

Health Systems Transformation Team

AGENDA

Wednesday, March 16, 2011

Note Location:

Cherry Avenue Training Center

3414 Cherry Avenue, Suite 150

Mt. Mazama Room

Keizer, OR 97303

6:00 pm to 9:00 pm

Public listen-only conference line – Dial: 877-455-8688, Participant code: 915042

#	Time	Item	Presenter
1	6:00	Welcome and agenda review	Bruce Goldberg Mike Bonetto
2	6:05	Review of feedback on definition and scope of Accountable Care Organizations	Diana Bianco
3	6:20	Timeline Response to comments on draft LC	Bruce Goldberg Mike Bonetto
4	7:20	Small group break out: Next steps in LC development	Diana Bianco and facilitators
5	8:30	Report out and large group discussion	Bruce Goldberg, Mike Bonetto Diana Bianco
6	8:50	March 23 agenda	Bruce Goldberg, Mike Bonetto
7	9:00	Adjourn	Bruce Goldberg, Mike Bonetto

Next Meeting:

Wednesday, March 23rd, 2011

Willamette University

Putnam University Center, Cafeteria

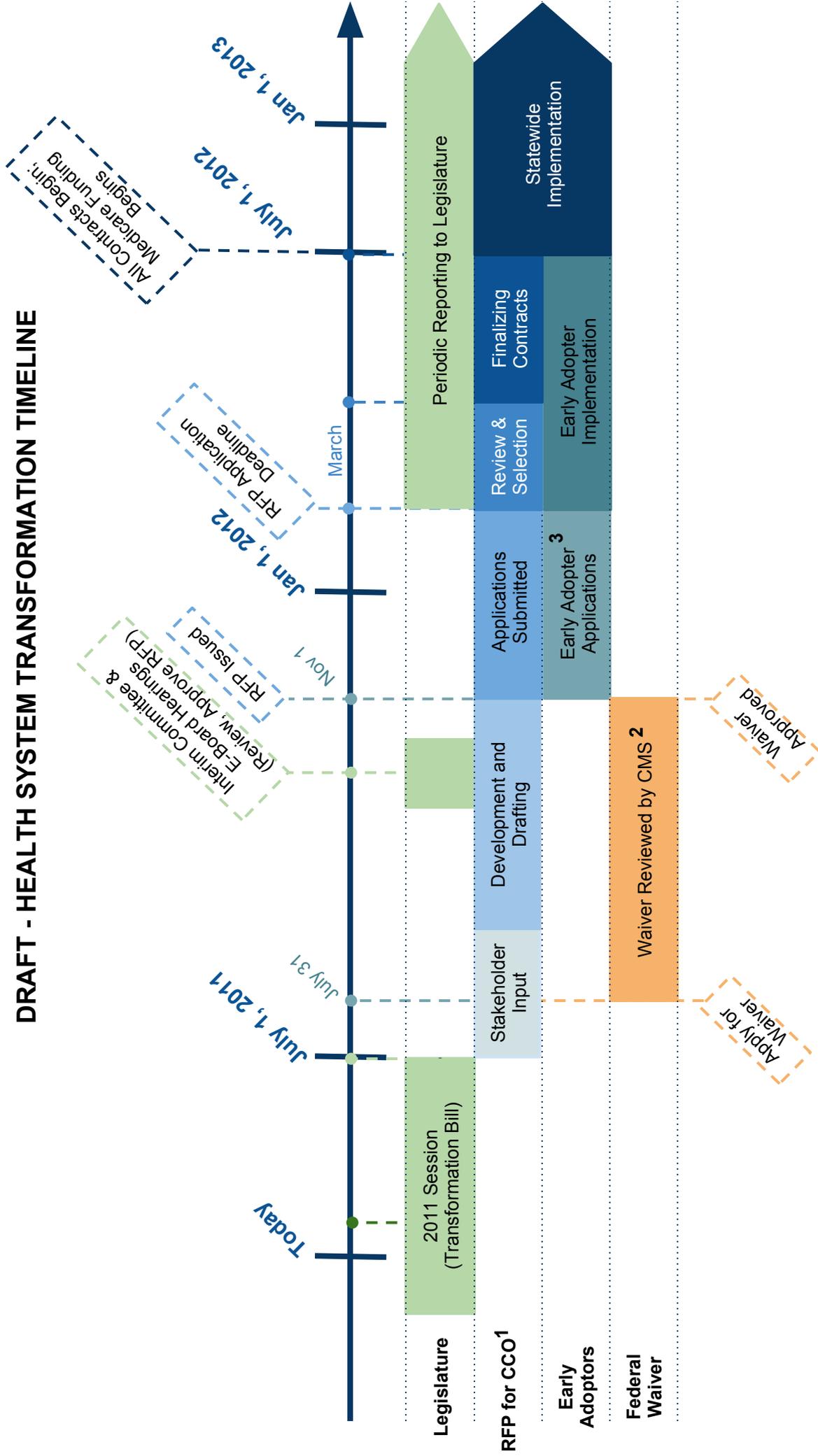
6:00 pm to 9:00 pm

Health System Transformation Team
Minutes
March 9, 2011
Willamette University
Putnam University Center
6:00 PM to 9:00 PM

