January 22, 2004
9:00 – 11:00 AM
Clackamas Community College Wilsonville
Rooms 111 & 112

Attendees:
Katie Gauthier, Jenny Pathak, Lorey Freeman, Kathy Cervantes, Paulos Sanna, Debbie Lamberger, Linda Hermon, Mary Ann Evans, Kim Harris Tierney, Dennis Deck, Bob Lowe, Joy Soares, Donna Harles, Liz Stevenson, Jeannene Smith, Tina Edlund, Lisa Krois, K. John McConnell

Facilitator: Tina Edlund

I. Welcome Message
II. OHREC Activities update:
III. Presentation by: John McConnell
IV. Measure 30 Discussion:
V. Other Activities
VI. Next Meeting:

Tina Edlund, Evaluation Research Director for the Office for Oregon Health Policy and Research, briefly discussed the series of OHREC past and future research projects that would look at the impacts on people as a result of changes in the Oregon Health Plan; both as a result of the waiver, approved last year and those due to budget cuts. (See attached research matrix for more detail on these projects.

OHREC Activities since last meeting:
Dr. Zerzan presented the results of her study of the Medically Needy Program to the Joint Committee on Health and Human Services at their request.

OHP2 Cohort Survey continues on the people who were on the Oregon Health Plan as of February 15, 2003. The first wave of surveys has come in and the second wave mailing is ready to go out.

The Legislative survey continues to be developed in an effort to learn how legislators prefer to receive their information and how we can best deliver it to them.

Presentation: K. John McConnell PhD presented findings from: "The Effect of Changes in Monthly Premiums and Administrative Lock-Out on OHP Enrollment" (full presentation available in PDF at www.ohpr.state.or.us)

Summary

- **Results**
  - **Before Implementation of the OHP2 Waiver**
    - **The Zero to 10% FPL income groups were most likely to stay enrolled.**
    - **10 –50% FPL next likely to stay enrolled**
    - **White, English speaking individuals more likely to stay enrolled**
    - **Couples were less likely to stay enrolled**
    - **Older individuals more likely to stay enrolled**
    - **The longer a person was on the plan were more likely to stay enrolled**
  - **After Implementation of OHP2**
    - **Between January 2003 and October 2003, enrollment in OHP Standard decreased from 87,700 to 49,000**
    - **Steepest decline in enrollment experienced by those with zero income. This group experienced a 58% decline from January 2003 to October 2003.**
    - **The "case mix" for OHP shifted as a result. The zero income category accounted for 41% of the OHP cases in October 2002. By October 2003 they accounted for 32% of the caseload.**

    - **Individuals enrolled for more than 7 months are more likely to continue with enrollment**
    - **Older individuals more likely to stay enrolled**
    - **85% to 100% FPL most likely to stay enrolled**
    - **Zero income group least likely to stay enrolled**
    - **Non-English speakers more likely to stay enrolled**
  - **Challenges**
    - Multiple changes in OHP during the same period present challenges in isolating cause or causes for changes in enrollment.
      - Benefit package change
      - Premium, co-pay changes
      - Administrative rule changes

Follow-up Discussion:

A representative from a Multnomah County Clinic described the inability to handle the current flow of patients, many of who are showing up without prescription coverage and in need of medications. One example given described diabetes patients reporting from the ER in need of insulin but without access.

Discussions continued regarding sponsorships by organizations that pay premiums on behalf of OHP patients so that they can maintain coverage. Oregon is reportedly working to put together a sponsorship program similar to that found at Yakima Valley Farm Workers in Washington. Concerns were expressed regarding the legalities behind certain sponsorship programs and the possibility that they may be seen as illegal kickbacks.

Measure 30 Discussion (see attached document for details):
Jeanene Smith, Deputy Administrator of the Office for Oregon Health Policy and Research discussed a handout regarding the proposed cutbacks to OHP if Ballot Measure 30 repeals the tax increase implemented by the legislature during the past session.

Questions raised:
Q: Have you had discussions with the federal government regarding what happens if Measure 30 doesn't pass?

A: Yes, there have been preliminary discussions. The response is generally to ask, why continue a demonstration without the expansion population. There is hope that they would consider maintaining the FHIAP and SCHIP programs that this would be seen as enough of an expansion to allow us to maintain the infrastructure that we've built and to maintain the prioritized list. Discussions continue regarding the cost of giving up the demonstration/prioritized list.

- This could potentially impact an estimated 89,000 people.
- Federal component if SCHIP programs are given up this results in giving up a 70/30 match, federal dollars. For every dollar cut there is an additional two dollar loss.
- OHP Standard; for every dollar cut there is an additional $1.70 loss.

Other Activities update:

Oregon Health Policy Commission met for the first time on January 21, 2004. This Commission was created under HB 3653 this last legislative session to act as the primary advisory committee on health care policy to the Administrator of the Office for Oregon

Health Policy and Research, the Governor and the Legislative Assembly. Members of the Commission are:

10 Citizens

Vanetta Abdellatif
Multnomah County Health Department

Jonathan Ater
Ater Wynne, LLP

Kerry Barnett, Chair
The Regence Group

Geoff Brown
Mercer Resource Consulting

Alice Dale
OPEU SEIU Local 49

Vickie Gates
Oregon Health Care Quality Corporation

Jim Lussier CEO
St. Charles Medical Center

Governor Barbara Roberts

Rick Wopat MD
Samaritan Health Physicians

4 Legislators

Representative Alan Bates
District 5
Ashland, Oregon

Senator Richard Devlin
District 19
Tualatin, Oregon

Representative Jeff Kruse
District 45
Roseburg, Oregon

Senator Ben Westlund
District 53
Tumalo, Oregon

Oregon Health Policy Commission Staff

Mike Bonetto
Oregon Health Policy Commission Director
Office for Oregon Health Policy and Research
Salem, Oregon

Bruce Goldberg MD
Administrator
Office for Oregon Health Policy and Research
Salem, Oregon

Kelley Cullison MBA MS
Executive Assistant
Office for Oregon Health Policy and Research
Salem, Oregon

The main tasks of the Commission are:

a. Develop a plan for and monitor the implementation of the State's health policy
b. Act as policy=making body for statewide data clearinghouse
c. Provide a forum for discussion of health policy and health care issues
d. Identify and analyze the significant health policy and health care issues affecting the state and make recommendations to the Governor
e. Prepare and submit to the Governor, the Legislative Assembly, resolutions relating to health policy and health care reform

As a result of this first meeting the commission will focus on developing a short term and long term vision. They will meet monthly initially. More information regarding the Health Policy Commission are available at www.ohpr.state.or.us.

Next Meeting:

"**Individual Contributing Factors to ED Utilization** " survey results presented by Tina Edlund, MS, from the Office for Oregon Health Policy & Research.

"**Satisfaction with Provider Communication Among Spanish-Speaking Medicaid Enrollees**" presented by David M. Mosen, PhD, MPH, Care Management Institute, Kaiser Permanente.

February 18, 2004
9:00 – 11:00 AM
Oregon State Library
Room 103
250 Winter ST NE
Salem, Oregon 97310

February 18, 2004
9:00 – 11:00 AM
Oregon State Library
250 Winter St. NE
Salem, Or

Attendees:
Linda Herman, Rick Berkobien, Chris Barber, Matt Carlson, John McConnell, Paulos Sanna, Charles Gallia, Judy Rinkin, Jenny Pathak, Alison Little, Olivia Thomas, Seth Wolpin, Joy Soares, Wendy Callander, Donna Harles, Kristen Johnson, Michael Wiltfong, Jeanene Smith, Tina Edlund, Lisa Krois,

Facilitator: Tina Edlund

I. Welcome Message
II. OHREC Activities Update
III. OHREC Research Brief
IV. OHPR Issue Brief
V. Presentation by: Tina Edlund
VI. Presentation by: David Mosen
VII. Next Meeting:

Tina Edlund, Evaluation Research Director for the Office for Oregon Health Policy and Research, briefly discussed the purpose of OHREC past and future research projects to evaluate impacts on people as a result of administrative changes and budget driven cuts to the Oregon Health Plan (OHP). (See attached research matrix for more detail on these projects).

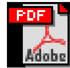
OHREC Activities Updates:

Cohort Study: A proposed study to follow people for three years. Approximately 2100 individuals have agreed to participate thus far. Additional funding has been requested through RWJ to follow them for the next two years.

Legislative Survey: A survey is currently taking place to asses legislators' informational needs. This will assist OHPR in providing information and data to decision-makers on subject areas and in formats optimal for this group. This OHREC project works towards the collaborative's goal of improving the flow of research to policymakers.

Research Brief
Premium Impact

Impact of Premiums Changes in the Oregon Health Plan
The overarching policy goal of the OHP2 redesign was to maintain or even expand coverage by implementing cost containment strategies. This brief addresses the specific impacts of these premium administrative changes to OHP2.

Issue Brief 
Gaps

Gaps in Health Insurance Coverage
A new study examines the stability of Americans' health insurance status over a continuous, four-year period from 1996 to 1999. This study's findings, recently published in *Health Affairs* (Pamela Farley Short and Deborah R. Graefe. Battery-Powered Health Insurance? Stability In Coverage of the Uninsured. *Health Affairs*, November/December 2003; 22(6): 244-255) found that relatively few Americans were continuously uninsured for the four years, but a sizable number of uninsured lacked a stable source of coverage. This issue brief includes the major findings and policy implications of this study.

Presentation:

Presentation: **"Individual Contributing Factors to ED Utilization"** survey results presented by Tina Edlund, MS, from the Office for Oregon Health Policy & Research.

ED Utilization

The Survey

- 33 questions, administered by face-to-face interviews
- Questions included:
  - Patient experience of care prior to ED visit, If any
  - Prior 12-month ED utilization
  - Prior 12-month health care utilization
  - Usual source of care
  - Unmet need (didn't get needed care, delayed care)
  - Current and previous health insurance status
  - Source of health insurance
  - Reasons for insurance loss
  - Demographics

Key Findings

- Lack of access not completely explanatory for those not consulting a physician before the ED visit
  - Less than one-third of the respondents reported that their clinics were closed when they came to the ED.
  - Less than 25% cited lack of available or timely appointments at their usual source of care as the reason for coming to the ED
- Coverage and usual source of care did not translate into fewer ED visits for OHP
  - OHP similar to commercially-insured in terms of having a usual source of care (81%), but still have significantly higher rates of ED visits than any other group.
  - OHP reported higher overall utilization than any other group
  - And even with the high self-reported utilization numbers, OHP also reports higher unmet need than a commercially-insured population
- On a self-report basis, OHP clients in OHSU ED much higher utilizers than OHP clients overall.
  - Not directly comparable because of different time frames in the questions, but previous surveys of the OHP population indicate much lower rates of ED and primary care utilization than this population reports.
- Seem to have much higher absolute need.
- Uninsured visiting OHSU largely short-term uninsured: 45% uninsured less than 1 year; 27% less than 6 months; and 12% never insured.
- OHP disenrollment (44%) and loss of employer-sponsored insurance (48%) –largely due to job loss – contributed equally to uninsured visits to the OHSU ED during the study period

Data Limitations

- Pilot study
- No generalizability beyond the OHSU ED.
  - OHP patients at OHSU ED different than overall OHP patients
  - Patients visiting OHSU ED different than other EDs as well as population overall
- No severity adjustments in the data
- Next steps: If funding is available, broader survey of statewide EDs. Add administrative data.

Presentation:

Presentation: "**Satisfaction with Provider Communication Among Spanish-Speaking Medicaid Enrollees**" presented by David M. Mosen, PhD, MPH, Care Management Institute, Kaiser Permanente.

Provider Satisfaction

Study Objectives

- Determine whether satisfaction with provider communication differs among Spanish vs. English Speakers
- Determine if differences between these groups can be explained by need for interpretive services

Limitations

- Small overall sample size
- Lack of data on several important factors that may impact provider satisfaction
    - Acculturation
    - Language proficiency
    - Provider language concordance
    - Quality of interpretive services received
- Limited power to detect differences among:
    - Those that needed and received interpretive services compared to those that needed and DID NOT receive interpretive services

Conclusions

- Spanish-speaking Parents reported significantly lower ratings on provider time spent with child
    - Parents that needed interpretive services reported lower satisfaction compared to English-speaking Parents
    - No difference in ratings of provider time spent with child among Spanish-speaking parents that needed interpretive services compared to English-speaking parents
- No other differences found

Implications for Policy and Practice

- Efforts are needed to ensure that Spanish-speaking patients have access to medical staff with Spanish proficiency
- It is important that sufficient time be spent with Spanish-Speakers that need interpretive services during pediatric medical encounters
- Further research is needed to understand:
  - To what extent do Spanish-speaking patients in need of interpretive services receive such services from professionally trained staff
  - Understand how variation in the quality of interpretive services impacts satisfaction with provider communication

Next Meeting:

Wednesday, March 17, 2004
1:00 to 3:00 PM
Room 111 and 112
Clackamas Community College
Advanced Technology Center
29353 SW Town Center Loop E
Wilsonville, Oregon

March 17, 2004
1:00 to 3:00 PM
Room 111 and 112
Clackamas Community College
Advanced Technology Center
29353 SW Town Center Loop E
Wilsonville, Oregon

Attendees:
Matt Carlson, Tonya Miler, Collaine Faddis, Seth Wolpin, Liz Stevenson, Tom Turrek, Craig Hostetler, Tom Fronk, Dennis Deck, Wyndy Wiitala, Roy Gabriel, Bob Lowe, Beryl Fletcher, Dana Selover, Neal Wallace, Jim Edge, Jean Phillips, John McConnell, Judy Renkin, Lorey Freeman, Jeff Lucas, Katie Gauthiev, Jenny Pathak, Jean Chung, Bill Wright, Maureen Schau, Kathy Cervantes, Joy Soares, Diane Lund, Pam McVay, Charles Gallia, Judy Mohr-Peterson, Jen Devoe, Dan Hartung, Kassie Clarke, Jeannene Smith, Tina Edlund, Lisa Krois,

Facilitator: Tina Edlund

I. Welcome Message
II. OHREC Activities update
III. Presentation by: Matt Carlson
IV. Presentation by: Dan Hartung
V. Next Meeting

Tina Edlund, Evaluation Research Director for the Office for Oregon Health Policy and Research, announced:

Dr. Robert Lowe has been invited to present a poster at the Society for Academic Emergency Medicine and Academy Health on his work on the impact of the changes in the Oregon Health Plan on accessing the Emergency Department at OHSU.

