilot new reimbursement models. The goals and principles below were put forth by various members, although the committee did not endorse the list as a whole. The payment reform council, established in the recommendation above, should further explore these concepts.

Potential goals of payment reform:

1. Improve population health and patient experience with care
    - Reward providers for good health outcomes.
    - Improve coordination and management of care, especially for people with chronic disease and reward providers who care for patients with complex care needs and/or multiple chronic conditions.
    - Strengthen primary care and support delivery system redesign centered around the integrated health home model.
    - Encourage providers to care for all patients, regardless of health status.
    - Encourage patient choices that improve adherence to recommended care processes, improve outcomes and reduce the costs of care.

2. Incentivize providers to be more accountable for delivering high-quality, efficient care
    - Enable and encourage providers to deliver high-quality, efficient, patient-centered care that is based on best available evidence and aligned with guidelines endorsed by the Quality Institute.
    - Incentivize providers to be responsible for quality and costs within their control.
    - Incentivize behavior that leads to improved population health, as well as better quality and more efficient care.

3. Control Costs
    - Identify areas of excess spending for fiscal opportunities to redeploy funds in areas where evidence demonstrates positive effects on population health.
    - Reduce overall health care spending.
    - Increase competition based on quality, efficiency, patient-centeredness and value of care provided.
    - Reward providers who innovate in finding ways to deliver health care that result in higher quality and lower cost care.
    - Move toward a system that encourages providers to reduce per capita spending through better coordination.
    - Align standards and methods of payments across the delivery system to minimize the administrative costs for providers in complying with multiple payment system requirements.

Design principles:

- Develop a mechanism to increase the public transparency of prices for health care services.
- Reduce administrative burden.
- Include providers in the design process in order to develop an effective design.
- Place higher value on primary care, case management and other cognitive services.
- Fairly reimburse providers for delivering services, for which they are currently not compensated, that increase quality and improve patient experience, including but not limited to:
    - Telephone and email communication;
    - Pharmacist medication management;
    - Behavioral health counseling;
    - Palliative care services; and

    - Conversations with patients about their goals of care and advance directive and POLST (for patients with advanced chronic disease) preferences.
- Develop a staged plan to allow for differences in provider and plan capacity to move to new payment models. The system should be continuously updated with the goals of developing a system that rewards providers who meet specific quality and efficiency targets, take responsibility for managing and coordinating patient care and follow evidence-based guidelines.
- Adjust payment for risk based on incidence of illness in a given population.
- Ensure a majority of providers and payers participate in payment reform so the system is efficient and cost-effective.
- Evaluate the effect of new payment strategies on total health care spending and the goals of improved quality, efficiency and care coordination.

Payment Reform Recommendation 2: New payment models should be tested within the infrastructure established by delivery system reform.

Accountable care districts (ACDs – See Recommendations above) provide a unique opportunity to test new reimbursement strategies designed to incentivize providers more accountable for quality, efficiency, health outcomes and care coordination. Since ACDs are designed to foster shared accountability for population health, they provide a framework to develop and test payment policies that reward effective population based care, coordination and efficiency, such as care coordination fees and global budgets. Pilots should be designed to promote investments in capacity that increase efficiency, while rewarding providers for the appropriate use of high-intensity, expensive services and procedures. Savings could initially be shared by providers and the community. The payment reform council should consider establishing a pilot project that facilitates collaboration between providers, purchasers and plans operating within particular accountable care districts to design and implement new reimbursement strategies aligned with the goals and principles established by the Delivery Systems Committee (see above).

IX. Comparative Effectiveness and Medical Technology Assessment

Evidence-based decision-making is a crucial component of a world class health system. When deciding between various treatment alternatives, patients and providers must have access to data about the benefits, risks and costs of alternative treatments if they are to make informed decisions. Comparative effectiveness research provides valuable information about the relative effectiveness and cost-effectiveness of alternative options. This information can be used to develop standard clinical guidelines and inform benefit design to ensure that health resources are utilized in a manner that maximizes health gains. In addition, comparative effectiveness analysis can be used to identify the effectiveness of individual patient-decision aids, which have been shown to help patients make better informed decisions, ease anxiety about decision making and increase the utilization of cost-effective treatment options.[19] There are currently a number of comparative effectiveness and medical technology assessment initiatives in place in Oregon and across the nation (See Appendix F for descriptions), but no mechanism to facilitate collaboration across efforts or to ensure that treatment and coverage decisions across the state are informed by the best available research and data.

Comparative Effectiveness Recommendation 1: Streamline and strengthen efforts to support comparative effectiveness research and ensure policy decisions are informed by the best available evidence. The state, led by the Health Resources Commission (HRC), should partner with other state and national public and private stakeholder groups already investing in comparative effectiveness research to create a more collaborative and coordinated effort. Funding for the HRC should be increased to allow the group to partner with existing state, national and international efforts, support high quality research and use the best available data and evidence to make public and transparent policy decisions. Comparative effectiveness research must be made available to providers, purchasers, and patients to guide treatment plans and inform decisions about health resource planning.

Comparative Effectiveness Recommendation 2: Endorse patient decision aids shown to increase the use of cost-effective care. The Oregon Health Fund Program (via the Quality Institute, HRC, HSC or other health commission) should identify and endorse the use of patient decision aids that have been shown to improve the quality of clinical decision making and increase the use of

[19] C. Schoen, et al. 2007. Bending the Curve: options for Achieving Savings and Improving Value in U.S. Health Spending. The Commonwealth Fund. Available:

cost-effective medical interventions for preference-sensitive care. Decision aids should be evaluated for their ability to meet patients' cultural, ethnic, racial and language needs. There should be a focus on identifying effective patient decision aids for conditions involving expensive, invasive and/or discretionary surgical procedures.

Comparative Effectiveness Recommendation 3: Develop standard sets of evidence-based guidelines for Oregon based on comparative effectiveness research. The state, led by the Quality Institute, Health Services Commission and Health Resources Commission, should lead a collaborative group of public and private purchasers and health plans in endorsing standard sets of clinical and social support guidelines for all providers serving Oregonians. This collaborative group should build on existing local, state, national and international efforts and review and endorse existing high-quality guidelines whenever possible. Where guidelines do not exist, the group may convene experts to create them. Standard guidelines should be updated as new research and data becomes available and evaluated over time to measure the effect on individual and population health and effective use of health care resources. Standard guidelines should be disseminated widely and providers should be required to use these guidelines in caring for patients in state funded health programs (OHP, OHFP, PEBB, OEBB). Private purchasers and health plans should develop policies that encourage the utilization of these guidelines. Initial efforts should be focused on identifying standard guidelines for the most prevalent chronic diseases.

Comparative Effectiveness Recommendation 4: Develop common policies across public and private health plans regarding the coverage of new and existing treatments, procedures and services based on comparative effectiveness research. The state, led by the Quality Institute, Health Resources Commission and Health Services Commission, should lead a collaborative group of public and private purchasers and health plans in developing consistent policies regarding the coverage of new and existing treatments, procedures and services. Whenever possible, coverage decisions should be made based on comparative effectiveness research and evidence and should be made based on the relative value of a treatment, procedure or service to the population as a whole. Where clear evidence does not exist, coverage decisions should be based on widely accepted best practices and standards of care. The state should not reinvent the wheel, but should build on national and local work by public and private organizations on the effectiveness of treatments, technology, and pharmaceuticals**.**

Further Discussion: While recognizing that there was inadequate time for the Committee to fully discuss the role of litigation in the delivery of care, it was

acknowledged that more time and effort needs to be put into that collective discussion. The Committee recognized that in many cases promoting evidence-based medicine will require providers not to do certain tests, procedures, etc. that their patient's may want. Protections for providers practicing evidence-based medicine and using standardized guidelines must be developed, while still protecting the rights of the patient.