Item
Welcome and agenda review (6:08 PM)
Medical Liability: Oregon Health Policy Board Task Force The review of the Medical Liability Task Force was given by Mic Alexander, Jeanene Smith, and Chuck Hofmann, who joined by phone. <ul style="list-style-type: none">• Dr. Hofmann gave a historical review of Oregon's medical liability system, dating back to 1857.• Mic Alexander gave a review of the deliberation that the Oregon Health Policy Board's Medical Liability Task Force went through while it was meeting regularly over the last year. The presentation can be found here on page 9. The Medical Liability Task Force's complete final recommendations were also presented, and are on page 17. -- There was some discussion about how to possibly quantify the cost of defensive medicine and medical liability. -- The question was also raised as to whether states with caps on damages have escaped medical inflation – another statistic that is hard to quantify.
Review of feedback on Legislative Concept for Health System Transformation Staff has compiled all the comments on the Legislative Concept and refined them into one document that lists and summarizes the main issues that were received through feedback. The summary document can be found here on page 61.
Small group break out: Legislative Concept Tonight's goal is to discuss the definition and scope of ACO's in the small group break out sessions. Choose the top two or three issues that your group believes deserves attention and discuss them in detail. Please also note the issues that your group does not have time to get to today.
Report out and large group discussion Diana Bianco facilitated the large group discussion: the Team heard from a speaker from each break out group. The three main issues that were overwhelmingly discussed were geography, governance, and definition. Consumer concerns were also a salient issue.
March 16 agenda Next week we will be moving through more of the comments on the Legislative Concept.
Adjourn (8:53 PM)

Next meeting:**March 16, 2011****Cherry Avenue Training Center****3414 Cherry Avenue, Suite 150****Mt. Mazama Room****Keizer, OR 97303****6:00 to 9:00 pm**

DRAFT - HEALTH SYSTEM TRANSFORMATION TIMELINE



¹ Request for Proposals for Coordinated Care Organizations.

² The federal waiver would include global budgeting, combining Medicare funding for dual-eligibles beneficiaries with Medicaid, and payment reform.

³ Early adopters must meet the same criteria of the RFP.

Straw person Summary: Coordinated Care Organizations

Coordinated Care Organization (CCO)

- Definition: CCO means a single organization that accepts responsibility for the cost of health care within a global budget and for delivery, management and quality of care delivered to the specific population of patients enrolled with the organization. A CCO may be a single corporate structure or a network of providers organized through contractual relationships.
- Populations: CCOs will be accountable for the overall health of its members, including serving members who are dually-eligible for Medicare and Medicaid.
- Governance: Governance needs to reflect the responsibility for risk, the major components of the health care delivery system, and the community at large. Flexibility is needed to address the business needs of the CCO, while remaining accountable to their community and populations.
 - CCOs must have a formal relationship with the mental health and public health authorities. This relationship could be contractual and/or include a role in governance.
 - Specific decision-making mechanisms will not be outlined in statute, but CCO decision-making needs to reflect input from:
 - Consumers including seniors, people with disabilities, people using behavioral health services, and
 - Ethnically diverse populations; and
 - Providers in the CCO
- Geography and Size: The size of a CCO should be sufficient to manage risk and address capacity; there will not be a specific designation of the number of CCOs or the number of areas. There can be multiple CCOs in an area with the number in any given area to be established by OHA through an RFP process.
- Integration and Scope: CCOs are responsible for the full integration of care for the specific population of persons enrolled with the organization, including their members who are dually eligible for Medicaid and Medicare.
 - A CCO will be responsible for the medical care of an individual in long term care. There is no intent for the management of long term care costs to be part of the CCO.
 - To allow for necessary integration and risk sharing, CCOs and providers must be protected from Antitrust, Stark, anti-kickback and Civil Monetary Penalty Laws.
 - CCO should prioritize working with CCO members with high needs and multiple chronic conditions, mental illness or chemical dependency to involve them in accessing and managing appropriate preventive, health, remedial and supportive care and services, and reducing the avoidable use of services provided in emergency rooms and hospital readmissions.

- Individuals should receive comprehensive transitional care, including appropriate follow-up, when there is a change in care setting, including but not limited to entering and leaving inpatient hospital or nursing facility to other care settings or return to their home, or for a significant change in care providers.
- Provider Networks:
 - Providers may participate in the networks of multiple CCOs.
 - CCOs should demonstrate excellence of operations including but not limited to network provider creation and management functions. They will use, to the maximum extent feasible, person centered primary care homes, including developing capacity for services in settings that are accessible to families, diverse communities, and underserved populations. Specialty services must include access to statewide resources as needed.
 - People should have a choice of providers within the CCOs' networks.
 - FQHCs, Rural Health Clinics (RHCs) and safety net clinics should be strongly supported to ensure their critical role in providing primary care and primary care home services for underserved populations.

