# Safety Net Advisory Council
# Recommendations to the Oregon Health Policy Board and Its Committees
# November 8, 2010

Members of the Safety Net Advisory Council (SNAC) reviewed preliminary recommendations of the Oregon Health Policy Board (OHPB) committees to ensure that the policies address the needs of the state's vulnerable populations. This document provides an overview of SNAC recommendations and considerations for the OHPB as it finalizes their comprehensive plan for health reform.

The Safety Net Advisory Council supports all recommendations contained in this document.

## Table of contents

Introduction
Overarching Recommendations to the OHPB
Recommendations to the OHPB Committees and OHA Staff

- Incentives and Outcomes…….6
- Health Information Technology Oversight Council…….8
- Workforce…….8
- Health Insurance Exchange…….10
- Health Improvement Plan…….11

## Introduction

Vulnerable populations are people who experience barriers that prevent them from having access to appropriate, timely, affordable and continuous care, in addition to other barriers that prevent them from achieving optimal health. Vulnerable groups generally face complex barriers more frequently when trying to access care than the general population. While the lack of adequate and affordable health insurance coverage is a prominent barrier among vulnerable populations, it is not the only barrier to good health. Many who seek out the health care safety net confront geographic, language and literacy, racial, ethnic, cultural, social and other economic barriers. In addition, there are a growing number of patients requiring mental health and substance abuse treatment; many struggle with homelessness or live in geographically isolated areas where access to physical, behavioral/mental and oral health care services is insufficient.

Oregon's racial and ethnic makeup is growing increasingly diverse and the safety net serves a disproportionately high percentage of culturally and racially diverse individuals. Safety net providers are seeing greater numbers of patients and those patients whom they are seeing are sicker and are presenting with more complex social and medical needs.

Fostering and maintaining health for this group requires comprehensive, wrap-around services and acknowledgement of all of the domains that touch their lives. These structures and supports are needed in order to avoid more intensive kinds of care that are ultimately too late, not effective and expensive. Further, with a large percent of the population living in poverty, care needs to be welcoming and grounded in an understanding of the socioeconomic determinants of health. Individuals will also require care coordination and assistance in navigating these systems.

There are a number of activities and provisions within state and federal health reform taking place concurrently that will affect the safety net. It is difficult to fully understand the impact of federal reform funding on Oregon's health care safety net. While the number of individuals with insurance will increase, it is anticipated that there will also be an increase in the number of people accessing the safety net – both newly insured and the remaining uninsured.

To meet the increased demand for services, delivery system reform is critical. Also, Oregon needs a robust primary care workforce trained with the skill set to serve vulnerable populations that receive better opportunities for loan repayment and is adequately compensated, as they often see more complex patients and may be working in more demanding environments. Delivery system and payment reform should be tailored to meet local needs and realities. Furthermore, careful consideration and flexibility should be given to those that serve high numbers of vulnerable individuals as they often face unique challenges.

**Safety Net Advisory Council**
**Recommendations to the Oregon Health Policy Board**
**November 8, 2010**

The Safety Net Advisory Council (SNAC) continues to stand behind their earlier recommendations to the Oregon Health Fund Board modified to reflect current state policy discussions and the passage of federal health reform.

The health care safety net is a key delivery system element for the protection of the health of Oregonians and the delivery of comprehensive primary (physical, mental, behavioral and oral health) services to vulnerable Oregonians.

1. **Stable Funding for the Safety Net**
   *The SNAC originally recommended establishing the Health Safety Net Fund that would support:*
   - Strategic investments to maintain infrastructure
   - New site development or expansion
   - Technical assistance to address specific organizational issues/challenges
   - Assist clinics with financial stability strategies

   The SNAC continues to support this recommendation and believes it is a necessary component to maintain essential services and support expansion of additional sites or services in areas of unmet need. The SNAC also recognizes that state funds are limited for the upcoming biennium. This recommendation was developed before federal reform passed with a mix of potential funding opportunities. While federal reform will not ensure adequate funding into the future, the SNAC believes a coordinated effort between state and local government, nonprofits and other related associations is needed to identify funding opportunities to support care for vulnerable populations. The OHA or other entity should convene stakeholders to review and learn about funding opportunities, encourage collaboration, track and review all federal and other national funding opportunities that would support Oregon and local safety net reforms, and align opportunities with appropriate implementers. Collaboration and integration of planning across these entities will help to leverage greater funding opportunities. The SNAC believes this is a key first step in establishing stable funding to maintain critical infrastructure and “grow” the health care safety net in a strategic and sustainable way.