X. Shared Decision Making

In a world class health system that delivers patient-centered care, providers work with patients and their families to make health care decisions aligned with their values and goals. Decision support processes can help patients understand the likely outcome of various care options, think about what is personally important about the risks and benefits of each option and make decisions with the support of their care team. Currently, providers are not adequately reimbursed for taking the time to fully engage patients in decision support processes.

Specific opportunities exist to improve the decision making processes for end-of-life care. Oregon has long been recognized as a leader in the provision of dignified end-of-life care and should continue to take steps to ensure that patient's wishes about life-sustaining treatments are known and followed. In the case of individuals with advanced chronic illness, the Physician Orders for Life-Sustaining Treatment (POLST) form can serve as an important tool to convey patient wishes. The POLST is different from an advanced directive, because it is signed by a physician or nurse practitioner, thus converting wishes for life-sustaining treatments into medical orders that can be followed by nursing facilities or emergency medical technicians. An Oregon Health & Science University survey found that in one in four cases where a POLST form had been filled out, it could not be found by emergency personnel in time to act on it. An electronic registry could help ensure that POLST forms are always available at the time of need.

Shared Decision Making Recommendation 1: The Oregon Health Fund Program (via the Quality Institute, HRC, HSC or other health commission) should develop or endorse evidence-based standardized decision support processes for integrated health homes and other care settings, which account for patients' cultural, ethnic, racial and language needs. Decision support processes should identify opportunities for members of the care team and patients to discuss alternate treatments and patient preferences and for providers to offer information to help patients: 1) understand the likely outcomes of various options; 2) think about what is personally important about the risks and benefits of each option; and 3) participate in decisions about their health care. Providers should also provide patients with information about potential costs

associated with alternative treatment options. These processes should include the use of patient decision aids where appropriate (See Comparative Effectiveness Recommendation 2). Initial efforts should be focused on developing shared decision making processes for patients with advanced chronic illness, who are hospitalized or have been recently hospitalized and patients considering having high-cost, preference-sensitive procedures. These processes should aid patients in making decisions about goals of care and give them the opportunity to complete advanced directives and Physician Orders for Life-Sustaining Treatment (POLST), where appropriate.

Shared Decision Making Recommendation 2: New payment methods should be used to encourage providers in state funded and private health programs to use decision making support processes and reimburse them for time spent engaged in tasks associated with these processes.

Shared Decision Making Recommendation 3: The state should partner with public and private stakeholders to develop and offer training courses to providers in facilitating shared decision making processes. Specific attention should initially be focused on training providers who work with patients with chronic illness.

Shared Decision Making Recommendation 4: A statewide electronic POLST Registry should be created to ensure the availability of the POLST form at the time of need.

XI. Public Health, Prevention and Wellness

Three in five deaths in Oregon are from heart disease, stroke, cancer, diabetes and chronic lower respiratory diseases and these diseases cost the state more than $1.4 billion every year. Chronic behavioral health conditions also account for a significant amount of morbidity and mortality and a large portion of health care spending. In 2006, the economic costs of substance abuse in Oregon were nearly $6 billion.[20] With better funded, evidence-based community efforts to detect and treat risk factors, a significant amount of chronic disease could be prevented, thus improving population health and reducing utilization of expensive and invasive acute treatments. A world class health care system provides high quality care once people are sick, but must invest in individual and population-based disease prevention and health promotion services to keep people healthy.

[20] R. Whelan, A. Josephson, and J. Holocombe. 2008. The Economic Costs of Alcohol and Drug Abuse in Oregon in 2006. EcoNorthwest.

Public Health Recommendation 1: The state should partner with public and private stakeholders, employers, schools and community organizations to establish priorities and develop aggressive goals for the prevention of chronic disease and other physical, oral and behavioral health conditions and reduction of unhealthy behaviors that contribute most to the mortality of Oregonians. These goals should include, but not be limited to preventing and reducing obesity and tobacco use. The development of the priorities and goals should be aligned with efforts of the Quality Institute.

Public Health Recommendation 2: The state should partner with local boards of health, providers, employers, schools, community organizations and other stakeholders to develop a statewide strategic plan for achieving these goals and a process for evaluating progress toward these goals. As part of its strategic plan, the state should work with appropriate stakeholders to identify population-based health activities with evidence of improving health outcomes. Prevention efforts should be seen as a priority of the state and health care dollars must be redirected to provide more robust funding for cost-effective population-based prevention efforts. This plan should be in collaboration with the efforts of the Quality Institute to ensure accountability and a continuous evaluation of the impact on population health. Where it is clear that additional resources are essential in order to carry out the plan, such activities would be considered for funding as presented under Recommendation 3 below.

Public Health Recommendation 3: The state should establish and fund a Community-Centered Health Initiatives Fund (CCHI) to fund primary and secondary prevention activities. This fund should be used to provide funding to develop and implement culturally and socially appropriate primary and secondary prevention activities in line with the goals and strategic plan discussed in Recommendations 1 and 2. These activities need to be aligned with the efforts of the Quality Institute to improve quality of care.

Activities funded by CCHI funds will meet the following criteria:

- Be based on community input;
- Be based on evidence and data, including population health measures reported by accountable care districts (see Accountable Care District Recommendations above);
- Will address behavior change at the individual, community and system levels;
- Coordinate efforts of local county health departments, community-based organizations, schools, employers and health care delivery system entities;
- Work to reduce health care disparities;

- Accountable for demonstrating measureable improvements in health status, health education and reduction of risk factors.

The funds would be directed to the following components:

Local Initiatives

- A portion of the CCHI will be used to fund activities delivered at the local level by county health departments, community-based organizations and health care delivery system entities. Community collaboratives, including local boards of health, community coalitions designed to increase access for vulnerable populations and/or improve quality of care, providers, employers, schools, community organizations and others, should play a lead role in developing and implement population health projects, building on existing efforts in the community.
    - Health care delivery system entities receiving Medicaid funding need to be a key aspect of these community efforts both locally and regionally, and must participate in the collaborative coordination councils.
    - Pilot payment reform and other efforts directed to particular accountable care health districts will need to be aligned with these local initiatives.

Regional Initiatives

- A portion of the CCHI will be used to fund regional efforts, particularly where local resources are insufficient to assure standards will be met.

State Initiatives

- A portion of the CCHI will be used to fund the Public Health Division of the Department of Human Services and other state government efforts to play a role in facilitating and coordinating local and regional prevention efforts. These funds will be used for standard setting, coordination, implementation assistance and evaluation in coordination. These activities will be coordinated with the Quality Institute's efforts. In addition, funds will be used to provide administrative support for local, regional and accountable care district initiatives, including:
    - Setting standards of performance for the state-set priority activities, and when appropriate, for other evidence-based prevention projects selected by 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.

- CCHI funds directed to state government will also be used to conduct state-level, evidence-based prevention and to develop and implement additional evidence-based prevention projects, aligned with the local and regional efforts, the Quality Institute, and other public or private efforts.

Public Health Recommendation 4: All state agencies, in partnership with PEBB, should develop a strategic plan for creating a culture of health for state employees. Workplace conditions across state agencies should encourage healthy behaviors, such as healthy eating and physical activity. The state should collaborate with private employers and health plans to establish best practices for effective workplace wellness programs.

XII. Administrative Simplification and Standardization

Administrative expenses account for a large percent of total health care spending and there are significant opportunities to contain costs by increasing administrative efficiency. In 2005, Oregon's eight largest insurers reported an average of seven percent of earned premiums going toward administrative costs, with two companies reporting administrative spending of twelve percent.[21] It is currently difficult for consumers and purchasers to use information about administrative efficiency in choosing a health plan, as there is little information publicly reported. To complicate the matter, there is currently no standard definition of administrative costs, which makes it difficult to compare across plans. Developing standard definitions of administrative costs and requiring health plans to be more transparent about their administrative spending could lead to competition between plans based on administrative efficiency.