Budget and Payment

- Global budget:
 - A global budget means a total amount established prospectively by the state to be paid to a CCO to provide the full continuum of services for its population. Within its budget, the CCO is responsible for the cost of delivery, management and quality of care delivered to the people enrolled with the CCO.
 - OHA will establish a process to develop global budgets and other activities associated with analysis and monitoring of CCO utilization and cost data and other financial metrics. This will be done utilizing national and statewide expertise and include legislative input. Budgets will be established that grow at a fixed rate. The traditional framework for actuarial soundness will not be applicable.
 - Risk adjustment mechanisms or risk mitigation strategies will be addressed in contract and rule
- Payment: CCOs will be required to demonstrate how they will apply alternative payment methodologies or methods, that move from predominantly fee-for-service to alternate payment methods, in order to base reimbursement on quality and value rather than volume of services. Restructured payments and incentives should reward comprehensive care coordination in new delivery models such as person-centered primary care homes.

Consumer Protection and Accountability

- Consumer Protection: Requirements for CCOs includes some provision for system navigation and for engaging the patient in their care and care planning,
 - Consumers must have access to competent advocate-system navigators, qualified peer wellness specialists, and qualified community health workers who are part of the care team to provide assistance appropriate to their needs (including language,

- culture etc) to access appropriate services and participate in processes affecting their care/services.
- Consumers will be encouraged within all aspects of the care and services system to use wellness and prevention resources, and to make healthy lifestyle choices.
 - Consumers are encouraged to work with their care teams, including providers and community resources appropriate to the consumer's needs as a whole person.
 - Consumers have the right to appeal decisions about their care and services, and to receive a timely response, within the CCO and with the Oregon Health Authority.
- **Accountability:** An expert workgroup will be convened by the Oregon Health Policy Board to develop metrics to be included in the RFP. Detailed requirements for accountability and metrics will be addressed in contract and rule.
 - *Financial Accountability* – CCOs will need to demonstrate excellence of operations, including best practices in financial management capabilities
 - *Community Accountability*- CCOs will be accountable for the overall health of children and adult members in their area, and for working cooperatively with community partners to address public health issues that affect the health of the community, including prioritizing health equity.
 - *Quality of Care* - Quality indicators are evaluated to assess ongoing health status of individuals, including demographic and diversity data, consistent with standard quality measures adopted by and timely reported to the Oregon Health Authority to evaluate costs, experience of care, and population health.

Implementation

- **Administrative simplification and Regulatory Relief** - To the extent allowable, regulatory and administrative requirements will be streamlined and consolidated, including federal standards, certification, and reporting.
- **Federal Waivers:** The Oregon Health Authority will be seeking federal approvals or waivers to establish global budgets, to blend Medicare and Medicaid funding for people who are dually-eligible for Medicare and Medicaid and to pay differently. There may be additional areas that will also require waivers from federal Medicaid and Medicare rules.

Other Issues

- **Medical Liability Issues:** Tort reform has been identified as a central component to health system transformation. Specific details around a proposal will need to be developed in order to move forward.

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APPROACH TO ISSUES RAISED IN COMMENTS ON THE DRAFT LEGISLATIVE CONCEPT
(Organized topically as issues are addressed in Straw Person Summary)

Coordinated Care Organizations

Definitions

COMMENTS:

- Concerns that description of ACO is too vague and does not include adequate reference to risk bearing.

APPROACH: Accountable organizations, which will be called Coordinated Care Organizations, will bear risk for delivering care within a budget established by contract.

Language:

“Coordinated Care Organizations” or “CCO” means a single integrated organization that accepts responsibility for delivery, management and quality of care for the specific population of patients enrolled with the CCO within a global budget fixed by contract.

Populations

COMMENTS: Request to clearly differentiate between standards/definitions of ACOs that will serve Medicaid, Medicare, dual- and triple-eligibles and other market segments.

APPROACH: All CCOs must be capable of delivering health services to all Medicaid eligible populations, including dual and triple-eligibles.

Language:

Services for Oregonians who are fully eligible for both Medicare and Medicaid are included within the transformed health system.

Coordinated care organizations responsible for providing Medicare and Medicaid services to individuals who are dually eligible.

Governance

COMMENTS: Concern over what or who decides what is covered.

RESPONSE: No change to the benefits covered after year 1 reductions is contemplated as part of health system transformation.

COMMENTS: Request for a clear a definition of regional health authorities that is openly discussed with broad input to determine boundaries, authority and characteristics of regional health authorities.

APPROACH: Coordination, planning and accountability between communities and CCOs should emerge out of natural communities of care. OHA is working with both the Association of Counties and others to better understand these issues and develop an approach to community oversight and planning.

Language:

Communities and regions are accountable for improving the health of their communities, reducing avoidable health gaps among different cultural groups and managing health care and service resources.