2. **Critical Tools**
   *The SNAC recommends support for widespread electronic health record (EHR) adoption across the Safety Net through:*
   - Providing a systematic approach to EHR adoption across the safety net
   - Assisting with the capital-intensive start-up and ongoing maintenance and technical assistance costs and extend this same assistance to smaller community health clinics that may not seek to achieve “meaningful use”

- Providing better patient and treatment information to improve the safety, quality, and efficiency of care
- Maximizing Medicaid incentive payments available for safety net providers to adopt, upgrade or implement EHRs through education and technical assistance (working with O-HITEC, Oregon's Regional Extension Center)
- Utilizing telehealth opportunities for rural safety net providers to be able to deliver better care through the electronic consultation of specialists and reducing the costs of travel to health centers for care

Oregon and the nation are moving toward greater readiness to implement health information technology. It is a key tool for realizing the broader goals of access, quality, safety, improved health, and cost reduction. The safety net provides care to many Oregonians who face barriers to care and who often move in and out of coverage and from provider to provider. Policy makers can help assure that electronic health records are available at the time of treatment for safety net patients. The barriers to broad adoption of health information technology across the safety net are substantial. They include significant start up and ongoing cost. The incentives required to adopt EHRs will differ from one type of safety net provider to another and some of the barriers to safety net providers will be reduced, but not eliminated with the Medicaid incentive payments. In addition, safety net clinics have much smaller operating margins than the private sector and have less access to capital. In general, what margin safety net clinics do have is funneled back into direct services.

3. **Data Integrity and Infrastructure**

*The SNAC supports robust and uniform data collection to inform policymakers, providers, researchers and consumers by:*

- Consistently capturing clinical, demographic (including race, ethnicity and primary language), population health and health outcomes data in a standardized fashion
- Establishing effective linkages between data sources to better understand health disparities and work towards equity
- Stratifying data to account for socioeconomic factors that affect vulnerable populations
- Informing payment reform methodologies, quality standards and care delivery mechanisms over the long-term
- Establishing an infrastructure to analyze metrics to determine the effectiveness of new policies

More is known about certain segments of the population accessing care through the safety net than others. Different sectors of the safety net vary in their ability to collect information. Safety net clinics that have health information technology are better able to collect and report quality measures than those clinics that do not have adequate technological infrastructure. These variations make it challenging to capture data

reflecting demand for services, workforce needs, and financial capacity to meet the needs across the entire safety net spectrum. In spite of these challenges however, we do know that Oregon's health care safety net represents significant primary care capacity. As we continue to advance our efforts through state and federal health reform efforts, it is critical to maximize the quality and utility of data collected to inform and address needs of vulnerable populations.

**4. Workforce**

*The SNAC supports the implementation of innovative approaches to meet safety net workforce needs by:*

- Recruiting, training and retaining an increased pipeline of mid-level providers to communities of need
- Optimize the Primary Care Services Loan Repayment Program by restoring funding at an adequate level and adding a loan forgiveness component to encourage Oregon students to choose health careers in areas of unmet need
- Strengthening rural practice incentives by updating the rural provider tax credit program to provide an increase in the tax credit from $5,000 to $10,000
- Supporting OHSU's Rural Scholars Program and Oregon Area Health Education Centers (AHEC) Locums Tenems Program, as well as efforts to expand Graduate Medical Educational (GME) training throughout the state

Significant health coverage expansions through federal and state reform are expected to result in an increased demand in the utilization of health care services. To meet the influx in demand, Oregon will need to develop a robust primary care workforce trained with the skills to serve those that have been historically left out of the health care system. There is a need for payment and other incentives that will reward providers for making critical primary and preventive care services available. Specific issues need to be addressed such as assuring an adequate provider "pipeline", preventing burn-out of existing providers, addressing misdistribution of workforce, providing workforce tools that will help safety net clinics remain viable and supporting communities in their efforts to evolve models that work. Like the rest of the health care delivery system, the safety net is dependent on its workforce. It is especially dependent on mid-levels and physicians who provide supervision, dentists, and, increasingly, behavioral/mental health professionals.