Reform efforts in Minnesota have demonstrated that there is significant money to be saved through a standardization of administrative transactions between providers and payers. In 2007, Minnesota passed an update to the state's Healthcare Administrative Simplification Act, which requires all health care payers and providers to electronically exchange information for eligibility, claims, and payment and remittance advice transactions, using common standards (content and format) developed by the Department of Health. Projected savings for 2008-2015 are $215 million.[22]

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[21] Oregon Department of Consumer and Business Services. 2007. *Health Insurance in Oregon*. Available: http://www.cbs.state.or.us/external/ins/health_report/health-report_intro.html.

[22] J. Golden. February 7, 2008. Health Information Technologies and Health Care Transformation. Presentation at the State Coverage Initiatives Winter Meeting. Nashville, TN.

Other opportunities to increase administrative efficiency exist at the provider level. Currently, providers spend a great deal of time cross-referencing formularies when making prescribing decisions, as insurers and policies utilize different lists. Time and money could be saved if mechanisms to simplify these processes were developed.

Administrative Simplification Recommendation 1: Increase transparency surrounding health plan and provider administrative spending. The state should build on existing efforts of public and private health plans, hospitals and providers to ensure the development of:

- A standard definition of "administrative costs" for health plans and providers.
- Requirements for all health plans (including Oregon Health Program) to be transparent about the % of premiums that are used for administrative costs and process for making this information easily available to the public.
- Requirements for providers to be more transparent about the percent of costs used for administrative tasks.

Administrative Simplification Recommendation 2: Develop standard formats and processes for eligibility, claims, and payment and remittance transactions. The state build on efforts of public and private stakeholders to ensure the development of standards, formats and rules for eligibility, claims, and payment and remittance transactions. By 2010, all providers and purchasers should be required to use standard formats and electronic exchange for these transactions (modeled after Minnesota Administrative Simplification Act).

Further Discussion: In considering opportunities to standardize definitions and transaction processes, members of the Committee described existing efforts in the state to bring stakeholders together to collaborate on these issues. Members were clear that they did not want the state to spend resources on duplicative efforts, but directed the state to be an active player in these initiatives.

Administrative Simplification Recommendation 3: Simplify and streamline prescribing processes to reduce the administrative burden to providers of being required to prescribe from multiple formularies. The state, led by the Quality Institute, Health Services Commission, Health Resources Commission or another agency or Commission, should lead a collaborative group of public and private purchasers, health plans and providers in developing and implementing mechanisms to simplify and standardize prescribing processes.

XIII. Reduced Pharmaceutical Spending

Pharmaceuticals account for eleven percent of total health care spending in Oregon.[23] Bulk purchasing arrangements established by purchasers and insurers can help reduce the cost of drugs and reduce overall health care spending. Many insurers negotiate directly with drug companies to reduce prices. Oregonians also benefit from the Oregon Prescription Drug Program (OPDP), a prescription drug purchasing pool, which makes discounted prescriptions available to uninsured or underinsured Oregonians. Businesses can also contract with OPDP to provide employee drug benefits. In July 2006, OPDP increased its purchasing power by joining with its counterpart in Washington to form the Northwest Prescription Drug Consortium. The average discount on an Rx purchased with an OPDP discount card is 45%.[24]

Reduced Pharmaceutical Spending Recommendation 1: Utilize bulk purchasing arrangements to maximize savings in pharmaceutical spending. All health plans, including state funded health programs, should purchase pharmaceuticals for enrollees through the Oregon Prescription Drug Program (OPDP) and the Northwest Prescription Drug Consortium unless they can show greater cost savings for their enrollees through other purchasing contracts or demonstrate another publicly justifiable reason.

Further Discussion: Whereas OPDP can provide significant savings to uninsured and underinsured individuals and some businesses, a few members stressed that there are multistate and national plans that have even more purchasing leverage. These members cautioned that there is no evidence to prove that OPDP should be the standard across the market and stressed that purchasers and plans should have the freedom to explore other purchasing arrangements.

[23] Office for Oregon Health Policy and Research. 2007. Trends in Oregon's Healthcare Market and the Oregon Health Plan: Report to the 74th Legislative Assembly. Available: http://www.oregon.gov/OHPPR/RSCH/docs/LegRpt2007_Final.pdf.
[24] More information about OPDP can be found at: http://www.oregon.gov/OHPPR/OPDP/index.shtml.

Section 3: Minority Report, Submitted by Stefan Ostrach

Overview: While I cannot in good conscience sign on to the Delivery Systems Committee Recommendations for reasons that I will be explain below, I do want to express my thanks and appreciation to everyone else on the Committee and the staff for the many hours of hard work and effort involved. I learned a lot in this process.

Major problems with the Majority Report derive from fatal flaws in the framework embodied in SB 329. Taking the option of a not-for-profit, single-payer delivery system off the table and seating all of the interests that make money from the current system at the table made real reform impossible.

A world class health system cannot be based on the current private insurance model. We pay much more for medical care and have demonstrably worse outcomes than other industrial countries (and even some still developing countries). Countries providing excellent, patient-centered primary care, chronic disease management, and palliative care at much lower cost rely on single-payer or very tightly regulated insurance models. Polls show that a majority of U.S. citizens -- and even of physicians -- support a not-for-profit national health care system, but the OHFB process rules that option out.

SB 329's second fundamental flaw is the notion that the health care system can be reformed on a state-by-state basis, especially in a small state like Oregon. We have a national system. Many of the cost drivers are national. Much of the funding is Federal. Even if the delivery system in Oregon could be changed, those hurt by the changes such as, for example, medical specialists, would likely migrate elsewhere.

Specifics:
Even within the limitations of SB 329's framework, however, the Majority Report does not address the charge given to the Committee to focus on cost control. There are no short-term cost reduction (or even containment) measures in the recommendations other than increased bulk drug purchasing. The direction this whole process seems to be going will be a boon for insurance companies – forcing hundreds of thousands of individuals to buy their products – and a boon for hospitals – relieving them of the cost of charity and other uncompensated care. Yet nothing is recommended for limiting claims ratios or accumulation of net revenues or profits above what is necessary for reserves. Nor is anything recommended to recapture or redeploy hospitals' and other organizations' savings from not having to provide charity and uncompensated care.

Discussion of insurance regulation stopped short when an insurance executive bragged that Oregon companies' performance was better than other states because 85 cents of every dollar is spent on health care. Taft-Hartley Trusts and other countries' single-payer systems have much lower administrative costs. Spending 15% of insurance premium dollars on non-medical expenses should be unacceptable, not applauded. Even more is wasted in administrative costs due to providers' needs to respond to demands of multiple payers.

Integrated health homes make logical sense, but will undoubtedly be more costly for the short term at least, with no evidence that long-term cost savings will result and no evidence that people want them. The IHH model may be good health policy, but it does not address the critical need to reduce costs soon.

Establishing a Quality Institute would require substantial funding for a duplicative new bureaucracy. The important data collection, compilation and reporting functions envisioned can be done more efficiently by the existing OHPR.

Financial transparency would be great, but is insufficient in itself to control costs. Data collection and reporting on the basis of Care Districts could be very useful, but the recommendation for Accountable Care Districts does nothing to establish a mechanism for holding anyone accountable. Regulation seems to have become be a dirty word, but how is there to be any accountability without it?

Incentives and rewards should not be necessary for providers to be accountable for quality, efficiency, health outcomes and care coordination. We need sticks to penalize providers who fail to do so. They already get paid all the carrots they need. We need to reduce costs, not add them through incentives to practice good medicine.

In sum, while many of the specific recommendations of the Committee would be positive reforms, the Majority Report pays only lip service to the goal of holding global Oregon health care costs to the CPI. The committee's recommendations would increase costs while failing to challenge the major profit centers. The recommendations do nothing to transform a system of competing loosely regulated private entities motivated primarily by accumulation of profit (or net revenue) and serving their own interests rather than the public good. Other basic needs of society such as water, sewage treatment, sanitation, roads, and utilities are provided through public, not-for-profit or tightly regulated

organizations. A health care delivery system that can result in a Healthy Oregon must be organized in a similar fashion.