COMMENTS:

- Request to involve a County Commissioner and/or the Association of Oregon Counties in the work.
- Support for specific requirements for ACO to establish formal relationship with county public health and mental health agencies in order to capitalize on county assets to achieve triple aim.
- Legislation should explicitly encourage collaboration with local communities and government entities while clarifying OHA oversight.
- This issue was mentioned in several breakout groups as well.

APPROACH: CCOs will be required to work with local governmental and community partners to achieve transformation goals. However, the mechanisms for ensuring that the interaction occurs have not yet been fully developed.

Language:

It is the intent of the legislature that communities and health systems must work together to find innovative solutions to reduce overall spending, increase access to care and improve health.

The CCO is accountable for the overall health of children and adult members in their area, and for working cooperatively with community partners to address public health issues that affect the health of the community.

Health equity is prioritized and disparities are reduced. CCO organizational structures must include ethnically diverse populations in the community, consumers including seniors, people with disabilities and people using mental health services, and ensure that CCO decision-making reflects the views of providers in the CCO network.

The CCO actively engages consumers in making its decisions that impact the populations served, the communities where it is located, and decisions about how integrated care is delivered.

COMMENTS: Concern that concept protects information sharing for public health activities required by law.

APPROACH: The legislative concept does not interfere with sharing information for public health activities required by law.

COMMENTS:

- Legislation should require that composition of ACO boards include consumers, the safety-net, public health, and other social service entities and that fewer than half of board members should be employed by (or have family members employed by) the health care industry. Decisions undertaken by these boards should be made transparent to the public.
- Almost all breakout groups supported a consumer voice in ACO governance.

APPROACH: CCO boards should be inclusive of the community and represent the diversity of the populations they serve, but the legislative concept stops short of prescribing board membership.

Language:

CCO organizational structures must include ethnically diverse populations in the community, consumers including seniors, people with disabilities and people using mental health services.

COMMENTS: Suggestion for stronger and clearer language that ACOs will build on and add value to ongoing local integration efforts. Concern that defining the ACO as “single integrated organizations” will cause an upheaval of existing integrative projects developed in most communities.

APPROACH: CCOs will not displace community resources. CCOs must work together with community partners, building on successful strategies and partnerships.

Language:

Communities and health systems work together to find innovative solutions to reduce overall spending, increase access to care and improve health.

Geography and Size:

COMMENTS:

- Should the legislation specify an appropriate number of ACOs for each region, weighing the population and provider base (e.g. one ACO for every 50,000 covered lives in a region)?
- Further clarification requested of how this proposal would impact all parts of the state, particularly those outside of the I-5 corridor.

APPROACH: The size of a CCO should be sufficient to manage risk and provide adequate capacity; the number of CCOs and the number of areas will not be predetermined. There may be multiple CCOs in an area.

Integration and Scope:

COMMENTS: Concerns expressed that references to transitional care are too limited and long-term care and supports are too vague.

RESPONSE: Effective care transitions are critical to achieving improved health outcomes and lower costs.

Language:

Individuals receive comprehensive transitional care, including appropriate follow-up, when there is a change in care setting, including but not limited to discharges from a hospital or nursing facility to other care settings or to their home, or a significant change in care providers.

COMMENTS:

- *Evidence base:* Questions regarding the evidence that the proposed approach will improve care, reduce costs, work well across all regions in the state, maintain or improve partnerships and correctly align financial incentives.
- *Approach:* Concern that integration of care occurs at the delivery system level, not with the entity through which the financing flows. Urge focus on outcomes as the objective not a specific structure unless there is a strong evidence base.

APPROACH: Improved care coordination and aligned incentives have the demonstrated effect of improving outcomes, as illustrated by examples presented at earlier meetings of the Team. A balance must be struck between the need to assure that evidence-based approaches are pursued with the need to allow flexibility for innovation. The focus on outcomes and measures will help policymakers determine over time whether the balance is right.

Language:

The CCO must achieve these results:

High quality information is collected and used to measure health outcomes, quality, costs, and clinical health information.

Quality and consistency of care are improved and costs are contained through new payment systems and standards that emphasize outcomes and value rather than volume

Quality indicators must be evaluated to assess ongoing health status of individuals, including demographic and diversity data, consistent with standard quality measures adopted by and timely reported to the Oregon Health Authority to evaluate costs, experience of care, and population health.

COMMENTS: Concern that no explicit definition of what integration means – what kind of relationships define integration?

APPROACH: CCOs and providers will have the flexibility to determine how best to integrate care. The transformed framework creates the conditions for improving care integration: blended funding and clear accountability for providing care for the whole person and coordinating health care with long-term care and other community supports and services.

Language:

Accountable care organizations are responsible for the full continuum of care for a defined population.

COMMENTS:

- Concern that current LC does not touch on social conditions outside of health care such as housing that critically impact health outcomes.
- Request that language should be added that health care systems should participate meaningfully in efforts to address drivers of health in their communities.
- Proposed additions to LC language regarding system and ACO attention to the drivers of ill health.

APPROACH: CCOs are accountable for health of their communities; to demonstrate good health outcomes, they will need to address all drivers of ill health. How they do it is not prescribed.