Dr.'s John McConnell and Neal Wallace have both been invited to present a poster at Academy Health on their study of the impacts of premium changes on the OHP Standard population.

Dr. Judy Zerzan, who studied the impacts of eliminating the Medically Needy Program in February 2003, has been invited to present her findings at both the Society of General Internal Medicine and Academy Health.

The office for Oregon Health Policy and Research has been invited to present a poster describing OHREC's process for connecting research to policy makers *and* a poster on the likely effects of the Medicare discount card on the former Medically Needy population.

Congratulations to all!

Presentation:
"The Impact of Program Changes on Health Care for the Oregon Health Plan Standard Population: Early Results from a Prospective Cohort Study" presented by Matthew J. Carlson, Ph.D. from Portland State University.

Impact of Program Changes

Study Objectives

- The purpose of this study is to assess the impact of benefit changes on the OHP Standard Population across three domains:
  - ☐ Enrollment
  - ☐ Access to care
  - ☐ Utilization

Conclusion and Implications

- Enrollment – Standard Population
  - ☐ Most who lost coverage remained uninsured.
  - ☐ Premium Cost was most common reason for loss of coverage.
  - ☐ Lowest income group was disproportionately affected by cost sharing.
  - ☐ Most would reapply if premiums were decreased.

Conclusion and Implications

- Access
  - ☐ Those who lost coverage had higher unmet needs for medical care, urgent care, mental health care and prescription medications.
  - ☐ Persons with chronic illness who lost coverage were more likely to report unmet health care needs.
  - ☐ Cost was primary reason for unmet health care needs.

Conclusion and Implications

- Utilization
  - ☐ Those who lost coverage were nearly 3 times more likely to have no usual source of care and were 4-5 times more likely to report the Emergency Department as usual source of care.
  - ☐ Those who lost coverage were less likely to have a primary care visit.
  - ☐ Loss of coverage increased the likelihood of an ED visit among individuals in the lowest income group especially those with chronic conditions.

Data Limitations

- Analysis is based on preliminary mail-return data including only the English speaking population.
- Data on enrollment, access, and utilization are based on self-report.
- Survey respondents may have higher rates of chronic illness than general OHP population.
- This is the baseline, cross-sectional survey and associations may not be causal.

Follow-up Discussion:

Q: Mental health was included on the first slide but not on the slides with analysis.

A: This is very preliminary analysis within a limited time frame; further analysis in this area will take place.

Q: Have you looked at the comparability of the OHP Plus and Standard Populations?

A: For the purpose of this presentation and initial analysis has been focused on the Standard population. Current focus is on the impacts of the cost-sharing among the standard population. The long term goal would be to assess the impacts and compare the Standard population, where the changes were made with the Plus population without this increased cost-sharing over a period of time to compare the impacts over the long term among these populations.

Q: As you looked at unmet need for mental health care did you look at the unmet need for substance abuse?

A: We did, they were not included because the number was quite low (approx. 2%) the need is higher for those without continuous coverage but the numbers get small when you break it down.

Q: What was the period of the survey.

A: The survey went into the field in early December, it was a three-wave mailing and we are continuing to receive surveys.

Q: Were there any surprises?

A: Yes, the impacts were more dramatic then anticipated.

Q: Of the people who left OHP and are now covered again, do you know how many of those are on standard and how many got a chance to come back onto plus?

A: Administrative data may be able to offer more insight in the complex patterns of enrollment and disenrollment.

Q: Why were Native Americans less likely to lose their coverage over the other groups?

A: Tribal members do not get disenrolled due to non-payment.

Comment: Understanding the differences between Native American disenrollment and other groups is interesting, but Asians also had very low rates of disenrollment.

Q: How do you plan to retain panel members over time.

A: They have signed written consent to continue, provided alternative contacts if we are unable to locate them, Christmas cards, run addresses against other state databases, aggressive panel tracking, financial incentives and phone follow-up.

Q: Do you worry about the look-back feature/recall bias.

A: That is always a concern. One thing we've done is restricted the recall window to six months as opposed to one year.

Comment: The results of this study are matching closely with the results of the premium impact study as to level of impact and dropping off particularly in the lowest income category.

Presentation:
"**An Evaluation of Prescription Drug Co-payments in the Oregon Health Plan Fee-For-Service Population: Preliminary Results**" presented by Daniel Hartung, Pharm.D. from OSU College of Pharmacy

Eval of RX Co-pay

Methods of Evaluation

- Brand/Generic Mix
- Average $/per prescription
- Rx/Volume (count of no. dispensed per member, per month (PMPM))
- $ PMPM
- Cohort Analysis – continuous eligibility (not enrolled in a fully capitated health plan)
    - Aggregate
    - Specific classes: cardiovascular, respiratory, diabetes, gastro-intestinal acid suppressant, non-steroidal anti-inflammatory drugs (NSAIDs), narcotic analgesics

Summary

- Average cost/rx
    - ↓ OHP Standard
    - ↑ OHP Plus
    - ↑ Carveout Drugs
- Increase in generic market share
    - Standard > >> Plus >>>> Carveout
- Marked reductions in Rx utilization (cohort)
    - OHP Standard: ↓ 33%
    - OHP Plus: ↓11%
    - Carveout Drugs: ↓15%

Summary

- Reduction varied by therapeutic category (cohort)
    - NSAIDs: 45% (OHP Standard), 30% (OHP Plus)
    - Respiratory: 45% (OHP Standard), 15% (Plus)
    - Diabetic medications (DM): 37% (OHP Standard), 6% (OHP Plus)
    - Narcotics: 23% (OHP Standard), 2% (Plus)

Limitations

- Impact of other concomitant policies
  - Temporary suspension of benefits March 03
  - Physician Managed Prescription Drug Program (PMPDP)
    In May 2003, perscribers of drugs not on the PMPDP lists were required to actively request a "Prior Authorization" by calling the State's pharmacy claims administrator. Perscribers were required only to listen to or read an educational message regarding the PMPDP research in order to receive the exception. The 2003 legislature passed a mandate (HB 3624) that prohibited OMAP from using "Prior Authorization."
    –October 1, 2003 the PDL reverted back to a voluntary process

- Health outcomes not assessed
- No control cohort
  - Discontinuation of critical medications
  - Shifting to generic alternatives
  - Medical service use (e.g. ED visits)

Follow-up Discussion:

Q: Referring to the "Dip" in May, are these claims based on date of service or are they the date of process? Wondering if the fact that prescription benefits were discontinued for a couple of weeks in March

A: It is the date of service, the date that the prescription was dispensed at the pharmacy. We don't think it has anything to do with the suspension of pharmacy benefits because it's not really a utilization thing, there is something wrong with the cost paid per prescription, specifically with that field.

Q: Are these the more expensive drugs?

A: There are some very expensive and very cheap drugs in here. That is something to address, if there are specifics in shifting to generic from brand. That is something to consider when evaluating the changes.

Q: Are you going to be doing any kind of study to find out the outcomes with the reductions? Are you really saving money on medications? On medical costs? Is there a cost shift?

A: That is a huge concern and that's why we want to look at the medical claims to at least try to address it. When you see dramatic drops in respiratory

medications, which potentially have acute onset of any medical adverse sequelae that you could see that if it was happening.

Next Meeting:

"A Preliminary Overview: Emergency Department/Room utilization as an indicator of quality and access in the Oregon Health Plan" presented by David Shute, MD of OMPRO

"Demographic Changes in Rural Oregon 1990 to 2000 and Dynamics of Future Changes" presented by George Hough, Jr. Ph.D. of Portland State University

Tuesday, April 20, 2004
9:00 AM to 11:00 AM
Oregon State Capitol Building
Hearing Room 50
900 Court Street NE
Salem, Oregon

April 20, 2004
9:00 – 11:00 AM
Oregon State Capitol
Hearing Room

Attendees:
Paulos Sanna, Jeff Lucas, Dennis Deck, Wendy Wiitala, Darren Coffman, Jenny Pathak, Jean Chung, Telema Rozenfeld, Laura Grandin, Tracy Gratto, Kari Mcfarlan, Kathy Cervantes, Sandy Johnson, David Shute, Olivia Mermas, Robert A. Lowe, George Hough, Elizabeth Baxter, Jeanene Smith, Tina Edlund, Lisa Krois, Jessica Miller, Charles Gallia

Facilitator: Tina Edlund, Evaluation Research Director, the Office for Oregon Health Policy and Research

I. Introductions
II. Welcome/OHREC Activities update
III. Presentation by Dr. Shute of OMPRO
IV. Presentation by George Hough, Jr. Ph.D., Population Research Center, Portland State University
V. Next Meeting:

OHREC Activities: Jeanene Smith, Deputy Administrator of the Office for Oregon Health Policy and Research, discussed decisions made by the recent April Emergency Board:

- The Emergency Board met the 1st week of April to rebalance the DHS Budget in response to the defeat of Measure 30
- No changes for the OHP Plus population
- No funds available for OHP Standard Population
- Seeking additional funding (possibly provider tax) in order to maintain at least a small portion of this population that can be sustainable through 2005-2007
- Were unable to bring back the former Medically Needy program but will maintain the state-funded program to cover low-income prescription drugs for HIV and transplant patients

Tina Edlund: - follow-up responses to questions have been submitted to RWJF Changes in Healthcare Financing and Organization (HCFO) program. This proposal originally contained three components - a study to expand on Dr. Lowe's earlier work which will assess Emergency Department (ED) use, comparing use of the ED before and after the changes occurred to the OHP as a measure of access to primary care for low-income Oregonians; a study by Dr. Neal Wallace from PSU and Dr. John McConnell from OHSU that will examine cost shifts within OHP that might result from the loss of some benefits – such as, hospital costs due to the elimination of outpatient mental health coverage for OHP beneficiaries; and the Cohort survey of OHP Standard and Plus clients –however, the cohort is no longer being considered by HCFO. OHREC is seeking additional funding from other sources to continue the cohort study.

Charles Gallia briefly discussed the relationship between the Oregon Medical Assistance Program and OMPRO. The External Quality and Review Organization (EQRO) required by the Centers for Medicare and Medicaid Services (CMS) to evaluate the quality of care provided to these clients. The state is obligated to contract with a peer review organization. Previous processes were found to be cumbersome and lengthy - providing interesting but outdated information. This process is expected to streamline transferring data into information in a timely and more useful fashion.

Presentation: "A Preliminary Overview: Emergency Department Utilization as an Indicator of Quality and Access in the Oregon Health Plan" presented by Dr. David Shute, OMPRO (See presentation for more details):

Data Analysis Findings
- Higher proportion of mental health, alcohol, drug dependency for ¡Ý18 compared to <18
- Higher proportion of injuries for <18 compared to ¡Ý18
- Higher proportion of injuries for male versus female
- Higher proportion of non-emergent visits for female versus male

Data Limitations
- This analysis intends to identify the nature of ED visits, not the extent to which the ED is utilized.
- The data are proportions of visits not counts or rates.

Some Caveats
- Visits are sorted by diagnosis which is assigned after evaluation
- Patients don't usually present with ICD-9 codes
- Most diagnoses spread across categories
- Prudent Layperson Rule
    - Emergency Medical Services are warranted when acute symptoms of sufficient severity are such that a prudent layperson, which possesses an average knowledge of health and medicine, would think that not seeking immediate medical attention would result in placing his/her health in serious jeopardy, or suffer serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Relationship Between Access and ED Visits
- Access to care in physician offices probably affects patterns of ED visits
- Many other variables also affect patterns of ED visits

Reactor: Dr. Robert A. Lowe, director of OHSU's Center for Policy and Research in Emergency Medicine.
- Billings Classification Algorithm valuable for comparing access to health care between population groups
- The algorithm separates appropriate and inappropriate use of the ED
- Recognizing that the level of appropriateness is subjective, there is some discussion around validity
- Not appropriate for triaging patients to primary care for inappropriate use of the ED
- Provides the best proxy for access to care and provides insight for policy –makers working to provide better access to care for these populations

Presentation: "Demographic Changes in Rural Oregon 1990 to 2000 and Dynamics of Future Changes" presented by George Hough, Jr. Ph.D. of the Population Research Center, Portland State University (See presentation for more details):

Population Change

- Oregon grew in Absolute and Relative Ways reflecting economic conditions from 1900-2000
- Washington County led the way in Absolute and Relative Change adding over 130,000 person and growing by over 40 percent from 1990-2000
- Deschutes County had the highest Relative Growth at almost 54 percent, but Absolute Growth of just over 40,000 persons

Age Dynamics for Oregon

- Oregon Gained 400,000 residents through Net In-Migration, 430,000 through Births and Lost 273,000 through Deaths for the Decade
- Urban and Rural Age Changes Reveal Opposite Dynamics – rapid aging in rural counties
- Deschutes County experienced growth across all age groups due to a large influx of new residents
- Curry County also experienced growth, but represented a retirement destination
- Columbia County appealed to those later in the lifecycle with Proximity to Urban Amenities
- Tillamook County represented a stable rural county, offering Economic Opportunities to many age segments

Race/Ethnicity and Age Dynamics

- Some rural counties are in a process of demographic replacement – aging white population is dying and minority populations are moving in and having children, especially Latinos
- The Hispanic/Latino population is growing and will continue to grow, based on in-migration and fertility
- Latinos are not dispersed throughout the rural landscape – their populations are concentrated in the small cities within rural counties
  - Three Examples – Hood River, Morrow, and Malheur Counties
- In general, minority representation is growing in Oregon, especially among the younger ages

Next OHREC Meeting:

Tuesday, June 15, 2004, 9:00-11:00am
Oregon State Library, Room 103
250 Winter Street NE
Salem, Or 97301

Presentation: "2004 Oregon Health Policymaker Survey: Information Wants and Needs" presented by **Jessica Machette**, Oregon Health and Science University

Presentation: "Moving from 'Welfare to Work': Planning for and securing health insurance in the context of welfare reform" presented by **Heather Hartley, Ph.D.**, Department of Sociology, Portland State University, **Karen Seccombe, Ph.D.**, School of Community Health, Portland State University and **Kim Hoffman, M.A.**, School of Community Health, Portland State University

May 18, 2004
1:00 to 3:00 PM
Room 112
Clackamas Community College
Advanced Technology Center
29353 SW Town Center Loop E
Wilsonville, Oregon

Attendees:
Dana Selover, Jenny Pathak, Carla Conrad, Andi Easton, Tom Melville, Nancy Abrams, Lauren Mitchell, Donna Harles, Tracy Gratto, Kari McFarlan, Wyndy Wiitala, L.J. Fagnan, Anne King, Valerie King, Charles Gallia, Kathy Cervantes, Alison Little, Jill Boyer-Guich, Clara J. Murray, Danielle Engels, Jeanenen Smith, Tina Edlund, Lisa Krois

Facilitator: Tina Edlund

I. Presentation by: Nancy Roberts
II. Presentation by: L.J. Fagnan, M.D.
III. Next Meeting

Presentation: **"Reducing the use of the Emergency Department for non-urgent services,"** Nancy Roberts, MPH, Providence Health System, Portland OR

Problem Statement
- Providence Health Systems Portland Emergency Departments(ED) care for over 150,000 patients each year
- About 1,600 visits a month are from patients of Providence Health Systems employed primary care physicians
- Many of these visits are for conditions that could have been safely cared for in a less acute setting (primary care office, immediate/urgent care center, or via telephone consultation with a doctor or nurse)
- Over 75% of these 1,600 visits (all discharged home) occurred during times when either the doctor's office or and immediate care center was open
- Providence Health Plan (about 36% of these visits) has rates of ED use/1,000 members higher than desired and on an upward trend
- Using the ED for such non-urgent care adds cost to the overall delivery of healthcare

Research Goals
- Identify the factors leading to non-urgent use of the emergency department by patients of Providence Health Systems employed primary care physicians
- Reduce the proportion of total ED visits by this patient population that are "potentially avoidable"
- Increase the likelihood that primary care services are delivered by the established provider

Defining a "Potentially Avoidable" ED visit

- No standard methodology was available to use electronic claims data to sort ED visits into "potentially avoidable" and "not avoidable"
- Designed an expert panel chart review process to establish "gold standard"
- Analyzed results of "gold standard" process to identify electronically captured characteristics that matched best with the "gold standard" determination
- Developed a set of electronic queries to extract and sort ED visits into "potentially avoidable" and "not avoidable on a monthly basis.

Hypothesis #1. Access: No appointment available in the clinic
Hypothesis #2. Convenience: Hours of clinic operations not convenient for patients
Hypothesis #3. Patient knowledge: Of options, that should/could call Primary Care Physician (PCP)
Hypothesis #4. Patient referred: By MD
Hypothesis #5. Patient referred: By Providence Registered Nurse
Hypothesis #6. Non-Medical Reasons: Drug Seeking

Next Steps

- Continue to implement overarching and clinic specific improvements
- Monitor all clinic and clinic specific results monthly and provide to clinic teams

Presentation: **Oregon Rural Practice-based Research Network (ORPRN)**, LJ Fagnan, MD, Network Director

Primary care Practice-Based Research Networks (PBRNs)
A group of affiliated ambulatory primary care practices that investigate questions related to community practice

- Uses the community as a laboratory

Advantages of PBRNs

- Access to important, but neglected phenomena
- Link questions from practice to answers for practice

PBRN Studies:

- Accentuate the richness of data about interactions between the practice and the community & between the clinician and the patient
- Are not just a review of the medical record and billing data
- Answer questions related to co-morbidities (Primary care clinicians see a broad spectrum of diseases at various stages.)

PBRN Tensions

- Between relevance and rigor
- Between a bottom-up and a top-down approach to identifying and researching issues and questions
- From the middle out

Level of Clinician Involvement

- Inactive
- Passive (opens practice, minimal participation)
- Active (opens practice, collects data)
- Fully active (designs and implements research)
- Hyperactive

Family Medicine Physicians and Research

- A call to all family physicians to be involved in the generation of new knowledge
- Create a record of the clinical questions that occur in practice
- Read original research: JAMA, BMJ, NEJM, Annals of Family Medicine
- Sixty-two percent of English family practices are involved in research

AHRQ Awards New Grants to PBRNs 2002

- 36 Primary Care Practice-Based Research Networks
- $3 million dollars in year one
- http://www.ahrq.gov/research/pbrnproj.htm

ORPRN-Oregon Rural Practice-based Research Network
Mission

To improve the health of rural Oregon by conducting and promoting research in partnerships with the communities and practitioners we serve.

Themes

- Focuses on the larger community
- IOM definition of primary care
- Community-Based Participatory Research (CBPR)
- Changing systems of care

ORPRN Denominator (est. 4/2004)

- Clinicians: 93
- 60 FPs, 5 IMs, 3 Peds, 11 PAs, 15 NPs
- Practices: 22
- Communities: 18
- Patients:120,000

ORPRN Clinician-oriented Outcomes

- Clinicians will not get home later for dinner than they do now
- Participation will not be a financial drain
- Participation will be stimulating and fun
- Clinicians will be proud of the research produced
- Produces research that they will be proud of

Goals and Objectives of ORPRN
- Woven into the fabric of the practice and community
- Durable, withstanding the test of time and changes in health care funding
- Develop an understanding of the health care values, dynamics, and structure of the practices in rural communities
- When you have seen one rural practice, you have seen one rural practice

Translating Research Into Practice (TRIP)
- It takes 17 years for valid research to reach clinical practices
- From Efficacy to Effectiveness
- http://www.ahcpr.gov/research/trip2fac.pdf

Barriers to Translation
- Clinician knowledge
- Patient-Clinician communication
- Attitudes, values, and beliefs of patient, clinician, family, community/culture, health care system
- Practice variations
- Clinical traditions
- Cost

Research Questions
- What are effective strategies to implement new findings and information?
- What strategies demonstrate behavior change in clinicians and practices?
- What are the strategies for identifying, validating, and addressing barriers to implementation of new findings

The "Hamster Health Care" System
- Clinicians have much more to do from preventive medicine to chronic illness care
- Medicalization of social problems-substance abuse, domestic abuse, snoring
- Patient communication-office visits, telephone, e-mail, Internet
- Coordination of care-case management, nursing home, school health, occupational health, grocery store care

Putting the Primary Care House in Order
- New work environment-creating a climate with less stress and overwork
- Systems of care that improve access and quality while relieving clinicians' workload
- Changes take place without major increases in total health care costs
- Grumbach. JAMA. 2002;288:889-893

Primary Care Home Remodeling
- Berwick, Donald. A User's Manual for the IOM's 'Quality Chasm' Report. *Health Affairs*. 2002;21:80-90

Umbrella Questions for PBRNs

- Is recruitment focused on practices or individual clinicians?
- What are the criteria for participation?
- Sustaining the network, what does it take?
- Where does a network look for infrastructure support?
- Who controls (owns) the network?
- Rigor vs. relevance, where is the balance?

ORPRN Organization

- Initial funding from The Oregon Opportunity
- Staff: Network Director, Manager, Research Investigators (3), Project Manager, Regional Research Associates (3)
- Bylaws
- Steering Committee
- Scientific Review Committee

Node Coordinator

- Develop and manage research studies
- Compliance: HIPAA, RCR
- Community relations
- Support member clinics and rural investigators-data base development, quality improvement projects

Current Projects Osteoporosis Survey

- All ORPRN clinicians providing adult care
- Women 65 years and older living in ORPRN communities

Clinical Information Study (CIS)

Qualitative research study, using semi-structured interviews, in six Oregon primary care clinic practices, to develop an understanding of information flow into, within, and out of community practice settings.

Chronic Opioid Therapy and Preventive Services

Study is a retrospective cohort design with the aim of investigating a possible association between chronic opioid therapy in the primary care setting and the performance of preventive health services.

Rural Health Clerkship Project Inventory

A systematic review and data inventory of 880 rural clerkship projects (1992-2002)*

* Third-year medical students complete a required population-based project during their six week rural clerkship rotation.

CHOICE: Exercise/MI, an RCT

An ORPRN collaboration with the OHSU School of Nursing.

Study is a randomized pilot trial of using motivational interviewing to increase lifestyle physical activity in underactive adults in rural communities. NCI submission April 2004

Health Information Technology (HIT) Implementation Grant
"Using HIT to Improve Medication Safety for Rural Elders"
Proposal submitted to AHRQ: April 2004

Colorectal Cancer Screening
Purpose is to improve the delivery and uptake, and evaluate the short-term outcomes of colorectal cancer screening in primary care practices.
Proposal development: Summer 2004

Prescription for Health
Sponsor: Robert Wood Johnson (RWJ)
A five-year initiative to fund practice-based research networks to evaluate interventions to change two or more health behaviors, (unhealthy diet, sedentary lifestyle, tobacco use, and alcohol abuse,) in routine primary care. Call for Round 2 proposals will be in December 2004

National Children's Study: Pilot Project
- The National Children's Study will examine the effects of environmental influences on the health and development of more than 100,000 children across the United States, following them before birth and until age 21.
- Pilot Project: a recruitment feasibility study
- PBRNs selected for the pilot study: ORPRN, GRIN, Duke PCRC, LANet, MAFPBRN, Rainbow Research Network

Community-Based Participatory Research (CBPR)
"The real world is complex, contextual and multiply determined. If our measures are to be relevant they must be multiple and multidimensional."

CBPR Principles
- Recognizes the community as the unit of identity
- Builds on community strengths and resources
- Facilitates a collaborative partnership in all phases of research
- Integrates knowledge and action for the mutual benefit of all partners

CBPR Principles
- Promotes a co-learning and empowering process that attends to social inequities
- Involves a cyclical and iterative process
- Disseminates findings and knowledge gained to all parties

Next Meeting: Tuesday, June 15, 2004

9:00 AM to 11:00 AM
Oregon State Library
Conference Room 103
250 Winter Street NE
Salem, Oregon

June 15, 2004
9:00 – 11:00 AM
Conference Room 103
Oregon State Library
250 Winter St NE
Salem, OR

Attendees:
Raj Gala, Dennis Deck, Wyndy Witala, Rick Berkobian, Judy Mohr-Peterson, Charles Gallia, Julie Massa, Mary Ann Evans, Jenny Pathak, Roy Gabriel, Dave Lyda, Linda Weight, John Britton, Kathy Cervantes, Jane Myers, Ron Tayler, Heather Hartley, Jessica Matchett, Lisa Krois, Tina Edlund

Facilitator: Tina Edlund

I. Presentation by: Jessica Matchet
II. Presentation by: Heather Hartley
III. Next Meeting:

Presentation: "2004 Oregon Health Policymaker Survey: Information Wants and Needs" presented by Jessica Machette, OHPR Intern and MD/MPH student, Oregon Health and Science University (see power point presentation for more information)

From research to policy - How can we make health policy research most useful to those making policy decisions?

- Policymakers receive large volumes of information on health policy research, but often don't get the answers they seek within these materials
- Health policy is only part of the job, but a complex and time consuming part; efficient communication around health policy research is essential

Basic Survey Statistics

- Legislators and staff identified with roles and responsibilities on health care committees
- Contacted by phone and/or email
    - 40 Elected: 10 surveyed
    - 15 Staff: 13 surveyed
    - 3 declined
- Telephone survey (56 questions)
    - Average length: 21 minutes

Who did we talk to?

- 5 Senators
- 5 Representatives
- 13 Staff

Average number of years in position:
- Elected: 5.0
- Staff: 3.9

Oregon-specific research data is preferred
When given 3 ways research data can be gathered, 60% ranked them in this order:
1. Gathered from populations in Oregon (78% ranked it 1st)
2. State to state comparative data
3. Gathered on a national basis

What makes information about health policy useful to you?
- 65.2% - applicability
- 8.6% for each of the following:
    - Reliability/accuracy/objectivity
    - Broad issues/trends
    - Includes interpretations/perspectives
    - Clear graphs/tables
    - Brevity

What makes information about health policy less useful to you?
- 22% - Inapplicable/unrelated/irrelevant to current issues in Oregon
- 22% - Lots of numbers without any interpretation
- 17% - Excess bulk/volume
- 17% - Unreliable/biased/not backed by solid research
- 13% - Regurgitated/recycled/old data

Are there sources you tend to trust more than others?
- 96% responded YES…and specified:
    - 36% - Kaiser Family Foundation
    - 27% - National Council of State Legislatures
    - 23% - Robert Wood Johnson Foundation
    - 23% - Journals (JAMA, Health Affairs, other nationally published journals)
    - 18% - Academic and university sources
    - 9% - Oregon Health Policy & Research

Most respondents don't have a regular set of steps they take when attempting to learn more about a given health policy issue
- 26% - Take regular steps to learn more
    - 10% of elected, 38% of staff
- 74% - Varies by issue

Sources most frequently cited as part of a "regular set of steps" used to learn more about a particular issue:
- 50% - Oregon Health Policy & Research
- 42% - Department of Human Services
- 25% for each – Lobbyists/Staff

Some specific sources mentioned…

- **E-mail news and health care updates**
  - 21%: Kaiser Family Foundation
  - 16%: Department of Human Services
  - 11%: National Conference of State Legislatures
  - 11%: Oregon Health Forum

- **Newsletters**
  - 32%: National Conference of State Legislatures
  - 32%: Oregon Health Forum

- **Newspapers:**
  - 42% locals or local clipping service
  - 32% NY Times
  - 16% Wall St Journal
  - 11% Washington Post

- **Radio -** 83% National Public Radio/Oregon Public Broadcasting

- **TV**
  - 67%: KOPB (public television)
  - 33%: Local news

- **Websites**
  - 35%: Kaiser Family Foundation
  - 24%: National Conference of State Legislatures
  - 18% for each: Department of Human Services, Health Affairs, search engine (Google)

Related conferences or meetings sponsored by local, state or national associations regularly attended:

- 30%: None
- 17%: National Conference of State Legislatures
- 13%: Council of State Governments

Other information, services, or help that would be useful

- 17% each:
  - Regular agency briefs/updates, and regular meetings with agencies/analysts
  - Improved ease of access to data, centralized location to locate information, such as a website
- 9% each: Webcasts, interim briefs, hard copy publications with references of research for more information

During the last legislative session, what health related information services would have been useful, that you were unable to obtain?