Respectfully submitted,

Stefan Ostrach

Appendix A: Delivery Systems Committee Charter from the Oregon Health Fund Board

I. Objective

The Delivery System Committee ("Committee") is chartered to provide the Board with policy recommendations to create high-performing health systems in Oregon that produce optimal value through the provision of high quality, timely, efficient, effective, and safe health care.

The Committee's recommendation will serve as a cornerstone to the success of the Board's final report. The work of the Committee is framed by several principles and goals outlined in SB 329:

- *Efficiency. The administration and delivery of health services must use the fewest resources necessary to produce the most effective health outcomes.*
- *Economic sustainability. Health service expenditures must be managed to ensure long-term sustainability….*
- *Use proven models of health care benefits, service delivery and payments that control costs and overutilization….*
- *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.*
- *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….*

The Board seeks, through the work of the Committee, more effective and efficient models of health care delivery that will address the health needs of all Oregonians through accountable health plans and other entities.

Bold and creative thinking is encouraged!

II. Scope

A. Assumptions:

In addition to the Board's *"Design Principles & Assumptions"* (attached), the Committee's work should be framed by the following assumptions:

1. While new revenue will be needed in the intermediate term to provide coverage to the currently uninsured, improving the performance of Oregon's delivery systems should provide opportunity to recapture or redeploy resources with consequent reduction in the annual rates of increase in health care costs.

2. The Committee's recommendations on system changes and cost containing strategies should apply to Oregon's delivery systems broadly, not solely to programs for the uninsured.

3. Proposed strategies for containing the rate of health care cost increases should include estimates of "savings" over a defined time period. Such projections will be used by the Finance Committee in the development of overall revenue requirements.

4. The following concepts are of priority interest to the Board:

- **Primary Care**

  Revitalizing primary care models to improve the capacity for and outcomes from preventive and chronic care services.

- **Managing Chronic Disease**

  Strategies for comprehensive, coordinated and sustained clinical management of the chronic diseases that significantly impact overall health care expenditures.

- **New Reimbursement Models**

  Strategies that move from fee-for-encounter (service) to financial incentives/rewards for providers who produce clinical outcomes that meet or exceed widely accepted standards of care.

- **Health Information Technology**

  Public policies and public-private collaborations that will increase the rate of diffusion and use health information technologies (e.g. electronic health records, registries, etc.) and ensure the interoperability of such technologies.

- **Information Transparency**

  Recommendations for a model Oregon Quality Institute that collects, measures and reports information on the performance of health care delivery systems including, but not limited to clinical quality and efficiency indicators. (See Oregon Quality Institute Work Group, below)

- **New Clinical Technologies**

  Recommendations to assure that the "added value" of new clinical technologies is broadly understood and that avoid inappropriate diffusion and utilization.

- **Public Health & Prevention**

Strategies to develop, implement, sustain, evaluate and finance public health and public-private programs that target critical population health issues such as the obesity in Oregon's population.

- **End-of-Life Care**

  Recommendations to improve end-of-life care that promote information about care options and advance directives, improve provider awareness of patient preferences and assure services for dignified care.

Note: The preceding list is not intended to limit the Committee's scope of investigation or recommendations.

B. Criteria:

The Committee should utilize the following criteria to evaluate proposed recommendations:

1. Does the recommendation improve the "value equation"? [Cost / Quality]

2. Does the recommendation contain the rate of growth of health care costs? Can the impact be measured objectively over time?

3. What is the anticipated timeframe for implementation?

- Short term? (1 to 2 years)
- Intermediate term? (3 to 5 years)
- Long term? (5+ years)

4. Does the recommendation require public policy action (statutory or regulatory)? Are the "politics" for such action: Favorable? Mixed? Unfavorable? Unknown?

5. Is voluntary collaboration among purchasers, providers, payers or consumers required to implement the recommendation? What is the "readiness" of key stakeholder groups to support such an effort?

C. Deliverables:

The Board anticipates receiving 5 to 10 recommendations from the Committee that address, in a strategic manner, the development of high-performing, value-producing health care systems. The recommendations may be prioritized.

Each recommendation should include, at minimum:

- A complete description of the recommended strategy and its intended objective(s).
- The method(s) for measuring the impact of the strategy over time.
- Estimates of "savings" achieved over a defined period of time through containing the rate of cost increases.

- The estimated timeframe for implementation with key milestones and risks.
- The impact of the strategy on key stakeholders.
- Reference citations to clinical or health services research relied upon in developing the recommendation.

III. Timing

The Committee will deliver its recommendations to the Board for review and public comment no later than April 30, 2008.

IV. Committee Membership

Name	Affiliation	City
Dick Stenson, Chair	Tuality Healthcare	Hillsboro
Maribeth Healey, Vice-Chair	Advocate	Clackamas
Doug Walta, MD, Vice-Chair	Providence Health and Services	Portland
Vanetta Abdellatif	Multnomah Co. Health Department , Health Policy Commission (HPC)	Portland
Mitch Anderson	Benton County Mental Health	Corvallis
Tina Castanares, MD	Physician, Safety Net Clinic	Hood River
David Ford	CareOregon	Portland
Vickie Gates	Consultant, HPC	Lake Oswego
William Humbert	Retired Firefighter	Gresham
Dale Johnson	Blount International, Inc.	Portland
Carolyn Kohn	Community Advocate	Grants Pass
Diane Lovell	AFSCME, PEBB Chair	Canby
Bart McMullan, MD	Regence BlueCross BlueShield of OR	Portland
Stefan Ostrach	Teamsters, Local 206	Eugene
Ken Provencher	PacificSource Health Plans	Eugene
Lillian Shirley, RN	Multnomah Co. Health Department	Portland
Mike Shirtcliff, DMD	Advantage Dental Plan, Inc.	Redmond
Charlie Tragesser	Polar Systems, Inc.	Lake Oswego
Rick Wopat, MD	Samaritan Health Services, HPC	Corvallis

V. Staff Resources

- Jeanene Smith, Administrator, Office for Oregon Health Policy and Research (OHPR) - Jeanene.Smith@state.or.us; 503-373-1625 (Lead staff)
- Tina Edlund, Deputy Administrator, OHPR – Tina.D.Edlund@state.or.us; 503-373-1848

- Ilana Weinbaum, Policy Analyst, OHPR – Ilana.Weinbaum@state.or.us; 503-373-2176
- Zarie Haverkate, Communications Coordinator, OHPR – Zarie.Haverkate@state.or.us; 503-373-1574

Oregon Quality Institute Work Group

Scope

In order to achieve a high-performing health care delivery system and contain cost increases, the State must work with providers, purchasers, payers and individuals to improve quality and transparency. The Oregon Quality Institute ("Institute") work group will make recommendations on the State's role in building on existing efforts to develop a public-private entity to coordinate the creation, collection and reporting of cost and quality information to improve health care purchasing and delivery. The work group's recommendations will address:

- How should an Institute be organized and governed? How will it coordinate with individual stakeholder efforts and support collaboration?
- How should an Institute be funded in the short and long term?
- How should cost and quality data be collected and stored in a central location?
- What state regulations should be examined for opportunities to increase efficiency and reduce administrative cost?
- How can an Institute foster provider capacity to collect data and use it for improvement?
- What dissemination formats will make information useful to a broad range of audiences?
- How should an Institute address issues of legal discovery and liability?
- What role can an Institute play in engaging Oregonians to use available data when making health care decisions?
- How can the State encourage more effective and coordinated value-based purchasing? How can the State strengthen its own efforts to use value-based purchasing to improve delivery of care for state employees and those served by the Oregon Health Plan?

Timing

The work group will deliver its analysis and findings to the Delivery Committee for review by February 2008.

Work Group Membership

The Institute work group will be comprised of select members of the Delivery Committee with expertise and interest in this topic. The Chair of the Committee may appoint additional members to the work group.

Appendix B - Excerpts from Reports Consulted in Developing a 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.