Language:

The organization is accountable for the overall health of children and adult members in their area, and for working cooperatively with community partners to address public health issues that affect the health of the community.

COMMENTS: *Long-term care integration:* Concern that integration will move long term care from a successful social model into a medical model. Consideration should be given to the best way to coordinate care between a social long term care case manager and an individual's medical primary care home.

APPROACH: CCOs will be responsible for providing health care services for all individuals, including those receiving long-term care services. They are expected to coordinate with long-term care case managers and providers of long-term care services. The blending of OHP and Medicare funding for those who are dually eligible for Medicaid and Medicare will improve incentives for coordination and for providing supports which, while not covered services, will help maintain independence and good health.

COMMENTS: *Mental health integration:* What is the relationship of the ACOs to civil commitment and community mental health/local MH authority to support integration?

APPROACH: The responsibilities of counties for civil commitments and for community mental health will not change. However, the state will no longer be contracting directly for OHP services with mental health organizations. The Oregon Health Plan funds for mental health and chemical dependency services (formerly through MHO contracts) will be included within the global budget of CCOs.

COMMENTS: *Reproductive health integration:* Request for reproductive health to be explicitly listed as element to be integrated along with others.

APPROACH: Current coverage of reproductive health services will not change; and CCO members will be able to access these services either through a CCO or on a fee-for-service as they do now. See ORS 414.153.

COMMENTS: Support expressed for the development of provider knowledge, skills, and attitudes for doing integrated health care to support integration.

APPROACH: CCOs will be responsible for fostering provider understanding of the integration concept and facilitating collaborative approaches to delivery system transformation.

Language:

CCOs must educate [providers] about the integrated approach, and how to access and communicate within the integrated system about an individual's plan and health history.

COMMENTS: Suggested LC language for this section regarding ACO responsibilities when medical errors occur.

RESPONSE: The Oregon Health Authority is addressing "never events" and other medical error issues in administrative rule. It is not addressed in the LC. Medicaid matching funds will not be available for payment for the Medicare definition of "never events", which includes many serious adverse events, beginning July 1, 2011.

COMMENTS: Suggest adding "avoidable" to the reference to reduction of the use of ER and hospital readmissions.

APPROACH:

Language:

CCOs must prioritize working with ACO members with high needs and multiple chronic conditions, mental illness or chemical dependency to involve them in accessing and managing appropriate preventive, health, remedial and supportive care and services, and reducing avoidable use of services provided in emergency rooms and hospital readmissions.

Provider Network:

COMMENTS:

- What standards will ACOs be held to in the creation and maintenance of their provider networks? Can providers belong to multiple ACOs?
- Provider networks should include alternative providers.

APPROACH: CCOs will be responsible for arranging to provide all covered services and establishing a network of providers, including primary care homes, sufficient to provide access to their population. Providers will be permitted to be part of multiple CCOs. CCO contracts may include provisions to ensure adequate capacity.

Language:

CCOs are responsible for the full continuum of care for a defined population. Each CCO or alternative integrated care system shall, at a minimum, have or obtain through contractual arrangement, the following functional capacities in accordance with the standards and contracts established by the Oregon Health Authority.

CCOs must demonstrate excellence of operations, including best practices in financial management capabilities, including but not limited to the management of claims processing and payment functions for CCO providers, and contract management capabilities, including but not limited to network provider creation and management functions.

CCOs must implement, to the maximum extent feasible, person centered primary care homes, including developing capacity for services in settings that are accessible to families, diverse communities, and underserved populations.

Language:

The bill will make necessary housekeeping changes to replace references to managed care with references to CCOs in ORS 414.153.

COMMENTS: Concern that a viable safety net is still needed in addition to the Accountable Care Organizations and their covered members and that Federally Qualified Health Centers provide integrated health homes should have a clear role.

APPROACH: There will be a continuing role for safety net services to individuals not enrolled in a CCO and as providers in the community. No change in their role is anticipated.

COMMENTS: Request for the RFP process should include a conscience clause provision to allow organizations with religious or moral limitations to participate while still serving their missions.

APPROACH: We do not anticipate changes to any other applicable law on this issue.

Budget and Payment

Global Budget:

COMMENTS:

- Request for more discussion and specificity on the term "global budget".
- Concern that global budget may work in some parts of the states easier than others.

APPROACH: A global budget means a total amount established prospectively by the state to be paid to a CCO to provide the full continuum of services for its population. Within its budget, the CCO is responsible for the cost of delivery, management and quality of care delivered to the individuals enrolled with the ACO.

Language:

A global budget means a total amount established prospectively by the state to be paid to a CCO to provide the full continuum of services for its population. Within its budget, the CCO is responsible for the cost of delivery, management and quality of care delivered to the individuals enrolled with the ACO.

COMMENT: Request for explicit language that says ACOs and their providers will share in any state-federal shared savings.

RESPONSE: Global budgets presume CCOs will retain savings from providing care efficiently. However, how savings achieved for Medicare will be shared between the state and the federal government, the state and CCOs, and CCOs will need to be determined as discussions proceed.