- 30%: Accurate/reliable/credible data
- 22%: Nothing
- 17%: Fast, easy access to data
- 13%: Details about the Oregon Health Plan

In the next two years, what are the 3 health care issues that you believe Oregon SHOULD address?

- 48%: Affordability/costs
- 35%: Prescription drug issues
- 30%: Service delivery
- 22% each: Access, uninsured, mental health
- 13% each: Long term care, tort reform, new insurance methods

In the next two years, what are the 3 health care issues that you believe Oregon WILL address?

- 43%: Oregon Health Plan
- 26%: Uninsured
- 22% each: Access, mental health, prescription drugs
- 17%: Tort reform

Top issues policymakers report needing more information about:

- Uninsured in general
- Uninsured: Impact/cost shifting to overall system
- Health care finance and delivery in general
- Health care finance and delivery: provider reimbursements
- Access: Safety Nets
- Prescription drug coverage
- Mental health and substance abuse
- Medical liability and tort reform

Oregon Health Policy & Research

- 91% reported having received materials or information from OHPR in the past
- 95% of those found the info helpful

Reasons cited as to why it was helpful:

- 30%: Trusted/reliable/credible
- 25% each: Relevant, concise
- 15% each: Timely, objective, key people
- 10%: Included references to research

Suggestions for improvement in Oregon Health Policy & Research materials

- Anticipate questions before they are raised, and have the info available
- Redesign website
- Focus on broad market trends/big picture
- Provide concrete solutions

Invited Presentation Reactor(s):

Rick Berkobien, Committee Administrator, Oregon State Legislature:

- ✓ Vast differences in depth of knowledge between professional legislators and citizen legislators
  - o Attributed to time constraints – reinforces the need for simpler formats for publications
    - Avoids the risk of losing the audience in technical jargon amongst an already hectic lifestyle

- ✓ A need to answer the "How" questions, specifically with regard to the Oregon Health Plan and its processes, procedures and development
  - o Specifically, concerns over the credibility and potential bias of research information coming from government agencies and the alignment between Oregon Health Policy & Research and other state agencies.
    - Use a non-partisan approach to presenting and delivering the information

Suggestions:

- Succinct information
- Both Pros & Cons of the issue
- Brief summaries
- Bullet points
- Charts
- Open honest discussion
- Both sides of the issue
- Lower reading levels
- At-A-Glance formatting
- Explanations of terms, concepts and acronym

John Britton, Legislative Fiscal Office, Oregon State Legislature:

- ✓ The frustrations of the legislature involving both the knowledge base issue as discussed by Rick Berkobian as well as the level of involvement and personal experience a legislator has in a specific issue.
  - OHP, a particularly frustration issue, as it is not a directly solvable issue
  - Growing frustration can ultimately lead to a lack of motivation to become deeply involved
- o Lobbyists, a potential roadblock issue, that can be frustrating as they can be dominating in their roles.
- o Difficulty in staying current on issues between sessions and the need for these materials.

Questions raised:

Q: How to present the recommendations in the research summary.

A: State the "*what*" and "*why*" of the outcomes and recommendation, providing a fair and balanced explanation of the conclusions that were reached.

Q: How are researchers expected to anticipate the questions that may be raised by legislators?

A: Find out what others are thinking about and what the legislators are thinking and anticipating as being up coming issues.

Q: How do researchers build trust and credibility in the eyes of the legislature?

A:

- Explain the "How to"
- Present ALL positions
- Provide the whole story, don't hide information or hold anything back
- Be persistent
- Increase communication across varying levels of the government (agencies, legislature etc…)
- Cross boundaries, provide a different perspective
- Be helpful

Presentation: "Moving from 'Welfare to Work': Planning for and securing insurance in the context of welfare reform" presented by Heather Hartley Ph.D., Department of Sociology, Portland State University (see power point presentation for more information)

Research Context

- One year not enough for most TANF leavers to find coverage
- Studies focus on economic struggles; less on health insurance
- Many former TANF recipients can't rely on new employers for coverage

Purpose

- Identify gaps in respondent knowledge about OHP
- Outline respondent motivations for and approaches to planning for health insurance coverage after expiration of transitional OHP coverage

Methods

- Representative sample of all individuals leaving TANF in Oregon 6-7 months prior to first interview
- Two year panel study
    - quantitative
    - qualitative

- 83 of 551 respondents participated in-depth, semi-structured face-to-face interviews

Insurance Status

- At Wave 2, only 2/3 of respondents and their children are all insured
- Those with insurance tend to be covered by the OHP
- Thus, knowledge of OHP procedures is of paramount importance

Lack of knowledge and information

- Assumptions regarding continuation of OHP coverage
- "Just get a job" mentality as a barrier to planning
- Communication between workers and TANF leavers

Assumptions about OHP coverage

Many respondents did not have sufficient information

- about income cutoffs
- about future coverage options

"Just get a job"

- Pressure exerted on TANF recipients can deflect attention from gathering information for health insurance planning

Communication

- Worker – TANF leaver communication impacts knowledge
- Conflicting information from different relevant offices
- Computer/paperwork glitches

Planning: motivations and actions

- "Day to day" mentality as barrier
- Dire health needs as (potentially) motivating force for planning
- Logistical problems/barriers to applying for OHP
- "Trade offs": Limiting work to keep insurance

"Day to day" mentality

- Lack of active planning was often used as a coping strategy
    - Avoid stressful or depressing processes
    - Push aside worries due to more immediate concerns

Health needs as motivational force

- Seeking out information
- Acquiring a job with adequate health insurance
- Limiting income to stay qualified for assistance

Problems applying for OHP

- Work schedules and OHP office hours
- Lack of public transportation

- Problems with mailings

Limiting work to keep insurance
- Sacrificing hours to secure or maintain OHP coverage
- Child support
- Discouraging raises from employers

Policy Implications
- TANF workers should assist recipients in planning
- "OHP specialists"
- Expansion of FHIAP

Invited Presentation Reactor(s):
Dave Lyda, TANF Manger:
- ✓ Expressed concerns regarding the lack of a comparison group for this study – ie. How are other comparable low-income groups doing in comparison to this one?
- ✓ Discussed policy implication in context of overall state fiscal difficulties

NEXT MEETING
Tuesday, September 21st
Clackamas Community College
Advanced Technology Center, Room 112
29353 SW Town Center Loop E
Wilsonville, Oregon

September 21, 2004
9:00 – 11:00 AM
Clackamas Community College Wilsonville
Room 112

Attendees:
John Britton, Dana Selover, Michelle Berlin, Rajiv Sharma, John McConnell, Fred Steele, Kris Gowen, Robert Lowe, Rachel Solotanoff, Matt Carlson, Jeanene Smith, Tina Edlund, Jen Devoe, Janne Boone, Lisa Krois,

Facilitator: Lisa Krois

I. Welcome Message
II. OHREC Activities update
III. Presentation: Rajiv Sharma
IV. Presentation: Michelle Berlin
V. Next Meeting:

Lisa Krois, from the Office for Oregon Health Policy and Research, briefly discussed staff changes, including Tina Edlund's move to Salem as the Data and Research Unit Manager with The Office for Oregon Health Policy and Research and introducing Dr. Jen Devoe who will be working with the office for Oregon Health Policy and Research as a fellow over the next three years on various projects within the agency.

OHREC Activities Update

Provider survey: OHPR/OHREC has been working with the Office of Medical Assistance Programs (OMAP), OMPRO and the Oregon Medical Association on a provider survey which is in the field now and will have results out in December.

Children's Access Survey: Dr. Devoe is working on a Children's Access Survey, currently in the development phase. The survey will assess barriers to covering children in Oregon.

Cohort Survey: The Commonwealth Fund has granted additional funding for the second wave of the OHP Cohort Survey. This survey will be in the field in November with results expected in February.

Oregon Health Values Survey: Telephone survey currently in the field, designed for the public to provide direction and input to the Oregon Health Policy Commission. Preliminary results available by the end of October.
Jeanene Smith, Deputy Administrator of OHPR, further explained the purpose and strategy of the Health Policy Commission: The Health Policy Commission was set up in

the last year, the charge from the Legislature and the Governors office is to outline the future of state health policy. They have been working on short term and long term approaches to that. They presented their short term/initial approaches to the Joint Committee on Human Services September 13, 2004. These will continue to be refined into legislative concepts for the upcoming legislative session. In addition, The Health Policy Commission is conducting a series of Public Forms around the state. The defining four areas the Policy Commission is looking at include: access, quality, cost and health status. A summary of these meetings will likely be available mid-October.

Presentation: Rajiv Sharma presented "Fluctuations in Short-term Demand: Implications for Hospital Admission and Discharge Behavior"

Background:

- Stochastic demand is a key feature of hospital operations
- Implications for costs, capacity requirements
- Examples: Cost of empty beds, impact of variance in demand/occupancy on hospital costs
- Anti-trust Framework: Implications for hospital competition, mergers, acquisitions, closures, and expansions
- Forecasting hospital demand

Motivation: Fluctuations in demand may have direct implications for hospital behavior.

- Capacity constraints may affect hospital admission and discharge behavior.
- Hospital may have to be selective in which patients it will admit.
- Hospital may have to be selective in which inpatients may remain.
- Existing literature does not deal with these issues and their implications.

What is new in our research?

- First paper to examine impact of short-term fluctuations in demand on hospitals' admission and discharge behavior.
- Focus on capacity issues.
- Develops theoretical framework that provides testable hypotheses.
- Tests hypotheses using Oregon discharge data from December 1, 1997 to November 30, 1998 (Office of Health Policy and Research).

Key technical innovations:

- Develop a test that permits us to detect discriminatory admissions practices towards patients with different types of insurance.
  - -no need to control for underlying differences in health and treatment seeking behavior of patients from different plans.
- Develop a simple proxy measure for the additional hospital resources that would ordinarily be used in the treatment of current inpatients.

Empirical issues:

- How do we detect times when hospitals have insufficient capacity?
- Occupancy rarely exceeds bed capacity (18 times out of more than 20,000 hosp days in our data).
- Capacity constraints apply whenever the quantity of any input necessary in treatment is insufficient for the patients the hospital would like to treat.
- Is capacity a hospital-wide, chain-wide, or market-wide phenomenon?

Solution: Different approaches to identifying days when hospitals may have inadequate capacity.
We use several approaches.

- We report results that arise when:
  - -Assume that each hospital serves a market comprising all hospitals within a 15 mile radius.
  - -Identify the 20% highest and lowest occupancy days in a hospital's market as, respectively, high and low demand days for that hospital.
  - -Postulate that hospital has sufficient capacity on low demand days, but may face capacity constraints on high demand days.

Summary of empirical results:

- Patients admitted on high demand days tend to have greater resource requirements in treatment than those admitted on days when demand is low.
- Patients discharged on high demand days leave earlier than expected when compared to those discharged on days when demand is low.
- Evidence of discrimination in admissions against OHP/Medicaid patients.
- Important differences in discharge patterns of patients with different types of insurance.

Main elements of theoretical model.

- Hospital patients differ in resource requirements in treatment. (LOS and intensity of treatment)
  - ->e.g., Medicare's DRG relative weights
- We do not examine issues of appropriateness or efficiency in treatment.

Model– Payment for treatment.

- Hospital treats patients from different insurance plans (plans X and Y).
- Plan X pays more than plan Y.
- Payment hospital receives for treating a patient is proportionate to the patient's resource requirements in treatment.

Model—Hospital preferences.

- Between two patients with same insurance but different resource requirements in treatment, the hospital prefers to treat the one whose requirements are greater.
- Between two patients with same resource requirements but different insurance, the hospital prefers to treat the one with the better paying insurance.

Reality check:

- Hospital behavior arises from a combination of hospital policies and physician decisions.
- Hospital behavior may not be uniform across departments.

Crux of theoretical results regarding the effects capacity constraints have on hospital behavior:

- When the hospital does not have enough capacity to treat all patients, it is forced to restrict admissions of some patients.
- It may also be forced to discharge some patients early.
- When the hospital does not have enough capacity, treatment of patients from low paying plans is affected more than the treatment of patients from high paying plans.

Main hypotheses resulting from theoretical analysis and corresponding empirical evidence.

- For all patients, regardless of insurance type, mean resource requirements will be higher when admissions are affected by insufficient capacity.
  Mean DRG relative-weight of those admitted on:
  High-Demand Days-> 1.143
  Low-Demand Days-> 1.087

- For patients with all types of insurance, proportion of patients with low resource requirements will be higher on low demand days.
  -See this by looking at the distribution of hosp admissions over resource requirements (CDF).

All CDFs have begin value 0 and end value 1.

Behavior towards patients with different types of insurance:

Assumption: The hospital values profit. If patients from different plans have identical treatment requirements and care seeking behavior, then

-the hospital will discriminate against patients from plans that do not cover marginal cost of treatment even when hospital has spare capacity.

-the hospital will discriminate against patients from the lower paying plans when capacity is insufficient.

How can we detect such discrimination?