2006 Executive Order 13410: Promoting Quality and Efficient Health Care in Federal Government Administered or Sponsored Health Care Programs – Four Cornerstones
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.

Appendix C: Recommendations from the Quality Institute Work Group to the Delivery Systems Committee

Oregon

Oregon Health Fund Board
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(503) 373.1779
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To: Members of the Oregon Health Fund Board
From: Members of the Oregon Health Fund Board Delivery Systems Committee
Subject: Quality Institute Work Group Report to the Delivery Committee
Date: April 23, 2008

On April 17, 2008 the Delivery Systems Committee received the enclosed report from its Quality Institute Work Group. The Committee agrees that ongoing quality assessment and a process for quality improvement is the keystone of any viable health care system and must be a central focus of any health reform plan. A single entity is needed to set the quality agenda for Oregon and lead and unify existing quality initiatives in a collaborative effort to move the state toward a higher performing health system. Therefore, the Delivery Systems Committee endorses the recommendations, but suggests that the Board consider the following issues before making final recommendations. The points below reflect suggestions made by Committee members during the April 17 meeting.

- **Clarify and strengthen language about aligning stakeholders around common quality metrics and setting standards for data collection and reporting**. The Quality Institute should set standards for what metrics are collected and reported and how data is collected and reported. Standards should aim to simplify and streamline processes, allow for meaningful comparisons across the health care system and reduce administrative costs associated with reporting different sets of measures to different purchasers and health plans. In addition, the Quality Institute should set performance benchmarks that can be adapted over time.
- **Efforts of the Quality Institute must support and be aligned with Accountable Care Districts and reform evaluation.** The data collected and reported by the Quality Institute should support performance evaluation within the healthcare system, but must also support community evaluation of performance. The Quality Institute should report data in a way that allows for meaningful comparisons across communities and accountable care districts. In addition, the Quality Institute must collect and report data that aligns and supports efforts to evaluate state funded health programs and health care reform.

- **Providing understandable and meaningful information about quality to consumers must be a priority.** "Understandable" should be added to the definition of transparency to reflect the need to ensure that public reporting be done in a way that is meaningful to lay persons. Recommendations should be reordered to put more of an emphasis on the need to engage and support consumers in quality improvement initiatives.
- **The recommended structure should be revisited after a comprehensive plan is developed.** Members questioned whether there would be a need for a separate and distinct Quality Institute with all of the entities created through reform. Members also suggested that the Board assess the role of private stakeholders in the public-private structure and suggested that these stakeholders provide specific testimony as to how a Quality Institute could enhance current efforts.
- **Greater transparency around cost is vital to reform and cost containment efforts.** The Delivery Committee did not necessarily recommend that the Quality Institute should take a more significant role in reporting data associated with costs than was recommended by the Work Group, but suggested that cost transparency needs to be addressed throughout the reform process.

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.[25] 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.[26] While there are numerous public and private efforts underway across the state to improve health care quality, SB 329 points to the need for a Quality

[25] 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.

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

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.[27] 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.[28] 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 an Oregon Quality Institute:

- 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

[27] Institute of Medicine. Crossing the Quality Chasm: A New Health System for the 21st Century. (2001). National Academy Press: Washington, DC.
[28] 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:

6. 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.

7. 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.

8. 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.

9. 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.

10. 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.

- 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.

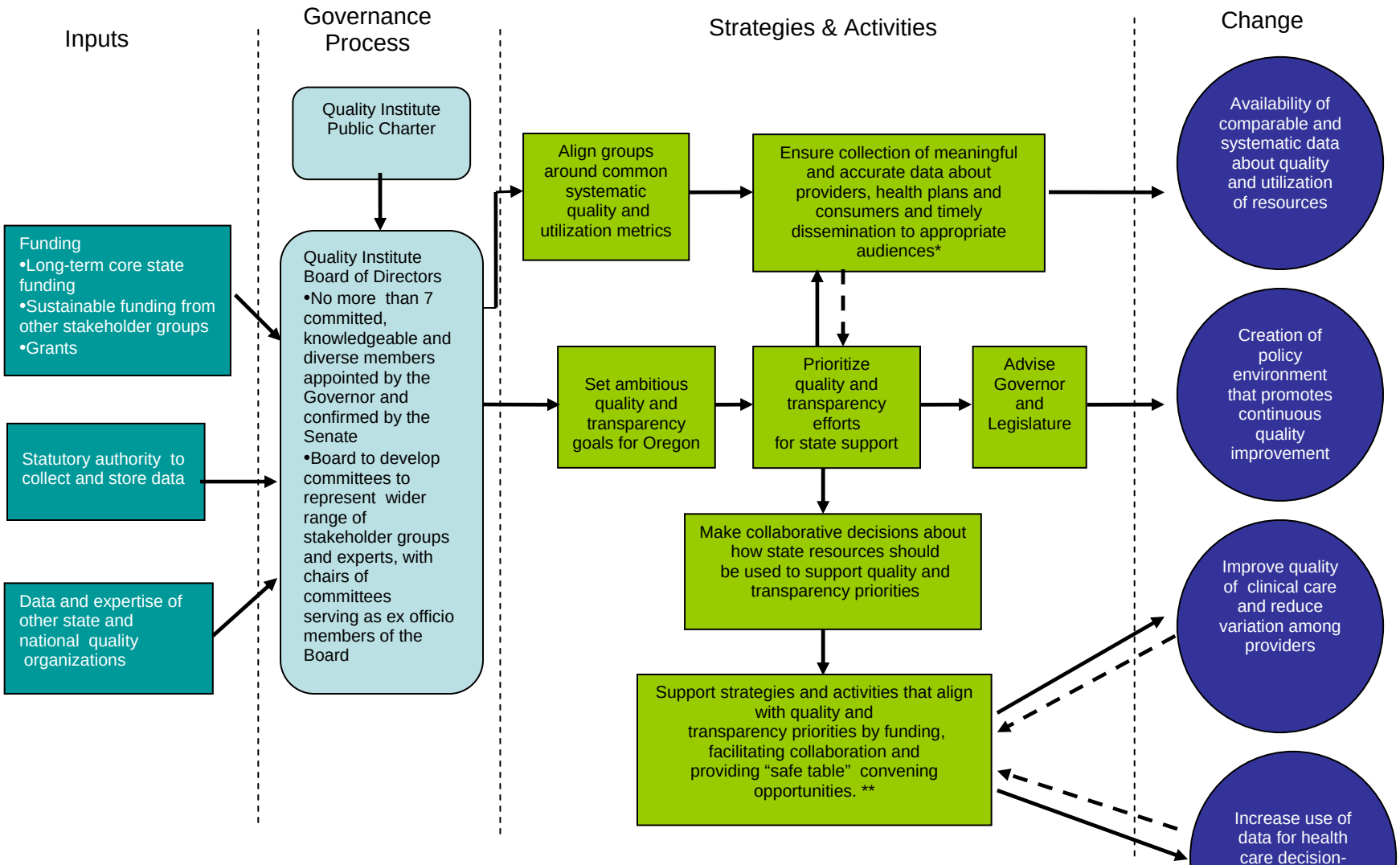
- Support efforts, in partnership with providers, to engage consumers in the use of quality and utilization data and evidence-based guidelines to make health decisions. Support efforts to engage patients in taking responsibility for their own health.

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



*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.[29] 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

[29] 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 an Oregon Quality Institute, 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.[30] 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

[30] 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:

6. 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).

7. 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).

8. 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[31]:

- 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).

9. 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).

10. 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):

[31] 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. [32]

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

[32] 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 1: 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 2: 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 3: 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.