COMMENT: Note that there is no mention of actuarial soundness of the single global budget.

APPROACH: The OHA actuary will be involved in the state's development of the global budgets and in other activities associated with analysis and monitoring of ACO costs, encounter data and other financial metrics. However, the traditional framework for actuarial soundness will not be applicable.

COMMENT: Concern that new entities could set provider rates low and continue a two-tiered system with a public model that underpays for services because the public budget just doesn't exist to pay fairly.

RESPONSE: Throughout these meetings, it has become abundantly clear that the state's budget is facing some serious limitations. This is an opportunity to move toward a transformed health and health care system that will achieve cost savings while providing more effective care. The success of this transformation should provide a model that can be built upon and that will be attractive to other health care payers. As the systems are blended, cost-shifting between payers should be reduced or eliminated.

Payment:

COMMENTS: Comments that payment and incentives should reward the provision of community-based supports for self-management of chronic diseases, engagement with community partners in policy development that addresses the factors that cause ill health and create the need for health care.

APPROACH: CCOs will be responsible for using community resources to achieve the objectives of health and well-being. Provider payment systems may be used to advance those goals, but they will not be prescribed in the legislation.

Language:

People are at the center of coordinated care and services delivered through CCO contracts using alternative payment methodologies that shift the focus to prevention, improve health equity, and utilize person-centered primary care homes, evidence-based practices and health information technology to improve health and health care

Quality and consistency of care are improved and costs are contained through new payment systems and standards that emphasize outcomes and value rather than volume

The system should hold CCOs and their providers responsible for the quality and efficiency of care they provide, reward good performance and keep total spending to a global budget that limits cost increases. Within the health care system, restructured payments and incentives should reward comprehensive care coordination in new delivery models such as person-centered primary care homes.

Alternative payment methodologies or methods will be used, that move from predominantly fee-for-service to alternate payment methods, in order to base reimbursement on quality rather than volume of services.

COMMENTS: Request that legislation be specific regarding risk-adjustment mechanisms.

APPROACH: Variations in population characteristics, including age and other factors, will be considered in establishing global budgets or risk mitigation strategies. As in current practice, this will be dealt with in contract and rule.

COMMENTS: Concern that incentives for the development of specialty services does not result in duplication of services and new costs to the total system. Should regional ACO's could be required or strongly incentivized to refer to centers with adequate volume and existing delivery platforms?

RESPONSE: CCOs will not instructed in statute, one way or the other, about use or development of specialty services.

Consumer Protection and Accountability

Consumer Protection:

COMMENTS:

- Request to clarify if ACOs are mandatory or voluntary for (a) Medicaid, (b) Medicare and (c) the dual eligibles. Will there be choice among ACOs? If so, what's the minimum number of ACOs for each region or community of the state?

APPROACH: Everyone will get their care through a CCO, subject to federal approval for the individuals who are dually eligible for Medicare and Medicaid.

COMMENTS:

- Request for language around patient activation/engagement and patient advocates/system navigators.
- Requests for further clarification of the rights and remedies consumers will have and the process by which they will be allowed to exercise these rights.
- Breakout groups mentioned the importance of the consumer right to choose providers, which is more important than choice of ACO.
- Breakout groups suggested ACOs should be required to demonstrate cultural competency.

APPROACH: CCO members will have appeal rights to the CCO and to OHA. The right to choice among providers participating in Medicaid in ORS 414.640 is not changed. More explicit language on patient role and the right to culturally competent care should be included in the legislation.

Language:

Individuals have a consistent and stable relationship with a care team that is responsible for comprehensive care management and service delivery that address preventive, supportive and therapeutic needs of the individual in a holistic fashion, using person-centered primary care homes and individual care plans to the extent feasible, and that provides assistance in navigating the system if needed.

Individuals receive comprehensive transitional care, including appropriate follow-up, when entering and leaving inpatient hospital or nursing facility to other care settings or return to their home.

Further language under consideration:

Consumers are partners in their own health and health care and services and not passive recipients of care. Consumers and families receive timely, complete, and accurate information in order to effectively participate in care and decision-making. Consumer and family knowledge, values, beliefs and cultural backgrounds are respected in the planning and delivery of care.

Consumers are educated about the integrated care approach being used in their community, and how to communicate within the community system to access care and services.

Consumers have access to competent advocate-system navigators such as qualified peer wellness specialists, and qualified community health workers who are part of the care team to provide assistance appropriate to their needs (including language, culture etc) to access appropriate services and participate in processes affecting their care/services.

Consumers are encouraged within all aspects of the care and services system to use wellness and prevention resources, and to make healthy lifestyle choices.

Consumers are encouraged to work with their care teams, including providers and community resources appropriate to the consumer's needs as a whole person.

Consumers have the right to appeal decisions about their care and services, and to receive a timely response, within the CCO and with the Oregon Health Authority.