- If patients from different plans have identical treatment requirements and care seeking behavior, then
  -average resource requirement in treatment is higher for admitted patients from lower paying plans.
  Mean DRG relative-weight of those admitted:

	Private	Medicare	OHP
High-Demand Days->	1.037	0.902	1.464
Low-Demand Days->	0.997	0.866	1.397

Detect discrimination from distribution of admitted patients:

- If patients from different plans have identical treatment requirements and care seeking behavior, then

  -the proportion of admitted patients with low resource requirements in treatment is greater for patients from higher paying plans on both high and low demand days. That is, examine distributions of patients admitted on high and low demand days (CDFs).

Do the results so far constitute evidence of discrimination?

- We can't be sure.
- Patients from different plans may have different treatment requirements and care seeking behavior.

How can we detect discrimination when different plans enroll different types of patients?

- If the hospital does not discriminate, patients affected by capacity constraints have similar treatment requirements regardless of their health plan.

  =>Specifically, maximum impact of capacity constraints is felt at higher level of treatment requirements by patients from lower paying plans.

  DRG relative-weight where difference between CDFs on high and low demand day is maximized:

	Private	Medicare	OHP
DRG RW where diff max->	0.828	0.584	1.377

Analyzing discharge behavior:

- Expected remaining length of stay (*ERLOS*) based on DRG and elapsed length of stay.
- Large *ERLOS* at discharge implies earlier than expected discharge.

  Mean *ERLOS* of those discharged:

	Private	Medicare	OHP
High-Demand Days->	3.022	3.415	4.052
Low-Demand Days->	2.822.	3.044	3.791

Conclusion:

- Examine impact of fluctuations in demand on hospital admission and discharge behavior.
- Patients admitted on high demand days have higher resource requirements than those admitted on low demand days.
- Patients discharged on high demand days are discharged earlier relative to expectations than those discharged on low demand days.
- Differences in treatment of OHP patients.

Areas for further research:
- Impact on health/resource use.
- Our technical innovations can be useful in detecting inequity in treatment elsewhere.
  -Women, minorities, lower income.
- Better identification of capacity constraints using more detailed data and observation.
- Our technical advances can have applications in demand forecasting.

Presentation: Michelle Berlin presented findings from: "Making the Grade on Women's Health: A National and State-by-State Report Card 2004"

Purpose
- Defines women's health broadly
- Provides a state-by-state and national overview of women's health status (status indicators)
- Highlights key policies to adopt to improve women's health status (policy indicators)
- Advocacy tool

Key Findings
- The nation and the states received poor grades for the status of women's health and are far from meeting the *Healthy People 2010* goals.
- No state came close to meeting all the policy indicator goals.
- On the policy indicators, since the previous *Report Card* issued in 2001, states have taken two steps forward and one step back.

Grading and Ranking of Status Indicators
- Benchmarks drawn primarily from HP 2010
- *Grades* indicate how close state is to meeting relevant benchmarks, while *ranks* illustrate how state compares to other states
- Grades take into account that states and nation still have several years to achieve 2010 benchmarks

Grading of Status Indicators
- Satisfactory – met the benchmark (most based on Healthy People 2010)
- Satisfactory Minus
- Unsatisfactory
- Fail

Evaluation of Policy Indicators

States are compared, but not graded, on the policy indicators.
- Meets Policy
- Limited Policy
- Weak Policy
- Minimal/Harmful Policy

Status Indicators

Purpose

To evaluate the state of women's overall health, status indicators measure:

- Women's access to health care services
- Degree to which women report
- Receiving preventive health care
- Engaging in health-promoting activities
- Occurrence of key women's health conditions
- Extent to which communities encourage women's well-being

How Status Indicators Selected

- Significant impact on quality of life, well-being
- Affect large numbers of women generally or in a specific population and/or age group
- Amenable to prevention, improvement
- Measurable through consistent reliable data
- Commonly used or broad consensus on use

Status Indicator Findings

- No state received a grade of S
- Six states received an F
- The nation met only 2 indicators and received an overall grade of U
- All states met one benchmark and missed eight

Oregon

Access to Health Care Services

- Women without health insurance F
- First trimester prenatal care U

Screening & Prevention

- Pap smears U
- Mammograms S
- Cholesterol screening F

Key Conditions

- Stroke death rate F
- Lung cancer death rate F
- High blood pressure F
- Diabetes U

Living in Healthy Community

- Poverty F
- Wage gap F

Policy Indicators
Purpose
- To evaluate states' performance in promoting women's health
- Based on state statutes, regulations, and programs addressing problems identified by health status indicators

How Policy Indicators Selected
- Address status indicators
- Measurable through consistent reliable data available for each state
- Comparable across states
- Adopted by one or more states

Policy Indicator Findings
- 25 states improved at least five policies
- Majority of states weakened one to three policies
- Only ONE policy goal was met by all the states

Policies Most Improved/Weakened

Improved

- Tobacco Sales Rates to Minors
- Medicaid Simplified Mail-in Applications
- Linguistic Access

Weakened

- Medicaid Co-payments on Prescription Drugs
- Funding for Tobacco Control Programs
- Clinic Access

Oregon:
Access to Health Insurance & Services

Medicaid eligibility by income

▪ Pregnant women	Limited
▪ Working parents	Limited
▪ Aged and disabled	No/harmful

Methods to expand Medicaid enrollment

▪ Presumptive eligibility (preg)	No/harmful
▪ Mail-in application	Meets
▪ Asset test for parents	No/Harmful

Public insurance for childless adults — Meets

Access to Specific Services

Pharmaceutical

▪ Medicaid Prescription Limits	Meets
▪ Medicaid Rx Co-Payment	No/Harmful

Breast/Cervical Cancer Treatment

▪ Medicaid Coverage	Meets

Family Planning

▪ Medicaid Waiver	Meets

Prevention

Nutrition

▪ Food Stamp Outreach	Meets
▪ Food Stamp Nutrition Ed	Meets

Smoking

- Medicaid Smoking Cessation Coverage Meets

Economic Security

▪ Child Support Pass-Through	No/Harmful
▪ Child Support Collection	Weak
▪ State Supplement SSI	Meets

Policy: Overall
Systemic Shortcomings Identified by Policy Indicators

- Women need better access to health insurance
- Insufficient access to specific health care providers/services, particularly reproductive health
- Preventive and health promoting measures must be more available
- Disparities and gaps in economic security continue to compromise women's health

Conclusions

- Since the last *Report Card* (2001), states have made more positive changes in their policies than harmful ones.
- But there is still a long way to go.
- Greater commitment to women's health needed at both state and federal levels.

NEXT MEETING:

October 19, 2004
9:00 – 11:00 AM
Oregon State Library Room 103
250 Winter ST NE
Salem, Oregon 97310

Presentation: "Access to Health Care and Welfare Reform" by Karen Seccombe, Professor of Community Health, Portland State University

Summary:
How has welfare reform changed the way that poor families access and use the health care system? This presentation is based on telephone interviews with a representative sample of over 600 families throughout Oregon who recently left Temporary Assistance to Needy Families (TANF) for work, and further in-depth interviews with 90 of these families in four key regions of the state. Families were interviewed at 2 points in time; first when their transitional Oregon Health Plan benefits were still in place, and then again one year later when their automatic OHP benefits had expired. What happens to the insurance status of adults and children after they leave TANF? What barriers or access problems do they face in securing health care? Are families leaving TANF able to get the health care that they need? And finally, do welfare reform policies have an affect on the health status of adults and their children? This presentation will summarize the findings of this important statewide study.

Presentation: "Factors Influencing Cessation of Maternity Care in Oregon" presented by Ariel Smits, MD, MPH, Department of Family Medicine at Oregon Health Sciences University

Brief Summary: Anecdotal evidence suggests many providers are stopping maternity care in Oregon and nationally. This study was a cross-sectional mail survey in October and November 2002 of all obstetrician/gynecologists, family physicians, general practitioners, and certified nurse midwives practicing in Oregon seeking to determine the proportion of maternity care providers who have stopped or are planning to stop delivering babies in Oregon and to identify the important factors influencing such practice changes. Our study suggests at as many as half of the maternity care providers in Oregon are planning to stop or have already stopped providing maternity care, raising concern about access to maternity care services.

Brief Bio: Ariel Smits, MD, MPH is a research fellow in the Department of Family Medicine at Oregon Health & Sciences University. Dr. Smits was awarded one of the two top research awards at the American Academy of Family Physicians' Scientific Assembly for her presentation of this survey, titled "Maternity Care in Oregon: A Survey of Providers."

October 19, 2004
9:00 – 11:00 AM
Oregon State Library
Room 103

Attendees:
Kevin Hamler-Dupras, John Saltz, Shelby Rihala, Jenny Pathak, Ariel Smits, Shelley Bain, Kathy Cervantes, Ron Taylor, Kris Gowen, Claire Matese, Jean Chung, Linda Herman, Roy Gabriel, Allison Little, Ellen C. Lowe, Lorey Freeman, Lisa Krois, Tina Edlund, Jeanne Smith, Jen Devoe, Janne Boone, Jessica Miller,

Facilitator: Lisa Krois

I. Introductions
II. OHREC Activities update
III. Presentation: Karen Seccombe, Kim Hoffman
IV. Presentation: Ariel Smits
V. Next Meeting:

OHREC Activities Update
Lisa Krois, from the Office for Oregon Health Policy and Research, briefly discussed current research projects and expected research results within the coming months.

Provider survey: OHPR/OHREC has been working with the Office of Medical Assistance Programs (OMAP), OMPRO and the Oregon Medical Association on a provider survey. The survey is in the field now and will have results out in December.

Children's Access Survey: Dr. Devoe is working on a Children's Access Survey, currently in the development phase. The survey will assess barriers to covering children in Oregon.

Cohort Survey: The Commonwealth Fund has granted additional funding for the second wave of the OHP Cohort Survey. This survey will be in the field in November with results expected in February.

Oregon Health Values Survey: Telephone survey currently in the field, designed for the public to provide direction and input to the Oregon Health Policy Commission. Preliminary results available by the end of October; full report due in November.

Legislative Survey: This survey looks at the informational needs of Legislators and staff. Results to be released at the end of the month.

PRESENTATION: ***Welfare Reform and Access to Health Care*****. Karen Seccombe, Ph.D., Kim Hoffman, A.B.D. School of Community Health, Portland State University**

"You can always get a place to stay by shacking up if you have to, and you can get food at a soup kitchen. But how am I supposed to pay for all those high price fancy doctor bills?"

Health problems, fear of losing insurance, and access to care are major concerns among welfare recipients

Medicaid was ranked as the most important benefit

National data indicate that poor women have greater health problems:

- self reports
- disability
- ADL

Poor children are more likely to suffer from chronic and acute ailments

Iron deficiency, diarrhea, asthma, lead paint poisoning…

Transitional Medicaid

When families leave TANF they receive 1 year of transitional Medicaid coverage

After that, where do they get coverage?

Are they able to get the health care that they need?

National and State Research Findings

Studies commonly report that 25-35% of adults and 15% of children are completely uninsured after leaving welfare.

Research Questions

- Do families lose their health insurance after transitional Medicaid?
- If so, with what consequences?
- Are welfare recipients concerned about this?

Oregon Health Plan

- Unique expanded Medicaid program
- Watched around the country
- Successfully reduced uninsured in Oregon from 18% to 11%

Study funded by the Agency for Healthcare Research and Quality (AHRQ)

- Telephone Survey in Oregon
  - Wave 1 N = 637
  - Wave 2 N= 552

- In-depth Qualitative Interviews
  - Wave 1 N = 90
  - Wave 2 N= 83

English and Spanish

Retention

- Quarterly phone "check-ups"
- National on-line directory
- Mailings
- Home visits

Sample Characteristics

- Female 90%
- Male 10%

- African American 6%
- Hispanic 18%
- White and Other 76%

- English speaking 89%
- Spanish speaking 11%

Very close to statewide averages

Health Status, Wave 2

- 30% of adults have fair or poor health
- 20% say health interferes with job
- 22% limited in activity due to health
- 39% have chronic problem or pain
- 14% less healthy than 6 months ago
- 17% have child with fair or poor health

"I can't tell you where my diabetes is right now...."

"I'm down to my last bottle of insulin…"

Importance of Health Insurance

- 40% claim OHP (Medicaid) is most valuable benefit
- 94% report that health insurance is of great importance to their family
- 40% worry more about getting health care since leaving TANF

"I've never had to use it myself, but my daughter couldn't do without it…."

"He has lead paint poisoning…The medical benefits—definitely it's the medical benefits that are the most important"

Health insurance is a pressing social policy problem

The magnitude of the problem is immense, and will only intensify over time as the single year of transitional Medicaid continues to expire for the welfare-to-work families.

Recommendations:

- Welfare workers should assist TANF recipients in not only job seeking but also health insurance planning.

- OHP (and other state Medicaid programs) must engage in increased outreach and provision of information.

- Federal or state governments must provide greater incentives for businesses to provide insurance to their workers if the U.S. plans to continue to rely upon employer-sponsored insurance as the foundation for coverage.

- Expand OHP and other state Medicaid funding

- Establish incentives so that more providers would be willing to serve OHP clients.

- Acknowledge personal barriers and develop policies and work with TANF-leavers to overcome them

It's been terrible… They need their shots, Scotty missed his shot, and we never got our dental work done. We had appointments. … I've got letters saying you have to finish your appointments, yet I don't have the coverage. …. I'm asking for help.

PRESENTATION: *Maternity Care in Oregon: A 2002 Survey of Providers*. Ariel K. Smits, MD, MPH

Background: Prenatal and Delivery Care

- Prenatal care reduces fetal and maternal morbidity and mortality
- Rural women and women with Medicaid are at higher risk for inadequate prenatal care
- Importance of maternity care providers for access to care
- Rumors of loss of maternity care providers in the state

Background: Research in the 1980's

- **Large numbers of providers stopped OB care in the 1980's**
  - Studies in multiple states, IOM report
  - Cost of professional liability insurance
  - Fear of litigation
  - Time and lifestyle issues
  - Interference with office practice
  - Associations: practice ownership, older age, longer length of practice

Background: Research in the 1980's

- Adequacy of prenatal care fell nationally in the 1980's (Children's Defense Fund 1995)
- Cuts in federal funding to maternal child health programs (York et al 96)
- Increased numbers of uninsured women
- Decreased numbers of practicing obstetricians (Murray and Bernfield 1988).