**Safety Net Advisory Council**
**OHPB Committee Specific Recommendations**
**November 8, 2010**

## INCENTIVE AND OUTCOMES COMMITTEE

*Quality and Efficiency*

- Quality Metrics

  **Recommendation:** The statewide scorecard on the health of Oregon should include mental health, dental health and vision indicators.

- Provider data collection

  **Recommendation:** Create accountability without creating administrative burden. Consider the differing capacities of entities to collect and report data, especially safety net providers. Encourage safety net entities to collaborate and standardize data. Take into account current capacity to report and provide technical assistance and other supports to ensure accurate and manageable data collection.

*Payment Reform*

- Primary Care Payment Transition

  **Recommendation:** One size doesn't fit all. There needs to be flexibility as to how this transition is implemented, especially for safety net providers that serve vulnerable populations.

  **Recommendation:** Transition payments are needed to incentivize successful implementation of elements of the patient centered primary care home (PCPCH) model. Such payments may include:

  - Same-day visits – (the ability for patients to see both a primary care physician and behaviorist on the same day and for the clinic to bill for this "same-day visit").
  - Coordination with emergency or urgent care, hospitals and specialists. Assure an effective feedback loop, which should incentivize both the primary care providers and those in other parts of the system.
  - Supporting efforts to implement electronic health records (EHR) in clinics and achieve meaningful use. Utilize EHR data as a tool for stratifying patients to inform payment for mental health, substance abuse, co-morbidities and social conditions.
  - Reimbursement for defined work and providers that improve care, such as panel managers, behaviorists, pharmacy managers, etc.

**Recommendation:** In the transition path for primary care, the payment reform committee envisions some payment in the form of shared savings. Shared savings revenue to practices could diminish over time as efficiencies are achieved in the delivery system, the level of reimbursement could be reduced as payers try to capture the savings. The reduction in reimbursement may in turn jeopardize safety net provider ability to maintain newly-formed infrastructure needed to sustain a PCPCH approach.

**Recommendation:** If adding requirements for PCPCH infrastructure and reporting, consider removing or augmenting current requirements so that safety net providers don't become overburdened (i.e. cannot simply add additional reporting requirements and add resources on top of current mandates).

**Recommendation:** Payment reform should include payment for comprehensive primary care services, including mental, behavioral and dental health in addition to alternative care services, some of which include those provided by naturopaths, acupuncturists, oriental medicine providers and chiropractors.

**Recommendation:** Review of the Federal Qualified Health Center and Rural Health Clinic prospective payment system (PPS) needs to occur in order to support full transition to a PCPCH model. In a transition period, current payments systems such as enhanced reimbursement should be maintained until support for comprehensive, quality services (including enabling services such as care management, interpretation, transportation, etc.) for vulnerable populations are built into all payment systems.

**Recommendation:** The payment model needs to be changed for all patients and not just chronic disease patients to support fundamental change at the practice level.

- Coordinated Payer Community

  Like other providers, those serving vulnerable populations work with multiple payers with differing quality and payment programs. Simplicity, consistency, and transparency would reduce the administrative burden on these providers who are already working in difficult environments.

  **Recommendation:** Purchasers should work with insurers to organize payment reforms to shift the burden of navigating the multi-payer system away from the providers. Carriers should be responsible for making payment transparent and easier to navigate for providers and patients.