Accountability:

COMMENTS:

- More description of quality standards requested because of their importance. Request that at minimum list credible authority that program would use as source for the standards, and specify method and frequency of evaluation.
- For accountability and health equity, suggested language be included that describes how overall health in an area is measured and to what standard of health the ACO will be held responsible.
- Requests that measures on consumer satisfaction, reductions in disparities in access and outcomes, timely access to care, and risk factors for the major drivers of ill health

(especially chronic disease and injuries) should be referenced in the collection of quality information.

- Requested need for clarity regarding how collected measures will be used to ensure accountability if deficiencies are detected.

APPROACH: Selecting useful metrics to ensure accountability is critically important and OHA is convening a group to work on developing metrics and reporting requirements. To ensure flexibility going forward, specific requirements will not be locked into statute but rather be addressed in contract and rule.

Language:

High quality information is collected and used to measure health outcomes, quality, costs, and clinical health information.

Quality indicators are evaluated to assess ongoing health status of individuals, including demographic and diversity data, consistent with standard quality measures adopted by and timely reported to the Oregon Health Authority to evaluate costs, experience of care, and population health.

COMMENTS: Encouraged strong financial oversight of the ACOs by OHA using clearly understood standards.

APPROACH: Strong financial oversight is important, and should be provided through contract oversight processes.

COMMENTS: Request for clearer definition of accountability. "Population accountability" could be defined.

APPROACH: CCOs are responsible for working with community partners to improve population health. They will need to do that in order to perform well on health metrics. However, any specific requirements will be addressed in contracts.

Language:

Communities and regions are accountable for improving the health of their communities....

COMMENTS: Suggestion that OHA develop standards and clearer expectations for some of the community-based supports that ACOs and primary care homes might link to (e.g. worksite wellness programs, chronic disease self-management resources, involvement of community health workers)

APPROACH: The OHA is doing ongoing development of implementation issues related to person centered primary care homes, and this is a suggestion that should be considered for that process.

Legislation:

CCOs must implement, to the maximum extent feasible, person centered primary care homes, including developing capacity for services in settings that are accessible to families, diverse communities, and underserved populations.

COMMENTS: Request that decisions undertaken by ACO boards to redistribute system funds should be made transparent to the public.

RESPONSE: CCOs will be required to involve consumers and the community in decision-making. How best to achieve this is under discussion.

Language:

The CCO must actively engage consumers in making decisions that impact the populations served, the communities where it is located, and decisions about how integrated care is delivered.

Implementation

Administrative Simplification:

COMMENTS: Request for explicit language about reducing regulatory and administrative burden, including mirroring federal standards, certification, and reporting where possible.

APPROACH: We are currently working on concrete steps to reduce administrative burden. A brief report will be prepared outlining the anticipated changes.

Language: To the extent practicable, regulatory and administrative requirements will be streamlined and consolidated.

Federal Waivers:

COMMENTS:

- Concern that federal approvals for Medicare should be clear on the populations included (duals, all, another subset) and the nature of the waivers (such as restrictions on choice).
- In addition to approvals listed, OHA could seek federal approvals to use Medicaid or Medicare funding streams for population health or public health services
- Request that legislation be clear regarding need for waivers to provide safe harbor from federal statutes and regulations which act as barriers to clinical integration and provider collaboration needed to facilitate formation of ACOs.

APPROACH: OHA will seek waivers to enable blending of funding streams and removal of barriers.

Other Implementation Issues:

COMMENTS: Request that provider networks along with representatives from the consumers, community social services, local government and public health be involved in drafting an RFP.

APPROACH: The Oregon Health Authority will provide for a public process to provide input into the RFP.

COMMENTS: Request for a phased or more gradual implementation timeline, including rolling acceptance of ACO proposals and 2014 as the target date for mature ACOs in each region

APPROACH: A timeline has been developed for discussion.

COMMENTS:

- Concerns voiced regarding the speed of implementation necessitated by the fiscal crisis, the ability of local health care "systems" to quickly adapt care delivery and financial systems, the ability of the State to effectively and even-handily manage performance-based contracts of a complexity unknown to them, and the likelihood of necessary federal approval.
- Concerns expressed that framework is not concrete enough to provide a clear path. How is this approach a platform for organizing reform across the private sector as well? Concern expressed that limiting the scope of this proposal to just Medicaid eligibles continues to leave lives outside the system and thus the pressure of cost shifting.

APPROACH: The legislation addresses the Medicaid population, including those individuals who are eligible for both Medicaid and Medicare. It becomes an initial platform for making delivery system changes that can influence the larger health care delivery system.

Other Issues

Medical Liability

COMMENTS: Does tort reform need to be in the mix of changes proposed? Recommendations on maximum liability exposure for ACO and its providers that comply with evidence-based protocols, practice standards, and shared decision-making.

APPROACH: Even though some issues related to tort reform have been discussed at several meetings, those issues could be addressed in a separate legislation.

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Memorandum

To: Health System Transformation Team Members

From: Jeremy Vandehey, OHA Community Engagement Coordinator

Date: March 16, 2011

Subject: Transformation public input: March 1, 2011 to March 15, 2011

Attached is the public input received in the last two weeks regarding the Transformation Team's work

Please let me know if you have any questions.