Background: Oregon as a Model State

- Small size congruent with comprehensive survey
- Low Medicaid reimbursement level
- Sharp rise in malpractice insurance cost after 1999 with loss of caps on non-economic damages

Maternity Care Survey Project

Cross-sectional descriptive self-administered mail survey of licensed obstetrical providers attempting to better understand obstetrical practice changes in Oregon

Project Goals

- Describe the demographics of current Oregon maternity care providers
- Determine if large numbers are actually quitting
- Determine the important factors relating to the decision to quit maternity care

Methods: Survey Instrument

- 25 questions, 8 pages
- Demographic information
- Types of maternity care included in practice
- Reasons for quitting maternity care if applicable
- Back-up maternity care
- Care of Medicaid patients
- Multiple question types
- Pilot tested

Survey Instrument: Reason for Quitting Choices

- No interest in OB care
- Interference with lifestyle
- Interference with family
- Conflicts with office practice

- Cost of professional liability insurance
- Fear of lawsuits
- Personal experience with lawsuits
- Hospital privileging issues
- Low OB patient volume in practice
- Concern with skill level
- Professional change
- Low reimbursement
- Back-up issues
- Other

Methods: Subjects

- **All OB/Gyns, FPs, GPs, and CNMs with active Oregon licenses with mailing addresses in Oregon or close areas of surrounding states**
  - **Mailing list:**
    - Oregon Board of Medical Examiners
    - Oregon State Board of Nursing
  - **Comprehensive survey rather than sample**
  - **Includes many non-OB providers**
    - Liability insurance survey: approx. 850 OB providers
    - Mailing: over 2000 providers
  - Excluded: lay midwives, LDEMs, other providers

Methods Continued

- **First mailing: October, 2002**
- **Second mailing: November, 2002**
- **Data entry in ACCESS**
- **Analysis with SPSS (11.0)**
  - Chi square
  - Logistic regression

Results

- **Mailed: 2158**
- **Returned: 1232 (58% response rate)**
  - 63% of OB/Gyns
  - 64% of CNMs
  - 53% of FPs
  - 39% of GPs
- **163 exclusions**
- **1069 total surveys analyzed**

Current OB Providers

- **Significant Associations with Stopping Maternity Care:**
  - Male
  - Practice Ownership
  - Pay own liability insurance

    - Rural
    - Work longer Hours
    - Oder Age

Current OB Providers

- **Medicaid**:
    - 384 (75.1%) see unlimited Medicaid
    - 220 (45%) of these plan to limit or stop accepting Medicaid
- **Back up:**
    - 236 (46.2%) currently
    - 45 (19%) plan to stop
    - 34 of these are outside of Portland

Providers Who Have Already Stopped Maternity Care

- 366 providers had at one time included OB in their practice
- Most common major reasons for quitting:
    - Interference with family (51.9%)
    - Cost of professional liability premium (47.5%)
    - Interference with lifestyle (47.1%)
    - Fear of lawsuits (41.3%)
- 125 (34%) quit 1999-2002

Comparison of Providers Who Have Stopped OB Care pre- and post-1999

- **Pre-1999 group**
    - Significantly more likely to cite interference with office or back-up difficulties
- **Post –1999 group**
    - Significantly more likely to cite cost of liability insurance as reason for quitting

Study Limitations

- Self report
- Respondent bias
- Exclusion of non-licensed providers
- Lack of data on incoming providers

Discussion

- **Liability premium increases 99-02:**
    - OB: 280%
    - FP w/OB: 375%
- **Large proportion (up to 70%) of patients are Medicaid**
    - Low reimbursement

Rural issues:

- Medical practice as a small business
- Large distances between providers
- Dependence on surgical back-up for continued maternity care

Implications

- **Access to care issues**
  - Rural and Medicaid
  - Future studies needed
- **Physician retention and recruitment issues**
- **Policy issues**
  - Health care system reform
  - Insurance reform
  - Tort reform

Questions?

- **Acknowledgements:**
  - Oregon Medical Association
  - Oregon Academy of Family Physicians
  - Oregon Chapter of American College of Obstetrics and Gynecology
  - Oregon Health & Science University Department of Family Medicine

Discussion, Questions and Answers

Q. I sometimes hear from physicians that the reluctance to take Medicaid patients is not just the reimbursement but the higher risk nature of the population, I wondered if what you looked at gave you any information on that.

A. In this particular study we didn't specifically ask them why they weren't taking Medicaid patients. In the review of the literature on that subject some certain themes come out, reimbursement is always the number one theme when providers are asked why they don't take Medicaid. Other reasons include: they are patients with multiple needs, they have high social needs that are hard to care for, there is a perception among providers that this population is more likely to sue (which actually is not the case)

Medicaid Advisory Committee Update: Jeanene Smith MD, MPH, Deputy Administrator Office for Oregon Health Policy and Research

OHREC research has been influencing policy. Both a budget note that came out of OMAP and a letter from the Medicaid advisory committee summarizing the research that our office had done under a Robert Wood Johnson grant regarding the impact of the changes to the Oregon health plan. The Medicaid Advisory Committee is a committee that advises the Medicaid agency about policy. They talked to John McConnell, the economist who did the evaluation of premium impact changes now that we've started to charge premiums in the OHP standard and the significant drop of off the 0-10% FPL level, and subsequently submitted a letter strongly recommending premiums be removed from this population. It is likely that OMAP will be putting forth that recommendation at the November E-Board. There is a cost, not so much in dollars but in people because of the way the Oregon Health Plan Standard is now funded (entirely through provider taxes and no general fund dollars). Therefore, results in a likely trade off of fewer people being

funded. However, some of the most vulnerable populations who are currently not having access to the health plans now would.

OHREC research also went down to California - presented with Cindy Mann before a Kaiser Family Foundation Forum for legislative staffers back in July. Governor Schwarzenegger had been thinking about imposing copays and premiums. The copays and premiums were postponed for further review after the forum.
The OHREC model is working to get this information back to the policy makers to make informed decisions; they couldn't afford to eliminate premiums entirely but they could at least make the change therefore the most vulnerable.

NEXT MEETING

Tuesday, November 16, 2004
1:00 to 3:00 PM (please note the change in time)
Clackamas Community College, Room 112
Advanced Technology Center
29353 SW Town Center Loop E
Wilsonville, Oregon

Presentation: **"The Center for Evidence Based Policy"** presented by John Santa, MD, Assistant Director for Health Projects at the Center for Evidence-based Policy at Oregon Health & Science University

Summary:
The Center for Evidence-based Policy builds on lessons learned from improving public policy in the fields of health care, the environment, and at risk children and youth. The Center seeks to move the world by organizing collaborative efforts to address commonly recognized problems, and then provide these efforts with the tools (levers) necessary to get the job done. The Center specializes in providing tools such as: identifying and disseminating the best available research to inform policy making; facilitating collaborative relationships that move beyond the inertia of the status quo; and strategic planning for and adaptive management of collaborative projects.
The Center is housed at Oregon Health and Science University, in the School of Medicine, Department of Public Health and Preventive Medicine, and is directed by Governor John Kitzhaber, MD.

Brief Bio: Dr. Santa is the Assistant Director for Health Projects at the Center for Evidence-based Policy at Oregon Health & Science University. As the former administrator of the Office for Oregon Health Policy and Research (1999-2003), he was involved with issues related to the uninsured, Medicaid, prescription drugs, and evidence-based medicine and served as the Chair of the Public Employees Benefit Board.

He was the principal investigator for two large grants during his state service; a HRSA grant to study state strategies to reduce the rate of uninsurance and a Robert Wood Johnson Foundation grant, *State Coverage Initiatives*, to develop, submit and implement a Medicaid waiver expanding coverage. Since leaving state government he has been involved in a variety of projects related to prescription drugs, disease management, health benefit design and other health policy topics. He currently practices General Internal Medicine at the Veterans Administration.

Presentation: Presentation: "**2004 Oregon Health Values Survey**" Barry F. Anderson, Ph.D., Emeritus, Department of Psychology, Portland State University and James Oliver, Oregon Health and Science University

Summary: The 2004 Health Values Survey explores public attitudes about health care in general and about several potential strategies for the Oregon Health Plan. Oregon Health Decisions directed the survey with funding from the Office of Oregon Health Policy and Research. The goal of the survey is to provide data to the Oregon Health Policy Commission to complement information developed through its series of Community Meetings held in the fall of 2004. Market Decisions Corporation of Portland conducted the survey using a random sample of 531 Oregonians in the period between September 14th and 28th 2004. Several items were repeated from two earlier surveys produced by Oregon Health Decisions in 1996 and 2000 to uncover trends in public opinion on these issues.

November 16, 2004
1:00 – 3:00 PM
CCC Wilsonville Training Center
Room 112

Attendees:
Daniel Touchette, Erika Barbower, Roy Gabriel, Dana Selover, Tom Turek, Marion David, Andrew Epstein, Beryl Fletcher, Damon Kuehl, April Love, Diane Prieb, Liz Baxter, Alison Little, Bob Lowe, Joanna Zamora, John, Tracy, Fred Steele, John Hinckley, Carol Misrack, Janet Meyer, Doris Cameron-Minard, Paul Nelsen, John Santa, James Oliver, Lisa Krois, Tina Edlund, Jeanne Smith, Jen Devoe, Janne Boone, Jessica Miller,

Facilitator: Lisa Krois

I. Introductions
II. OHREC Activities update
III. Presentation: "The Drug Effectiveness Review Project" John Santa M.D
IV. Presentation: "Oregon Health Policy Commission: Community Forums" Sept. 2004. Elizabeth Baxter
V. Presentation: "2004 Oregon Health Values Survey" James Oliver
VI. Presentation: "The Oregon Health Decisions Story" Barry F. Anderson, Ph.D.

OHREC Activities Update
Lisa Krois, from the Office for Oregon Health Policy and Research, briefly discussed current research projects and expected research results within the coming months:

Provider survey: OHPR/OHREC has been working with the Office of Medical Assistance Programs (OMAP), OMPRO and the Oregon Medical Association on a provider survey. The survey is in the field now and will have results out in December.

Children's Access to Healthcare survey: OHPR/OHREC has been working with Dr. Devoe (OHSU) on a Children's Access to Healthcare Survey. This project is currently in the development phase. The survey will assess barriers parents face when trying to obtain publicly financed health insurance for their children in Oregon.

Cohort Survey: The Commonwealth Fund has granted additional funding for the second wave of the OHP Cohort Survey. This survey will be in the field in November with results expected in February.

Legislative Survey: This survey, conducted earlier this year, looks at the informational needs of Legislators and staff. Results to be released at the end of the month.

Presentation: "The Drug Effectiveness Review Project" John Santa M.D., Center for Evidence-based Policy, Oregon Health & Science University

The Drug Effectiveness Review Project

Objectives

- Provide information
- Get and give constructive feedback
- Establish a "science" relationship
- Improve how the health care system works for all of us

The Ethics of Pharmaceutical Benefit Management
Burton S.L. et al, Health Affairs, 20, #5, Sept/Oct 2001

- Accept resource constraints
- Help the sick
- Protect the worst off
- Respect autonomy
- Sustain trust
- Promote inclusive decision making

The Drug Effectiveness Review Project

- Systematic evidence-based drug class reviews focusing on comparative effectiveness to support preferred drug list, formulary, disease management or patient information activities.
- Focus on the most important 25 drug classes
- Update every 6-12 months
- Each participant uses local decision makers to draw conclusions from the evidence for their use. Globalize evidence, localize decisions.
- Process and products available to the public

Topics

1. PPIs
2. Long-acting opioids
3. Statins
4. NSAIDs
5. Estrogens
6. Triptans
7. Muscle Relaxants
8. Oral Hypoglycemics
9. Incontinence Drugs
10. ACE Inhibitors
11. Beta Blockers
12. Calcium Channel Blockers
13. ARBs
14. 2nd Generation Antidepressants
15. Atypical Anti-psychotics
16. 2nd Generation Antihistamines
17. Anticonvulsants with Mood Stabilizing Properties
18. Inhaled Corticosteroids
19. ADHD Drugs
20. Alzheimer's Drugs
21. Anti-platelet Drugs
22. 22. Osteoporosis Drugs

Center for Evidence-based Policy

- MISSION: To address policy challenges by applying the best available evidence through self-governing communities of interest.
- Department of Public Health and Preventive Medicine, Oregon Health & Sciences University
- Supports collaboration, facilitates communication

OHSU Evidence Based Practice Center

- AHRQ designated EPC. Department of Medical Informatics and Clinical Epidemiology, OHSU School of Medicine
- Agreement with Center for drug class reviews.
- Credible, responsive source of comprehensive information.
- Reports provided to local decision-making bodies.