- Incentives to Provide Care to the Safety Net Population

  **Recommendation:** If payers/providers can opt out of serving the safety net population and contracting with community providers, due to the complexity of care, some will. This burdens the few providers that will see Medicaid/Medicare patients. OHA contracting

standards could incentivize participating providers to have a balanced patient load that reflects the needs of the community—by demographic characteristics or type of coverage. In addition, incentives should take into account the differences in community needs that may require for example, for providers to work non-traditional hours in underserved areas. Thus incentives for after hours and alternative hours care should be considered.

- Risk Adjustment

  **Recommendation:** When considering risk adjustment for payment or quality measurement purposes, we need to find a way to consider social disparities in addition to the risk factors normally taken into account in medical risk adjustment.

**Health Information Technology Oversight Council**

- Technical Assistance

  **Recommendation:** Many providers are not aware of current efforts and/or how to access technical assistance. Efforts to support HIT adoption and utilization should focus on getting information on current efforts to the safety net clinics and informing them of opportunities and available assistance.

  **Recommendation:** Many safety net clinics do not have the necessary infrastructure and technical support needed to utilize the technology at a level that provides a return on investment. While a powerful tool for managing care, improving health, conducting research and developing data-driven policies, the cost of deploying and sustaining HIT on a clinic-by-clinic basis is financially out of reach for many safety net providers. Therefore, support and technical assistance should be offered to ensure entities and providers have the tools to function at their highest capacity of HIT utilization and/or achieve meaningful use.

- Federal Funding

  **Recommendation:** Ensure that Oregon is leveraging all available funding opportunities for the adoption and implementation of HIT and that this information is reaching the appropriate institutions and providers in a timely fashion.

**Workforce**

- Provider Training

  **Recommendation:** There is a need for learning communities to focus on delivery system reform efforts, identify and prioritize workforce needs, and to help organizations strengthen capacity for delivering care in new ways. Learning communities should:

- Draw on the safety net, whose expertise and experience is becoming increasingly relevant to all health delivery settings.
- Address the specific needs of the safety net in order to become PCPCHs and meet other delivery system reform goals.
- Promote cross-fertilization among mainstream and safety net providers.
- Serve as a learning environment for educational facilities that are training our next wave of providers by integrating educational facilities and students into the learning communities on a continuous basis.

**Recommendation:** Need to recruit, train and retain providers who come from or reflect the communities they serve, by incentivizing "Oregon grown" providers through in-state educational enrollment practices.

- Data Needs

**Recommendation:** Need better information about workforce capacity, distribution of providers, availability of various types of providers, retirement plans, etc. This is key to addressing workforce needs. Efforts to collect workforce data require coordination and collaboration between local, state and federal databases. The Workforce Committee should gather, analyze and publish relevant data and use it to make strategic plans for addressing workforce challenges. Specific uses for this kind of information include:

- Informing the admissions processes of Oregon health profession schools or programs.
- Reviewing the criteria for Oregon's primary care loan repayment program (what kind of practitioners are needed and where?).
- Facilitate paths that support providers to serve the needs of vulnerable populations.

**Recommendation:** The following should be included in the Workforce Database:

- Cultural competency of providers – may be done through patient satisfaction surveys, and evaluation of other metrics that include the use of services that support provision of services to people with special needs
- Homegrown Oregon providers vs. out of state/country, both those trained here and those coming from out-of-state to practice in state
- Mental health and vision providers
- Preventative services being furnished by providers
- Retiring providers services
- Telemedicine with regards to provider availability. Do you provide/receive telemedicine services and where?
- Turnover rates of providers
- Employment status (full or part-time)
- Location type (public, private, hospital, clinic, etc.) and if practitioners are practicing in multiple locations
- Whether practice locations are in urban or rural areas

- The State should explore the following areas for further development:

  **Recommendation:** Encourage providers to work at the top of their license by reimbursing them in ways that support working at their fullest capacity.

  **Recommendation:** Consider how best to utilize a wide range of providers, including alternative care providers, dental health providers, mental health providers, behavioral health providers and community health workers within our system.

