

**Oregon Incentives & Outcomes Committee
Meeting Summary**

July 15, 2010
8:30am – Noon

Committee Members in Attendance

Mike Bonetto, Health Policy Board liaison
Denise Honzel, Co Chair
John Worcester, Co Chair
Bart McMullan, Payment Reform Subcommittee Chair (by phone)
Glenn Rodriguez, Quality & Efficiency Subcommittee Chair
Chris DeMars
Stephanie Dreyfuss
Laura Etherton
Megan Haase (by phone)
David Labby
William Murray
William Olson
Morgan O'Toole
Sujata Sanghvi
Rick Wopat (by phone)
Seth Bernstein
Ken House
Robert Marsali
Mary Minniti
Jim Russel (by phone)
David Schlactus
Brett Sheppard, MD
Rachel Solotaroff, MD
Joe Zaerr

Committee Members not in Attendance

Nancy Clarke
Dan Clay
David Dorr
Steve Jasperson
Jim Kahan
Jim Russell
Dick Stenson
Thomas Syltebo, MD

OHPR and OHA Staff in Attendance

Jeanene Smith
Barney Speight (by phone)

Gretchen Morley
Lynn-Marie Crider
Lisa Angus

Meeting Summary (Committee actions or decisions in bold)

The meeting began at 8:30. Denise Honzel opened the meeting and gave an overview of the agenda.

Previous Minutes were accepted as submitted.

Bylaws were accepted as revised.

Gretchen Morley noted that coordinating the work of the many Health Policy Board and OHA committees was becoming more important as work was progressing. Email consultations and coordination will likely be required since there is limited time available in meetings for one committee to react to another's developing recommendations. In addition, all Committee Chairs and staff will meet on July 21 to discuss the intersections of their work.

Barney Speight answered a few questions about the work of the Public Employers' Health Purchasing Committee. He noted that:

- Most purchasers have already finalized their 2011 plan designs, so fall and winter are good times to work with people on 2012 designs.
- The Committee is having conversations with different entities about standardizing payment approaches (as opposed to prices) for public and private reimbursement (e.g. DRGs).
- Pay-for-performance is an approach that's on the table and some public purchasers, like PEBB, use it already in select areas. It would be fascinating to have a standard approach to P4P (both payment methods and quality measures) that all carriers could adopt.

Jeanene Smith gave an update from the Health Policy Board. The cost of health care is a big focus for the Board, especially given the state's budget crunch. In terms of recommendations, the Board does not want a long report; the hope instead is that Committees will outline key action steps for the next 1-3 years, then for the period beyond that. Key points of the subsequent discussion included:

- In terms of scope, the Board is interested in both pilots and widespread change and would like to see changes in both the public and private sectors, although it has the ability to act sooner or more directly in the public sector.
- Containing cost growth is probably a more realistic goal for the short term than lowering costs. Some have suggested that a 1.5% growth rate should be the target, but sustainability is also important.

- Debating whether to address low hanging fruit or embark on big system changes is not productive; both are necessary. What we know how to do can be characterized as low hanging fruit and we should get better at doing that. Simultaneously, we should do pilot projects to learn how to make the changes we don't yet know how to do most effectively.

Denise Honzel summarized the conversation by noting that the Committee must produce action-oriented recommendations for the short and long-term, in order to deliver results that are going to drive efficiency and take costs out of the system.

Bart McMullan gave an overview of the Payment Reform Subcommittee's activities to date. The Subcommittee developed some principles for their work and is now moving to identify concrete proposals for payment reform in three areas: primary care, specialty care, and hospitals. Some of the wide variation in payment practices may also need to be addressed as a first step. Suggestions and comments for the payment reform subcommittee included:

- Adding some language to the principles' preamble to emphasize the importance of patient activation (or consumer engagement) and the important role of employers and other purchasers.
- Standardizing units of service or reimbursement is less important than standardizing the idea that we want to buy quality, rather than service outputs.
- The Subcommittee is on the right track, but can it accomplish everything it hopes to do before October?

Glenn Rodriguez gave an overview of the Quality & Efficiency Subcommittee's activities and noted that it was helpful to hear about the Payment Reform principles and workplan, since part of the Quality & Efficiency Subcommittee's role is to support that work. The Subcommittee has spent some time on the tension between short-term deliverables (the need to identify measures that we can use now) and long-term direction (the opportunity to identify measures that are useful tools for driving transformation in the delivery system). The Quality & Efficiency Subcommittee has small workgroups in three topic areas (patient-centeredness; cost & efficiency; and quality, safety, and effectiveness) and a representative from each group briefly updated the full Committee on their conversations to date.

To start a discussion about integrating the Subcommittees' work, Jeanene Smith presented a few hypothetical payment reforms or incentives along with examples of quality measures that might be used in administering or evaluating those incentives. It was noted again that the Health Policy Board is likely to be particularly focused on cost and efficiency. In subsequent discussion, Committee members said that having a common priority list of high cost items and/or areas where quality deficits are large would be helpful for focusing and integrating the Committee work. Staff will prepare a draft list of such items, along with criteria that the Committee can use to prioritize among the items.

Public Comment:

Jamie Sewell from the CHP Group, a complementary/alternative medicine (CAM) PPO in Beaverton, commented on the potential of CAM to help with system reform. While there is relatively little mention of CAM providers in health reform discussions, since they don't represent a large portion of healthcare spending, Ms. Sewell noted that CAM providers represent a trained and ready port-of-entry into care. CAM is also a low-utilization model. Ms. Sewell offered to share a white paper on how CAM can help mitigate problems with cost, quality, and access with any interested Committee members.

The Committee adjourned its meeting at 10:45.