Appendix D - Appendix D: Delivery Systems Committee Inventory of Possible Cost Containment Strategies – Draft for Discussion at 3/13 Meeting

GOAL: Correct Health Care Price Signals

Strategy	**Possible Approaches**	**Target**	**One-Time or Long-Term Savings**
Uniform payer rates	Uniform payment rates for hospitals and/or all providers based on % Medicare rate	Providers	One-Time reduction with long term savings
Administrative Simplification	Encourage health insurers and/or purchasers to adopt common forms and procedures for enrollment and billing across all payers, matching Medicare requirements as close as possible	Health Plans, Purchasers,Providers	Long-Term
	Standard procedures for data collection and reporting of quality measures (correlated with Quality Institute recommendations)	Health plans, Providers	Long-Term
	Develop standard definition of "administrative costs" and require plans to be transparent about how much spent on administrative services	Health Plans	??
Health Plan Regulation	Set minimum loss ratios	Health plans	??
	Cap administrative costs and profits/net income of insurance providers	Health plans	??
	Add investment income and insurer profits as key factors to be reported and considered in rate approval process	Health plans	??
	Increase transparency by defining insurance rate filings as public records open to public scrutiny	Health plans	??
	Expand scope of insurance rate review to larger groups	Health plans	??

Hospital Regulation	Limit percent of profit/net income of hospitals with due regard for capital investment needs	Hospitals	One-Time
	New/more explicit requirements around hospital profit and investment in community in return for non-profit tax treatment	Hospitals	??
Reduce Pharmaceutical Spending	Bulk purchasing for all OHFP through OPDP and NW Purchasing Consortium	Pharmaceutical Co.	One-Time
	Single statewide formulary - required for all public programs and voluntary for others	Providers, Health Plans	Long-Term

Goal: Improve Quality and Efficiency of Care Provided Across Oregon

Strategy	**Possible Approaches**	**Target**	**One-Time or Long-Term Savings**
Paying for Quality	Competitive contracting/value-based purchasing for publicly and privately purchased healthcare	Purchasers	Long-term
	No billing for National Quality Forum "never events"	Health plans, providers	Long-term
	Provide incentives to providers who deliver high quality care (must be cost neutral overall to create a differential between top and bottom performers)	Providers	Long-term
Improved Quality and Transparency	Recommendations from Quality Institute Work Group to be received 3/08 on how to make appropriate cost and quality data easily accessible to multiple stakeholder groups		
Health Information Technology	Recommendations from HIIAC on how to promote widespread adoption of interoperable electronic health records and other health information technologies to support health care decision-making		

Goal: Adjust Demand for Care by Encouraging Healthy Behaviors and Informed Decision-Making

Strategy	Possible Approaches	Target	One-Time or Long-Term Savings
Public health strategies	Fund public health activities with evidence of positive outcomes	Consumers	Long-term
Health Plan Design	Support plan design the encourages healthy behaviors, prevention and disease management	Consumers	Long-term
	Explore no/reduced copays for preventative services	Consumers	Long-term
	Increased cost-sharing for treatment options found to be inconsistent with clinical guidelines	Consumers	Long-term
Creating Culture of Health	Encourage employers, schools and community organizations to build a culture of health and encourage activities that reduce absenteeism, decrease disability rates and increase productivity	Consumers, Communities	Long-term
	Build culture of health for state employees	State employees	Long-term
Shared Decision Making	Encourage use of patient decision aids before having certain preference sensitive procedures where have been shown to increase use of cost-effective interventions	Providers, patients	Long-term

Goal: Adjust Supply of Care Through Incentives to Encourage Provision of Effective and Efficient Care

Strategy	Possible Approaches	Target	Long-Term or Short-Term
Targeted Capital Investment	Redesign certificate of need or establish alternative program to effectively control costs, reduce duplicative services and encourage investments in primary care	Providers	Long-Term
	Creation of centers of excellence program	Providers	Long-Term
	Pilot regional health planning organizations	Providers and Communities	Long-Term
Comparative Effectiveness/Medical Technology Assessment	Create collaboration around evaluation of new devises, drugs, procedures and other treatments for comparative effectiveness through expanded role for state's HRC/HSC or through a new entity	All	Long-Term
	Develop and/or endorse clinical guidelines for OHFP providers and widespread statewide adoption	Providers	Long-Term
	Require OHFP plans to design benefits from evidence of added value of treatments and procedures and consistently update using new information	Health Plans	Long-Term
	Pilot projects that require private and public purchasers and health plans to collaborate around joint policies regarding coverage of new technologies and procedures	Health Plans, Purchasers	Long-Term
Provider Payment Strategies Focused on Integrated Health Home (most likely a combination of approaches will be	Bundled per member per month prospective payments for providing integrated health home services (risk adjusted)	Providers	Long-Term
	Capitated payment to integrated health homes to provide all primary care and disease management services (tied to clinical guidelines, risk-adjusted)		
	Pay for Process - Reward providers for providing integrated health home services		

needed)	Pay for Performance - Reward providers for better health outcomes, higher quality and more efficient use of resources		
Provider Payment Strategies to be Applied to Integrated Health Homes and Across Wider Delivery System	Bundled payments based on episodes of care or portion of episodes of care	Providers	Long-Term
	Condition specific capitation		
	Performance payments for practices able to meet quality goals		
Hospital payments	Hospital pay for performance with bonus payments based on top performance, absolute performance and/or performance improvement	Hospitals	Long-Term

Resources Consulted in Developing Inventory:

- C. Schoen, et al. 2007. *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending*. The Commonwealth Fund. Available: http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=620087
- M. Trinity, et al. 2008. *State of the States.* Robert Wood Johnson State Coverage Initiatives. http://statecoverage.net/pdf/StateofStates2008.pdf
- *Health Care Transformation Task Force: Recommendations Submitted to Governor Tim Pawlenty and the Minnesota State Legislature*. 2008. Available: http://www.health.state.mn.us/divs/hpsc/hep/transform/ ttfreportfinal.pdf
- The Legislative Commission on Health Care Access. 2008. *Final Report: Recommendations Submitted to the Minnesota State Legislature*. http://www.commissions.leg.state.mn.us/lchca/HCAC%20Report%20final%202-08.pdf
- Blue Ribbon Commission for Health Care Reform. 2008. *Final Report to the Colorado General Assembly*. Available: http://www.colorado.gov/cs/Satellite?c=Page&cid=1201542097631&pagename= BlueRibbon%2FRIBBLayout

- H. Olsen. 2006. Catamount Health: Vermont's Health Care Reform Plan. Available: http://www.une.edu/com/chppr/pdf/catamounthealth_olson.pdf.
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- J. Ockene, et al. 2007. *Integrating Evidence-Based Clinical and Community Strategies to Improve Health.* American Journal of Preventative Medicine. 32(3): 244-252.
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- M. Frendrick and M. Chernew. 2006. *Value-based Insurance Design: Aligning Incentives to Bridge the Divide Between Quality Improvement and Cost Containment.* The American Journal of Managed Care. 12: SP5-SSP10.
- E. Fisher, et al. 2006. *Creating Accountable Care Organizations: The Extended Hospital Medical Staff. Health Affairs*. Web Exclusive: w44–w57.
- A. Gorroll, et al. 2007. Fundamental Reform of Payment for Adult Primary Care: Comprehensive Payment for Comprehensive Care. Journal of General Internal Medicine. 22(3)410–15.
- F. de Brantes and J. A. Camillus. 2007. Evidence-Informed Case Rates: A New Health Care Payment Model. The Commonwealth Fund. Available: http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=47827

Appendix E – The Commonwealth Fund's Commission on a High Performance Health System Policy Options for Achieving Cost Savings and Improving Value in the U.S. Health Care System and Cumulative Impact of National Health Expenditures

From: C. Schoen, et al. 2007. *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending*. The Commonwealth Fund. Available: http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=620087

	One-Year Impact on NHE (billions)	Cumulative Five-Year Impact on NHE (billions)	Cumulative 10-Year Impact on NHE (billions)
Producing and Using Better Information			
1. Promoting Health Information Technology	$8	$14	–$88
2. Center for Medical Effectiveness and Health Care Decision-Making	–$18	–$125	–$368
3. Patient Shared Decision-Making	–$1	–$4	–$9
Promoting Health and Disease Prevention			
4. Public Health: Reducing Tobacco Use	–$5	–$64	–$191
5. Public Health: Reducing Obesity	–$3	–$61	–$283
6. Positive Incentives for Health	$0	–$5	–$19
Aligning Incentives with Quality and Efficiency			
7. Hospital Pay-for-Performance	–$2	–$14	–$34
8. Episode-of-Care Payment	–$17	–$96	–$229
9. Strengthening Primary Care and Care Coordination	–$5	–$60	–$194
10. Limit Federal Tax Exemptions for Premium Contributions	–$10	–$55	–$131
Correcting Price Signals in the Health Care Market			
11. Reset Benchmark Rates for Medicare Advantage Plans	–$3	–$20	–$50
12. Competitive Bidding	–$7	–$42	–$104
13. Negotiated Prescription Drug Prices	–$3	–$16	–$43
14. All-Payer Provider Payment Methods and Rates	$2	–$23	–$122
15. Limit Payment Updates in High-Cost Areas	–$4	–$43	–$158

Note: A negative number indicates spending decreases compared with projected expenditures (i.e., savings); a positive indicates spending increases.