  **Recommendation:** Support pilots for peer and group delivered services. If pilots are found successful, support training opportunities for these services and require OHA programs to reimburse for them.

**Health Insurance Exchange**

- Affordability

  **Recommendation:** Ensure that coverage options within the Exchange consider all barriers to care for vulnerable populations when determining affordability. Such options should not include higher rates or a reduced level of benefits for vulnerable populations who may be experiencing barriers to seeking care based on a number of factors that are not generally identified with current insurance products. Lastly, make certain that people know how they can become enrolled and access services.

- Risk Adjustment

  **Recommendation:** When considering risk adjustment for payment or quality measurement purposes, we need to find a way to consider social disparities in addition to the risk factors normally taken into account in medical risk adjustment. This may require stratifying patients or developing risk adjustments to account for socioeconomic disparities

- Operation of the Exchange

  **Recommendation:** The Exchange needs to be structured so that widespread adoption of primary care is incentivized as a clear pathway to managing costs and providing care to people using the safety net. The Exchange should be set up in a way to support the widespread adoption of PCPCHs so that people do not have to change their primary care provider, particularly if they cycle between Medicaid and Exchange plans.

  **Recommendation:** Promote community-based outreach and enrollments efforts that capitalize on where the strongest patient centered relationships exist. Consider the involvement of a diverse group of people to be involved in outreach, enrollment, and service efforts. This may include caseworkers, community people, etc. Clarify the role of clinics with regards to educating and informing patients about the Exchange.

**Recommendation:** Require plans within the Exchange to participate in Medicaid.

**Recommendation:** Provide flexibility in defining plan provider panels to reflect community needs and realities. For example, some communities may be served well by including community health workers on provider panels.

**Recommendation:** Assure oversight for the Exchange that will ensure operational performance, clinical quality and competency, and community and patient satisfaction. The exchange should hold both the payers and providers accountable. For example, a secret shopper program should be implemented to make sure patients have access to provider panels. Many states, such as California and Pennsylvania, have implemented successful secret shopper programs.

**Recommendation:** Ensure that any Oregon resident has the option to buy coverage if they don't qualify for other programs.

**Health Improvement Plan Committee**

- Achieve health equity and population health by improving social, economic and environmental factors.

  **Recommendation:** The goal of improving educational attainment rates for populations with disparities is believed to be fairly distant from the responsibilities of the health care community. Concerns were voiced that more short-term measurable actions that could involve health care providers are needed in addition to addressing longer-term social determinants. Identify and pilot access models that create stronger linkages between education systems and health care provider systems.

- Preventing chronic diseases by reducing Obesity prevalence, Tobacco use, and Alcohol abuse.

  **Recommendation:** As population health interventions relate to nutrition, physical activity, tobacco use and alcohol consumption, all of which result from a number of complex factors, care provided should address the needs of the whole person by considering the impact of behavioral health, addictive diseases and oral health and hygiene on the impact of population health overall.

  **Recommendation:** Stringent tobacco cessation requirements in certain multi-unit housing facilities that have programs oriented towards mental health treatment, behavioral health treatment and alcohol and drug treatment, may make it more difficult for people in such settings to overcome some of these greater challenges. Recognize these targeted groups and apply a phased-in tobacco cessation strategy in multi-unit housing facilities affiliated

with such programs. Avoid unintended consequences, such as a tobacco free environment that would keep homeless people on the street.

- Stimulate public health, community, and health system linkages, innovation and integration that increase coordination and reduce duplication.

  **Recommendation:** Encourage cohesion around identifying and adopting a few vetted national models for chronic disease programs and push for uniformity rather than everyone piloting new, unique, individual programs that may or may not be evidence-based. Promote adopted models and measure their effectiveness.

  **Recommendation:** Encourage flexibility as to where targeted case management occurs, so that it is provided in areas beyond local health departments and tribal health organizations. Case management should be community-based, in order to target the right people, and needs to be evidence-based, cost-effective and address the needs of the whole person within the context of their family and community across the lifespan. There should be coordination and streamlining of the variety of case management services to minimize confusion of these efforts.