Governance Group

- 15 Organizations
- State Medicaid organizations
- State employee plans
- Private organizations
- Decisions to be made
- Key policy decisions
- Drug classes to be reviewed
- Key questions
- Timelines

Current Announced Participants

- Alaska
- Arkansas
- California Healthcare Foundation (CalPERS and several advocacy groups collaborating)
- Canadian Coordinating Office of Health Technology Assessment (CCOHTA)
- Idaho
- Kansas
- Michigan
- Minnesota
- Missouri
- North Carolina
- Oregon
- Washington
- Wisconsin
- Wyoming

Rx Policy Process

- Need/Reason
- Politics
- Information
- Purchasing/Pricing
- Incentives/Disincentives
- Litigation

The Drug Effectiveness Review Project is a collaborative information project

Evidence-based Systematic Review Process

- Problem formulation/key questions
- Find evidence
- Select evidence
- Synthesize and present
- Peer review and revision
- Maintain and update

Expert Information Process

- Experts may underplay controversy or select only supportive evidence
- Without systematic approach bias may be introduced
- Experts may ask good research questions but the wrong questions for patients and providers
- Experts may not be aware of all evidence
- Experts may or may not disclose conflicts

Conflict of Interest

- Center and EPC staff have no direct conflict of interest, disclosure process
- Participating organization representatives have no direct conflict of interest.
- Policy posted on web site
- Participating organizations each have conflict of interest policy

Relevant Examples

- Heartburn/Proton pump inhibitors
- Chronic pain/Long acting opioids
- Arthritis/NSAIDs and COX2s
- Heart Failure/BetaBlockers
- High cholesterol/Statins

Relevant Examples

- Second generation antidepressants
- Comparative effectiveness—number needed to treat
- SSRIs vs SSNIs
- Adverse effects
- Atypical antipsychotics
- Comparative effectiveness
- Adverse effects
- Mood stabilizers
- Bipolar—comparative effectiveness, ?? Effectiveness for some drugs

Implications and Opportunities

- Gain the stage
- Stabilize the process
- Promote market competition
- Reallocate resources
- Improve outcomes
- Safety
- Expectations

Local Decision Makers

- All participants commit to conflict of interest process
- All the participants have public processes as part of their decision making process
- Participants use information in a variety of ways
- Several use as primary preferred drug list information
- Several use as a secondary confirmation of internal or PBM information
- Several use for information/education to consumers

Consumer Groups

- Information to consumers.
- Easily accessible
- Just in time
- Transparent
- Accountability
- Where are our $$$ going?
- Safety
- Influence the research agenda
- If we don't insist on good information can we ever expect to get it?
- Access for the uninsured

"Perfect Competition"

- Homogeneity of product
- Perfect information
- Freedom of entry and exit
- Numerous small firms and customers

Microeconomics Principles and Policy, Baumol, W.J., and Binder A.S.

Opportunities

- Commonwealth
- Kaiser Family Foundation
- University of Washington

Web Site

- Information, timelines, draft and final key questions, draft and final reports.
- **Public can comment on key questions and draft reports.**
- Contact information **www.ohsu.edu/drugeffectiveness**

More Information

- Project website at www.ohsu.edu/drugeffectiveness
- Email comments/questions regarding the Center to santaj@ohsu.edu
- Call John Santa at 503-494-2691 if questions regarding the Center or Project
- Follow local decision-makers websites
- Contact local decision-makers regarding information about their decision-making process

Presentation: Oregon Health Policy Commission: Community Forums, Sept. 2004
Elizabeth Baxter, Special Projects, Office for Oregon Health Policy and Research

Sites, Participation came from the following counties:

- Benton
- Clackamas
- Deschutes
- Gillam
- Grant
- Harney
- Lane
- Klamath
- Jackson
- Josephine
- Lincoln
- Malheur
- Marion
- Multnomah
- Polk
- Umatilla
- Union
- Wallowa
- Washington
- Yamhill

Health Care Costs:

- In 2003: 20 million American families had problems paying medical bills
    - Two-thirds of those families had health insurance coverage.

Discussion: Controlling Cost

- CONCERNS
  - The 'System' (administrative cost, cost-shift, reimbursement constraints, 'defensive medicine')
  - Services (drugs, technology)
  - Changes in populations (aging, chronic conditions)

- SOLUTIONS
  - Control drug costs/advertising
  - Regulate insurer rate increases
  - Tort reform
  - Fund/reimburse prevention and health education

Access

- Of those without insurance:
  - Almost half postpone seeking care because of costs
  - More than a third need care but did not get it
- Challenges –
  - Geography
  - Workforce shortages
  - Less populated areas

Discussion: Ensuring Access

- CONCERNS
  - Workforce shortages
  - Barriers to access (geographic, transportation, uninsurance, language, culture, immigration status)
  - Changes to OHP

- SOLUTIONS
  - Broaden scopes of practice
  - Improve reimbursement
  - Provide incentives for providers to practice in rural areas

Quality

"just because outstanding care is available does not mean that it is always provided or that everyone has access to that care"

- CONCERNS
  - The 'System' (Accountability, inefficiencies, inconsistent definitions of quality, inadequate workforce to ensure quality)

- SOLUTIONS
  - Public information about quality measures
  - Communication tools – technology and team
  - Publicly available Information on cost
  - Reduce administrative burdens
  - Increase use of evidence-based practices

Health Status

- One third of deaths in Oregon can be attributed to these 3 behaviors:
- Tobacco use
- Lack of physical activity
- Poor eating habits

Discussion: Improving Health

- CONCERNS
  - Education
  - Nutrition
  - Tobacco
  - Individual responsibility

- SOLUTIONS
  - Schools to provide physical education, health education
  - Eliminate or regulate vending machines / fast food in schools
  - Reimbursement for prevention/health education

Lessons Learned:

- Know what you want to learn – focus.
- Only ask for information that you will use.
- Give feedback about what happens with their input
- Build on credibility; continue the dialogue.

Presentation: "2004 Oregon Health Values Survey" James Oliver, Oregon Health and Science University

Survey FAQs

- What type of survey?
  - Computer-assisted telephone interview (randomly dialed)
- How many people?
  - 531
- Is that enough people?
  - Representative sample of the entire state
  - Maximum standard error: ± 2.17% (1.96*SE= ± 4.25%)
  - Maximum pooled SE for 2000 and 2004: ± 2.73% (1.96*SE= ± 5.35%)

Data analysis

- SAS 9.1
  - Survey Frequencies procedure (aka "proc surveyfreq")
    - Incorporates 9 strata (region)
    - Applies survey weights
    - Calculates chi-square statistics
      - SE is weighted by stratum
    - Does not calculate exact tests

- **Priority among groups**
  - New in the 2004 survey
  - Five questions
    - Name top priority in Q1, second priority in Q2, etc.
    - Groups:
      - infants and small children
      - children age 7-17
      - Adults age 18-64
      - Adults age 65+
      - Pregnant women
- **Priority among services**
  - Eight questions, new in 2004
  - Same format
    - Services
      - Primary and preventive care
      - Hospital services
      - Prescription drug coverage
      - vision services
      - Mental health services
      - Substance abuse treatment

Presentation: The Oregon Health Decisions Story**,** Barry F. Anderson, Ph.D., Emeritus, Department of Psychology, Portland State University

Frustrated Citizenship

- Soon after Ralph Crawshaw had been appointed head of the Oregon Statewide Health Coordinating Council, it became clear that the Council alone could do little against entrenched interests about high health care costs and *de facto* rationing. The Council turned to the public.

Political Theory

- Mike Garland added to Crawshaw's experience an ethical foundation based in part on Benjamin Barber's theory of strong democracy.

Decision Science

- Barry Anderson introduced fact-value separation and other decision science concepts to help define the proper roles of public values and scientific expertise.

QOL in Allocating Health Care Resources

- These strands were brought together at a Health Care Parliament, chaired by Mitch Greenlick, and published as a booklet of principles (copies available after the presentation).

The Oregon Health Plan

- John Kitzhaber saw these principles incorporated into law as the requirement to prioritize health services on the basis of values obtained from community meetings.

American Health Decisions

- OHD was an Oregon first. Soon, similar organizations sprang up in other states and in other countries, and the various state organizations came together as AHD.

OHD Meetings & Surveys

- The ideal OHD meeting involves:
  - A prepared *"receptor site"*
  - *Hosting* by a respected local leader
  - *Assurance* that what is said at the meeting will be transmitted to the "receptor site" for use in decision making.
  - *Fact-value* separation.
  - A *"graffiti wall"* to help participants keep track of the questions and their ideas and to edit what will be forwarded to the "receptor site".

Geneforum

- Greg Fowler established Geneforum, an OHD spin-off dedicated to informing the public and its representatives about genetic science and obtaining public value judgments for use in decision making. Geneforum employs Web site interactives, surveys, and talks more than community meetings.

December 14, 2004
9:00 – 11:00 AM
Oregon State Library
Room 103

Attendees:
David Pollack, Roy Gabriel, Robin McKnight, Janne Boone, Mike Barker, Vickie Gates, Alison Little, Dennis Deck, Matt Carlson, Melissa Thompson, Jennifer Wisdom, Tammy Nelson, Peggy Lacombe, Lisa Krois, Jeanene Smith, Tina Edlund

Facilitator: Lisa Krois

I. Introductions
II. OHREC Activities update
III. Presentation: Oregon's Mental Health Service System for Children, Marion David PhD
IV. Presentation: Substance Abuse Services under the Oregon Health Plan: Still Changing After All These Years, Roy M. Gabriel, Ph.D. and Dennis D. Deck, Ph.D
V. Next Meeting: January 18, 2005

OHREC Activities Update
Lisa Krois, from the Office for Oregon Health Policy and Research, briefly discussed current research projects and expected research results within the coming months.

Provider survey: OHPR/OHREC has been working with the Office of Medical Assistance Programs (OMAP), OMPRO and the Oregon Medical Association on a provider survey. The survey is in the field now and will have results out in December.

Children's Access to Healthcare survey: OHPR/OHREC has been working with Dr. Devoe (OHSU) on a Children's Access to Healthcare Survey. This project is currently in the development phase. The survey will assess barriers parents face when trying to obtain publicly financed health insurance for their children in Oregon.

Cohort Survey: OHPR/OHREC has been working with Prof. Mathew Carlson (PSU) and Bill Writght (Providence CORE) on the second wave of the OHP Cohort Survey. This survey was fielded in late November and results are expected in February.

Presentation: Oregon's Mental Health Service System for Children; Recent trends in provision of mental health services & Changes in characteristics of children served, Marion R. David PhD, Office of Mental Health and Addiction Services, Oregon Department of Human Services

Present goal:
Begin to broadly describe what is happening within the children's service system.

Future goals:
Explain significant trends and patterns in the data.

Predict impact of treatment on client well being (accomplished in part via linking of these data to other data sources, e.g., child welfare data, juvenile justice data)

Data Sources for Current Analyses

- Client Process Monitoring System (CPMS)
- Medicaid Database (MMIS)

Client Process Monitoring System (CPMS) tracks:

- Clients receiving outpatient (non-hospital) treatment from a government-funded mental health / addiction services provider, regardless of insurance eligibility
- Both clients receiving outpatient mental health services and outpatient chemical dependency services (different data elements for these two groups)
- Episodes of service: Data on client at beginning and end of treatment episode (does not contain data on service encounters within episode)

Medicaid database tracks:

- Eligibility and enrollment status of clients who are at some point eligible for services reimbursable through Medicaid
- All health care encounters associated with Medicaid claims (mental health treatment is more often reimbursable through Medicaid than chemical dependency treatment)
- Client and provider demographics and characteristics
- Billing information (service charges)

Analyses of data on all children who received government-funded mental health or chemical dependency services between 1/1999 and 12/2003 (Excludes children seen in hospital settings only)

How many children are in treatment for mental health and/or addiction problems?
In 2003, per CPMS, over 30,000 children had an open chart with a government-funded mental health or addiction services treatment provider.

Far more children were in treatment for mental health problems than for chemical dependency problems. Only a small fraction was in treatment for both mental illness and chemical dependency.

Has there been any change in the number of children receiving treatment?
The number of children in treatment for mental health problems has been increasing (at a decreasing rate) at least since 1999.

The number in treatment for chemical dependency also increased (at a decreasing rate) from 1999 to 2002, but then decreased from 2002 to 2003.

What is the ethnic/racial heritage of the children receiving mental health and/or chemical dependency services?

Race / Ethnicity of Children in Treatment 2003

- Asian 1.17
- Black 6.15
- Hispanic 10.54
- Native American 4.24
- Other or Unknown 2.28
- White, Non-Hispanic 75.61

* "In Treatment" = Chart open for at least one day in 2003.
(Data Source: CPMS)*

Has there been any change in the ethnic/racial diversity of children receiving mental health and/or chemical dependency services?
There has been an increase in the diversity of the treatment population. Much of the increase in diversity is attributable to an increase in the number of Hispanic children in treatment.

In 2003, 11% of the treated population identified as Hispanic. 5 years earlier, in 1999, only 8% of the treated population identified as Hispanic.

Where do the children receiving mental health and/or addiction services live?
Per CPMS, approximately 25% of the children in treatment live in Multnomah county. An additional 20% live in Lane and Marion counties.

What are the age and sex distributions of children in treatment for mental health and/or addiction problems?
The number of children in either mental health or addiction treatment increases with age, until at least age 16.

After age 3, the number of boys in treatment exceeds the number of girls in treatment. Children in treatment for chemical dependency are significantly older, on average, than children in treatment for mental illness.

The number of boys in treatment exceeds the number of girls in treatment. This is true within both the population treated for mental health problems and the population treated for chemical dependency.

Exception: There are more girls aged 15+ than boys aged 15+ in treatment with a mental health provider.

Has there been any change in the age distribution of children in treatment?
Per CPMS, the mean age of children in treatment increased from just over 11 (in 1999) to almost 12 ½ (in 2001). Per this same data source, mean age changed little between 2001 and 2003.

An increase in the average age of children in treatment is also apparent within the subset of children who are Medicaid-eligible and receiving mental health services through managed care. (Change from just under 11 in 1999 to over 12 in 2001-2003.)

The change in the age distribution of children in treatment is not clearly attributable to a change in the average age at entry into service.

What types of services are being provided to children in treatment for mental health / chemical dependency problems?

The bulk of services provided are basic outpatient services for mental health and addiction problems.

The older children typically receive different services than the younger children.

The children receiving mental health outpatient services or psychiatric day treatment services are more likely to be under 12 than over 12.

The children receiving chemical dependency services of any kind, psychiatric residential services, or crisis services are more likely to be over 12 than under 12.

The duration of a service episode typically depends, in part, both on the type of service and on the age of the child.

Has there been any change in the nature or frequency of services provided to children in treatment?

There has been an increase in the frequency with which Medicaid-eligible children receive case management and medication management services through mental health managed care organizations.
There has been relatively little change in the frequency with which Medicaid-eligible children receive individual, family, and/or group therapy services through mental health managed care.

What diagnoses are most common among the children treated in MHO settings?

The most common diagnoses are adjustment disorders, conduct / oppositional defiant disorders, ADHD, depressive disorders, and anxiety disorders (particularly PTSD).