Appendix F: Summary of Select National and State Comparative Effectiveness Initiatives

Initiatives in Oregon

- The Health Resources Commission (HRC) was created as part of the Oregon Health Plan to encourage 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 of medical technologies and their impact on the health and health care of Oregonians. The HRC conducts medical technology (including treatments) assessments, serves as a statewide clearinghouse for medical technology information; identifies information which is needed but lacking for informed decision making regarding medical technology, provides a public forum for discussion and development of consensus regarding significant emerging issues related to medical technology; and informs health care decision makers, including consumers, of its findings and recommendations regarding trends, developments and issues related to medical technology. The HRC is also responsible for the conduct of evidence based reviews of pharmaceutical agents, provides a process for public input into these evaluations, and provides healthcare decision makers, including consumers, access to this information.
- Oregon's Health Services Commission (HSC) is responsible for developing and maintaining the Prioritized List, which ranks health services based on the comparative benefits of each service to the entire population served. The Commission is directed to encourage effective and efficient medical evaluation and treatment by considering both the clinical effectiveness and cost-effectiveness of health services in determining their relative importance. The Health Services Commission reported a new Prioritized List of Health Services for the 2007-09 biennium, which places a new emphasis on preventive care and chronic disease and also reflects a better account of clinical effectiveness and cost-effectiveness into the ranking of health services. The list is used to determine the services that are covered by the Oregon Health Plan.
- The Drug Effectiveness Review Project (DERP) is a collaboration of organizations that have joined together to obtain the best available evidence on effectiveness and safety comparisons between drugs in the same class, and to apply the information to public policy and decision making in local settings. Each participating organization contributes an equal amount to the financing of the DERP, and guides its operation through a self-governing process in which each organization is equally represented. The drug classes to be studied, key questions, timelines and final approval of draft reports are all determined by the DERP participants through this self-governance process. The DERP product is a series of comprehensive, updated and unbiased systematic reviews conducted by Evidence Based Practice Centers (EPC) with oversight and coordination from the Oregon EPC. Current DERP participating organizations are: Arkansas; Canadian Agency for Drugs and Technologies in Health; Idaho; Kansas; Michigan; Minnesota; Missouri; Montana; North Carolina; New York; Oregon; Washington; Wisconsin; Wyoming. The Center for Evidence-based Policy (CENTER) at OHSU supports the collaboration by executing the agreements and the contracts required to operate the collaboration, and by staffing the governance

process that directs the Project. In addition, the CENTER supports communication between the participating organizations and the EPCs, provides technical assistance to participating organizations on the understanding and use of systematic reviews, ensures that timelines are met and manages communication among the participating organizations, between pharmaceutical companies and the Project. The CENTER does not participate in the evaluation of the evidence nor does the CENTER have a vote in any governance issue or process.

- The Drug Effectiveness Review Project (DERP) is a collaboration of organizations that have joined together to obtain the best available evidence on effectiveness and safety comparisons between drugs in the same class, and to apply the information to public policy and decision making in local settings. DERP is funded by the Agency for Healthcare Research and Quality, along with participating organization and is based at Oregon's Center for Evidence-Based Policy at OHSU. The Oregon Evidence-Based Practice Center, also at OHSU, is a participating member in DERP, as are organizations from Arkansas, Idaho, Kansas, Michigan, Minnesota, Missouri, Montana, North Carolina, New York, Washington, Wisconsin and Wyoming and the Canadian Agency for Drugs and Technologies in Health.
- The Medicaid Evidence- based Decisions (MED) Project was established in 2006 as a self-governing collaboration of state Medicaid agencies across the U.S. The project was developed as a response to the need for high quality evidence to support benefit design and coverage decisions. Due to the self-governing nature of MED, focus remains on the issues of greatest importance to Medicaid agencies and the populations they cover. As part of OHSU's Center for Evidence-based Policy, the MED Project provides participants with a unique set of high quality resources designed to assist Medicaid agencies in providing better healthcare and improving their use of available resources. MED's clinical evidence reports (and other resources) clarify and interpret what evidence exists, documenting its quality and relevance. Current MED organizations include the following states: Alaska, Alabama, Arkansas, Kansas, Minnesota, North Carolina, Missouri, Montana, Oklahoma, Oregon, and Washington.

National Initiatives

Excerpts from: G. Jacobsan. 2007. Comparative Clinical Effectiveness and Cost-Effectiveness Research, Background, History, and Overview. Congessional Research Services Report for Congress. For citations and more information on individual efforts see full report at: http://assets.opencrs.com/rpts/RL34208_20071015.pdf

- The Academy of Managed Care Pharmacy disseminates guidelines for conducting formulary assessments to help ensure that any increased utilization of pharmaceuticals and vaccines is based on good scientific evidence and value.
- The Agency for Healthcare Research and Quality is an agency within the Department of Health and Human Services established to perform outcomes research and clinical practice guidelines development. Specific AHRQ programs include: the Centers for Education and Research on Therapeutics (CERTs); the Developing Evidence to Inform Decisions about Effectiveness (DEcIDE) Program; the Evidence-based Practice Centers (EPCs); and the Research Initiative in Clinical Economics (RICE).

These centers conduct technology assessments, comparative effectiveness research, pharmaceutical outcomes research, and economic valuations of health care services.
    - Centers for Education and Research on Therapeutics (CERTSs) conducts pharmaceutical outcomes research that compares health, risks, benefits, cost-effectiveness, economic implications and interactions of treatments.
    - The Developing Evidence to Inform Decisions about Effectiveness Program (DEcIDE) was created to conduct and support research on outcomes, comparative clinical effectiveness, and appropriateness of pharmaceuticals, devices, and health care services.
    - The Evidence-based Practice Centers Program (EPC) program was established to improve the quality, effectiveness, and appropriateness of health care through technology assessments, evidence reports, and research on the methods for systematic reviews. The reports inform public and private insurers' coverage decisions and are used to develop quality measures, educational materials, guidelines, and research agendas. Cost-effectiveness analysis has been used as a research tool in some of the reports.
    - Research Initiative in Clinical Economics (RICE) funds research on the cost-effectiveness, cost-benefit, and methods for estimating the value of health care interventions.
- The Technology Evaluation Center (TEC) of the BlueCross BlueShield (BCBS) Association has been assessing the relative effectiveness and appropriateness of different technologies since 1985. The Center's evaluations focus on the relative effectiveness of technologies, particularly with regard to the effect upon health outcomes, such as length of life, quality of life, and functional abilities.
- Consumer Reports' Best Buy Drugs Project is a non-profit project of Consumer Reports that is primarily supported by educational grants. The project synthesizes DERP findings in order to provide comparative effectiveness information about drugs to health care consumers and providers, and selects "Best Buy picks" within drug classes. The most influential factor in the selection process is the drug's effectiveness.
- The Department of Defense PharmacoEconomic Center (PEC) was established with the mission is to "improve the clinical, economic, and humanistic outcomes of drug therapy in support of the readiness and managed healthcare missions of the Military Health System." The center performs cost-effectiveness analyses, develops formulary lists, provides drug treatment guidelines for the Veterans Health Administration, and monitors drugs' use, cost, and pharmacoeconomics within the Military Health System. Some of the evaluations by the PEC are publicly available.
- The U.S. Preventive Services Task Force (USPSTF) was established in 1984 as an independent federal advisory committee, under the U.S. Public Health Service, and given the responsibility of developing clinical practice guidelines for primary care physicians. The guidelines, in general, focus on the prevention of diseases, and compare preventative methods.
- The Pharmacy Benefits Management Strategic Healthcare Group (PBMSHG) was established within the Veterans Health Administration (VHA) in 1995 to improve the health status of veterans by encouraging the appropriate use of medications. The group compares and publishes analyses of the effectiveness of drugs in the same

class, produces clinical practice guidelines, and drug monographs, in addition to establishing the Department of Veterans Affairs' (VA) formulary, drug pricing, and contracts.

- The State of Washington's Health Technology Assessment Program was created in 2006 to ensure that health technologies purchased by the state are safe and effective and coverage decisions made by various state agencies are consistent, transparent and based on evidence.

Appendix G: Physician Orders for Life Sustaining Treatment (POLST) Paradigm

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Physician Orders
for Life-Sustaining Treatment (POLST)

First follow these orders, then contact physician, NP, or PA. This is a Physician Order Sheet based on the person's medical condition and wishes. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.

Last Name	
First Name/ Middle Initial	
Date of Birth	

A *Check One*

CARDIOPULMONARY RESUSCITATION (CPR): **Person has no pulse and is not breathing.**

☐ Attempt Resuscitation/CPR ☐ Do Not Attempt Resuscitation/DNR (Allow Natural Death)

When not in cardiopulmonary arrest, follow orders in **B**, **C** and **D**.

B *Check One*

MEDICAL INTERVENTIONS: **Person has pulse and/or is breathing.**

☐ **Comfort Measures Only** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. ***Do not transfer*** *to hospital for life-sustaining treatment.* ***Transfer*** *if comfort needs cannot be met in current location.*

☐ **Limited Additional Interventions** Includes care described above. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. ***Transfer*** *to hospital if indicated. Avoid intensive care.*

☐ **Full Treatment** Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. ***Transfer*** *to hospital if indicated. Includes intensive care.*

Additional Orders: _____

_____

C *Check One*

ANTIBIOTICS

☐ No antibiotics. Use other measures to relieve symptoms.
☐ Determine use or limitation of antibiotics when infection occurs.
☐ Use antibiotics if life can be prolonged.

Additional Orders: _____

D *Check One*

ARTIFICIALLY ADMINISTERED NUTRITION: **Always offer food by mouth if feasible.**

☐ No artificial nutrition by tube.
☐ Defined trial period of artificial nutrition by tube.
☐ Long-term artificial nutrition by tube.

Additional Orders: _____

E

REASON FOR ORDERS AND SIGNATURES

Discussed with:
☐ Patient
☐ Parent of Minor
☐ Health Care Representative
☐ Court-Appointed Guardian
☐ Other:_____

My signature below indicates these orders are consistent with the person's preferences, if known. See medical record for further documentation.

Print Physician/NP/PA Name and Phone Number ( )		Office Use Only
Physician/NP /PA Signature (mandatory)	Date	

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

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Signature of Person, Parent of Minor, or Guardian/Health Care Representative

Significant thought has been given to life-sustaining treatment. Preferences have been expressed to a physician and/or health care professional(s). This document reflects those treatment preferences.

(If signed by surrogate, preferences expressed must reflect patient's wishes as best understood by surrogate.)

Signature (optional)	Name (print)	Relationship (write "self" if patient)

Contact Information

Surrogate (optional)	Relationship	Phone Number	
Health Care Professional Preparing Form (optional)	Preparer Title	Phone Number	Date Prepared
PA's Supervising Physician		Phone Number	

Directions for Health Care Professionals

Completing POLST

Must be completed by a health care professional based on patient preferences and medical indications.

POLST must be signed by a physician/NP/PA to be valid. Verbal orders are acceptable with follow-up signature by physician/NP/PA in accordance with facility/community policy.

Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid.

Using POLST

Any incomplete section of POLST implies full treatment for that section.

No defibrillator (including AEDs) should be used on a person who has chosen "Do Not Attempt Resuscitation."

Oral fluids and nutrition must always be offered if medically feasible.

When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).

IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only."

Treatment of dehydration is a measure which prolongs life. A person who desires IV fluids should indicate "Limited Interventions" or "Full Treatment."

A person with capacity, or the surrogate of a person without capacity, can request alternative treatment.

Reviewing POLST

This POLST should be reviewed periodically and if:
(1) The person is transferred from one care setting or care level to another, or
(2) There is a substantial change in the person's health status, or
(3) The person's treatment preferences change.

Draw line through sections A through E and write "VOID" in large letters if POLST is replaced or becomes invalid.

The Oregon POLST Task Force

The POLST program was developed by the Oregon POLST Task Force. POLST is housed at Oregon Health & Science University's Center for Ethics in Health Care. Others seeking permission to use the copyrighted form may contact the Center for Ethics in Health Care. Research on the POLST program is available online at <**www.polst.org**> or by contacting the Task Force at <**polst@ohsu.edu**>.

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

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Appendix H: Safety Net Advisory Council Recommendations to the Delivery Systems Committee

Safety Net Advisory Council Recommendations to the OHFB Delivery System Committee for inclusion as recommendations to the full board.
May 9, 2008

Safety Net

The health care safety net is a key delivery system element for the protection of the health of Oregonians and the delivery of community-based care (SB 329).

1. Recommendation 1: To help assure the on-going viability of the safety net the state should establish a Safety Net Integrity fund. The Safety Net Integrity Fund will assist in preserving the safety net and maintaining community based patient-centered services for those who face barriers to care. The Integrity Fund will provide a source of capital for safety net clinics to maintain essential services and support expansion for additional sites or services in areas of unmet need. Stable funding will enable Oregon to maintain critical infrastructure and "grow" the health care safety net in a strategic and sustainable way.

2. Recommendation 2: The state should develop a plan to assure an adequate safety net workforce. Baby boomer retirements will have an especially strong impact on the safety net and rural areas in particular. Specific issues need to be addressed such as assuring an adequate provider "pipeline", preventing burn-out of existing providers, addressing misdistribution of workforce, providing workforce tools that will help safety net clinics remain viable and supporting communities in their efforts to evolve models that work. Like the rest of the health care delivery system the safety net is dependent on its workforce. It is especially dependent on mid-levels and physicians who provide supervision, dentists and increasingly, behavioral/mental health professionals.

3. The state should assure that primary care safety net providers are included in accountable health plans provider panels and as participants in Accountable Health Districts. The safety net is a "Living" Innovation lab for many of the leading initiatives in health care today. Examples include addressing health care disparities, implementing integrated health homes, employing culturally competent care practice, providing affordable care, use of allied health professionals, and application of evidence based practice. These mission driven organizations should be an integral part of key components of delivery system renewal.

4. The State should develop and implement a plan to assure safety net provider adoption of electronic health records. Oregon and the nation are moving toward greater readiness to implement health information technology. It is a key tool for realizing the broader goals of access, quality, safety, improved health and cost reduction. The safety net provides care to many Oregonians who face barriers to care and who often move in and out of coverage and from provider to provider. Policy makers can help assure that

electronic health records are available at the time of treatment for safety net patients. The barriers to broad adoption of health information technology across the safety net are substantial. They include significant start up and ongoing cost. In addition, safety net clinics have much smaller operating margins than the private sector and have less access to capital. In general, what margin safety net clinics do have is funneled back into services.

Note: The Safety Net Advisory Council has previously provided more detailed recommendations. A summary of those recommendations is available for Committee reference.