The probability that a child carries one of these diagnoses has changed little over the past 5 years. Exception: The frequency with which children are being diagnosed with conduct disorder / oppositional defiant disorder appears to be decreasing.

Analyses of data on all children who received chemical dependency services between 1/1999 and 12/2003

Marijuana and alcohol are the drugs most commonly used (per report) by children in treatment for chemical dependency. Methamphetamine is also used by a substantial minority of the children in treatment.

Boys in treatment for chemical dependency are more likely than girls, per report, to have used marijuana and hallucinogens. Girls in treatment for chemical dependency are more likely than boys, per report, to have used alcohol, methamphetamine / amphetamine, cocaine, and heroin.

There is typically a several-year lag between age of first use of alcohol/drugs and age of index treatment for chemical dependency.

Mean time from first abuse to treatment = 4.2 years

The age at which children begin using psychoactive substances (per report) depends in part on the substance being used.

The typical child in treatment for chemical dependency has been arrested at least once (per report) in the 5 years preceding treatment.

Among children in treatment for chemical dependency, reported use of marijuana, alcohol, hallucinogens, and inhalants has decreased over the past 5 years.

Among Children in treatment for chemical dependency, reported use of amphetamines / methamphetamines has increased over the past 5 years.

Summary:

Each year, per CPMS, as many as 30,000 Oregonian children receive mental health and / or chemical dependency services through the state government.

In a typical year, about 80%, of the children are in treatment for mental health problems, 15% for chemical dependency problems, and 5% for both mental health and chemical dependency problems.

The number of children in treatment increases with age, and except among very young children, the number of boys in treatment exceeds the number of girls in treatment.

The children in treatment are older and ethnically more diverse than they were five years ago.

Most services are provided on an outpatient basis. In 2003, almost 90% of service episodes were outpatient mental health services (73%) or outpatient chemical dependency services (15%).

The duration of service episodes ranges widely, from a mean of 6 days (crisis services for children over 12, in 2003) to a mean of 475 days (psychiatric day treatment services for children 0-12, in 2003)

The fraction of children receiving some form of case management on the course of a year has been increasing, from about 28% in 1999 to almost 40% in 2003.

The fraction of children receiving some form of medication management in the course of a year has also been increasing, from under 16% in 1999 to over 24% in 2003.

The fraction of children receiving individual, family and group therapy in the course of a year has changed little. About 60% of the children in treatment receive individual therapy, about 50% receive family therapy, and about 15% receive group therapy.

There has been little change in the diagnosis carried by children carry a diagnosis of adjustment disorder or parent-child problem. Conduct / oppositional defiant disorders, depressive disorders, ADHD, and anxiety disorders are each diagnosed in about 10 – 20% of the children.

Marijuana and alcohol are the drugs most commonly used by children in treatment for chemical dependency. In 2003, 86% of the children reported use of marijuana, and 77% reported use of alcohol.

Methamphetamines / amphetamines are also used by a substantial minority of the children in treatment. 21% reported use if these drugs in 2003.

In 2003, the boys in treatment for chemical dependency were more likely than the girls to report having used marijuana (88.5% vs. 80%) and hallucinogens (5% vs. 3.5%).

The girls were more likely than the boys to report having used alcohol (80% vs. 78%), amphetamines (29% vs. 13%), Cocaine (5% vs. 2%), and heroin (1.5% vs. 0.7%).

Among the children treated in 2003 for chemical dependency, there was, on average, a 4-year lag between first use of alcohol/drugs and the beginning of the index treatment episode.
The age at which children begin using psychoactive substances (per report) depends in part on the substance being used. On average, children begin using alcohol and marijuana at age 12 ½, inhalants and heroin at age 13, hallucinogens at age 13 ½ an cocaine and amphetamines at age 14.

The typical child in treatment for chemical dependency reports having been arrested at least once in the past 5 years (in 2003, mean number of arrests = 2.6, median =1).

Among children in treatment for chemical dependency reported use of marijuana, alcohol, hallucinogens, an inhalants has decreased over the past 5 years. Reported use of amphetamines / methamphetamines, however, has steadily increased.

Presentation: "Substance Abuse Services Under the Oregon Health Plan: Still Changing After All These Years", Roy M. Gavriel, Ph. D. and Dennis D. Deck, Ph.D., RMC Research Corporation

RMC Research Corporation:
Who Are We?

- A private, for-profit research, evaluation, training and technical assistance organization
- Headquarters in Portsmouth, NH
- Regional offices in Portland, OR; Denver, CO; Arlington, VA; and Long Beach, CA
- Portland office
    - Opened in 1990; 2 staff and $200,000 in contracts
    - Now 35 staff and about $6 M in grants and contracts
    - Evaluation and Policy Studies in: Behavioral health, School/Community-based Prevention, Math/Science Ed, Reading Comprehension

And the Important Question:
What Does "RMC" stand for?

- ***QUALITY***

Other Members of RMC Research Team

- Kelly Vander Ley – Quantitative Analyst, Co-Occurring SA/MH Disorders; Behavioral Health and Primary Care
- Wyndy Wiitala – Quantitative Analyst, Administrative data
- Kathy Laws & Ryan D'Ambrosio – Qualitative Analysts, SA Prevention and Treatment, Evidence-based Practices
- Jeff Knudsen – Survey methodology, SA Tx Workforce, SA Prevention
- Jane Grover – Culturally Competent evaluation methods, American Indian Behavioral Health programs
- Matthew Carlson – alumnus

RMC History of Research on OHP and Substance Abuse Services

- 1996 – SAMHSA CSAT: Effects of Managed Care on Utilization and Outcomes of SA Tx Services for Medicaid Adults
- 1997 – SAMHSA CSAT: …for Medicaid Adolescents
- 1999 – SAMHSA CSAT: Follow-up and Continued study on both populations
- 2000 – NIAAA (w/OHSU)
- 2000 – OR OADAP – Qualitative interviews w/providers and MCOs in all OR counties
- 2001 – SAMHSA CSAT – Effectiveness of Integrated COD Tx
- 2002 – NIDA – Effects of Different Financing Mechanisms on Methadone Maintenance Tx (Supplement in 2003 to focus on impact of cuts)
- 2004 – RWJ – Effects of Statewide Budget Reductions on Substance Abuse and Mental Health Services for Oregon's Most Vulnerable Citizens

Key Elements of RMC Research on OHP

- Three-pronged methodology:
    - Construction, analysis of statewide analytic databases

    - Longitudinal follow-up studies of clients in Tx, using standardized instruments
    - Qualitative interviews of key stakeholders at state, county and local provider levels
- Comparisons w/state of Washington in most studies
    - Similar in demographics to Oregon, but very different in health/SA policies
- Partners, partners, partners
    - OR, WA state SA/BH agency, Medicaid staff
    - OHSU investigators (Depts of Psychiatry, Public Health & Preventive Medicine)
    - OHREC

Administrative Data Studies
- Trends in Medicaid enrollment and
- Substance Abuse Treatment access and utilization
- By Medicaid eligibility groups
- By adult and adolescent populations
- Development of treatment outcome measures, severity indicators

Sidebar: Publicly-funded SA Tx Services
- About 30,000 adults received publicly-funded SA Tx in Oregon in 2000 – about 10,000 of them supported by Medicaid
- Major Tx modalities for OHP adults
    - Outpatient (60% – 70%)
    - Residential (10% – 15%)
    - Methadone Maintenance (5%)
    - Detoxification (15% – 20%)
- Distribution of modalities differs slightly for various Medicaid eligibility groups and for those supported by other public funded
- At the best of times, only 1 in 4 or 1 in 5 adults who need alcohol or drug treatment actually receive it ("Treatment Gap")

What We Learned about Access to Tx under the OHP
- Contrary to concerns accompanying the shift to managed care, access to SA Tx did not decline; in fact it increased dramatically for adults under OHP
- No coincident reduction in access to Tx by other publicly-funded adults (i.e., not simply cost shifting)
- No difference in severity of clients treated under OHP vs. other public funds (i.e., not "skimming off the top")
- Large variation in access to Tx for adults enrolled in different managed care organizations
- Little increase in access to Tx for adolescents

What about Outcomes of SA Treatment?
- Limited information available statewide from administrative databases. RMC formulation:
    - Retention in Tx (advantages over length of stay)
    - Tx Completion (clinical judgment at provider level)
    - Abstinence from AOD at discharge from Tx (self-report)
    - Readmission to Tx within year (a good thing? A bad thing?)

- More detailed, but less generalizable, information available from prospective sample studies
    - Addiction Severity Index (ASI): Degree of problems in alcohol use, drug use, mental health, medical condition, employment, criminal justice involvement
    - Global Appraisal of Individual Needs(GAIN): 8 outcome domains
    - Client Satisfaction with Tx Services
    - Interviews of client samples at Tx entry, 6 mos. and 12 mos. later

Outcomes: Findings from Longitudinal Adult Study Samples

- Significant declines in all problem domains from baseline to 6 mo. follow-up. Improvement persisted, but did not continue, through 12 mo. follow-up
- Strongest difference with comparison state was in more significant improvement in mental and physical health among Oregon clients
- Greater, more lasting improvement among clients who were less severe, had fewer prior Tx episodes, and reported satisfaction with services received
- No differences in Tx outcome by gender, race/ethnicity, self-reported motivation/readiness for Tx, degree of integration in COD Tx

What SA Tx Providers Told Us

- Transition through Medicaid expansion and managed care included several phases and all were difficult. Providers had to become better "business people."
- Objected to added layers of administration between funding and care; and alleged underwriting of financial losses on physical health care (fruits of integration)
- Different financing approaches across MCOs very influential in quality/consistency of care
- Mandating ASAM diagnosis and placement criteria significantly "professionalized" the field

Outcomes: Statewide Findings 1992-1998

- Little change in administrative data outcomes from pre- to post-OHP expansion; and similar trends to those found in comparison state, Washington
- For Outpatient Tx:
    - Retention inTx for at least 90 days: 40% to 50%
    - Tx Completion: 25% to 33%
    - Abstinence at discharge: 45% to 55%
    - Readmission to another Tx episode: 30% to 35%
- More positive outcomes for those who had longer continuity of Medicaid coverage and those with lower SA problem severity

Outcomes for Methadone:
Retention (1 year)

- Increased retention in Oregon explains the dramatic increase in MMT utilization starting about 1997.
- Driving force appears to be more adequate financing in Oregon compared to Washington which led to state differences in provider behavior and ultimately better client outcomes.
- Forthcoming in Deck & Carlson (2005) JBHSR [Jan issue]
- We expect something of a reversal in the two states over the next year or two as the impact of cuts to OHPS in Oregon and expanded capacity and funding in Washington play out.

But That Was Then…

- Changes in OHP since 2002 have affected SA services dramatically
    - Monthly premiums, co-pays
    - Elimination of SA/MH benefit for OHP Standard 3/03
    - 51% disenrollment in OHP beginning in 2003
        - Both voluntary and disciplinary
        - Disproportionate among lowest income, most medically needy
    - Decline in use of outpatient, methadone maintenance services since beginning of 2003 for both OHP Standard and Plus
    - Resumption of SA/MH benefit for OHP Standard, 8/03
    - Now what?

RMC Continuing Study
Tentative Conclusion:
General Impacts

- The impact on OHPS was immediate and greater than can be explained by disenrollment from Medicaid.
- The impacts are not restricted to OHPS (or even Medicaid).
    - Our data suggests that there has been a broader decline in utilization, consistent with the provider reports of widespread layoffs and clinic closures.
    - Oregon faces potential penalties for failure to meet the Maintenance of Effort criteria for the SAPT Block Grant as a result of these declines.
- There is little evidence that those who lost coverage are getting treatment through alternative public sources or self-pay. There as only a modest increase in non-Medicaid admissions.
- The exception is that 60% of those enrolled in Methadone elected to self-pay (or payers/providers found stop gap funding to reduce impact). Who remains appears not be a function of ability to pay but rather past history in MMT and severity.

Tentative Conclusions:
Opiate addicts

- Opiate dependence is highly prevalent among OHPS (20% of those presenting for tx).
- In 2003, the rate of new admissions for OHPS opiate addicts dropped 53% (controlling for disenrollment) .
- Those who do present (controlling for disenrollment) are:
    - Less than half as likely to be placed in the most appropriate modality: a methadone maintenance program.
    - Usually have a past history of MMT.
- Thus we are no longer reaching many of the individuals we most want to get into treatment.

So What? Why are we concerned about declines in participation in SA Treatment?

- Individuals who need SA care and do not receive it will get help in hospitals, emergency rooms, or wind up in jail – all far more expensive than timely, effective SA Tx
- With all of its imperfections, SA Tx services for those who need them have been definitively shown to:
    - Reduce subsequent health care needs and costs

- Reduce criminal behavior and incarceration rates
- Increase employment rates and legal income

Continuing Study Efforts

- Tracking trends in SA and MH Tx access and utilization
- Interviewing samples of clients who expressed need for SA or MH Tx services or who had received these services prior to elimination of benefit 3/03. Retrospective inquiry into
    - Services received (SA/MH Tx, medical)
    - Employment, legal experience
    - Family relationships
- Interviewing administrators and providers at state, county and local levels
- Pushing results to policy forums

Methodological Postscript

- Believe strongly in complementary value of three-pronged methodology
    - Admin data comprehensive but full of developmental challenges and indicators are a bit blunt for program/system improvement purposes
    - Longitudinal studies provide sharper outcomes, but are very expensive and have limited generalizability
    - Key informant interviews and focus group provide unique insights and perspectives but not always accurate ("seldom right, but never in doubt")

Methodological Postscript (cont.)

- Longitudinal client sample studies suffer from absence of no-treatment control. Newly designed treatment vs "treatment as usual" studies are increasing, but ethical obstacles to having an equivalent "no treatment" group.
- Most convincing cost studies are those using administrative data, comparing over time:
    - Those who needed and received SA TX
    - Those with equivalent need but did not receive SA Tx