**Public Input for the Oregon Health Policy Board
and the Health Systems Transformation Team**

March 1, 2011 – March 15, 2011

Doc #	Summary	Comment Type	Writer
1	The healthcare system is too fragmented, and the whole overall health of a patient needs to be looked at by doctors. My husband has had severe headaches since his sinus surgery, and it seems like the surgeons feel as though their job is already done.	Email submitted: 3/1/2011	Sally Haffner
2	Some metrics that might be worth including are environmental metrics that have to do with overall health, such as number of grocery stores in an area that sell fresh produce, presence of sidewalks, lights, etc.	Email submitted: 3/2/2011	Margy Robinson
3	The state of Oregon should consider using a Single Payer system, funded by a sales tax.	Email submitted: 3/2/2011	Dick Noren
4	In strong support of Oregon Project Independence, a cost saver it and of itself.	Email submitted: 3/3/2011	Nasrin Rahatzad
5	The Governor's task force on brain injury recommends an integrated health system that: <ul style="list-style-type: none"> • Provides a continuum of care available to people with brain injury in Oregon. • Fully integrates services for people with brain injury into the new Oregon Health Plan. • Includes continued oversight by a taskforce or commission on brain injury to assist in the prevention and treatment of brain injury 	Memo submitted: 3/3/2011	Don Hood
6	Start a "Person Centered Pay as You Grow" Plan; support community health clinics; provide basic preventive services such as dental; have all working Oregonians contribute to a personal health fund for themselves each month.	Email submitted: 3/4/2011	Amy Anderson
7	The system should be designed to prop people up temporarily, until they can successfully help themselves. As is, the system simply allows people to continue asking for help indefinitely, without ever helping themselves.	Email submitted: 3/4/2011	Sherri Cartwright
8	I am requesting that Oregon Medicaid no longer reimburse licensed direct entry midwives for <i>high-risk</i> home births. National and international research show these births <i>will</i> result in preventable fetal death and illness.	Email submitted: 3/4/2011	Lani Doser

9	Any health system reform <i>must</i> include tort reform, even if it is a difficult subject to approach.	Email submitted: 3/4/2011	Stanley Donahoo
10	The low hanging fruit is excess hospital admissions, readmissions, lengths of stay, and ER utilization of seniors and disabled. The most easily instituted structural reform: a 24/7/365 corps of nurse practitioners associated with each Area Agency on Aging and Disabled alongside or within an Accountable Entity.	Email Submitted: 3/7/2011	Michael Saslow
11	Please fund peer wellness coaching. Those who have solved their own health problems should have the opportunity to help others solve theirs, too.	Email Submitted: 3/7/2011	Fred Abbe
12	A new health system must have the consumer as the nucleus, with the ability to direct and manage their own care.	Email Submitted: 3/8/2011	Tina Treasure
13	Every dollar spent on comprehensive access to contraception will save \$9.25 in health care costs! Reproductive health should be explicitly listed alongside other areas of health when creating health system change.	Email Submitted: 3/8/2011	Anne Morrill
14	Multiple points regarding regulatory barriers to efficiency. See attachment.	Email Submitted: 3/8/2011	Tim Markwell
15	At mental health agencies, the necessary documentation to stay in compliance and eliminate liability claims continues to increase dramatically. It is very inefficient and should be reformed.	Email Submitted: 3/9/2011	Scott Willi
16	Please make sure that Oregon maintains its enviable Long Term Care system, and retains the systems emphasis on choice, independence, and dignity. The frail and elderly are increasingly concerned of looming budget cuts that could have consequences for their future well being.	Email Submitted: 3/10/2011	Darvel Lloyd
17	Language for the proposed L.C. that should reassure potential supporters of transformation who are concerned about advances that have already been achieved somehow being left out of a new system. See attachment for language.	Email Submitted: 3/10/2011	Michael Saslow
18	Oregon is doing much of what is required under the proposed ACA rules for the Community First Choice plan. Will we be applying for this waiver? There is a 6% incentive on the table, and it seems to be very much aligned with the Triple Aim.	Email Submitted: 3/10/2011	Suzanne Huffman

19	I have been a consumer of LTC services for 16 years and have a well established network of team members that help me live a life of both mental and physical health. For almost 30 years Oregon's LTC system has been nationally renowned. I understand that there will be some cuts to these services, but I think it is important that the basic integrity of Oregon's community based system be preserved.	Email Submitted: 3/14/2011	Michael Volpe
20	Given that the governor's focus is to develop a fully integrated health care system, it seems prudent to me to keep OHA and DHS under one roof. At the very least, all Medicaid and Medicare policy functions should be under one OHA roof.	Email Submitted: 3/14/2011	Don Fries
21	People must have "Freedom of Health Care" – that means health insurance covering things like chiropractors, acupuncturists, naturopaths, etc. The State would save money in the long run if patients had those options, rather than keeping those patients on ineffective drug regimens for thirty years. Also, people must be rewarded for being proactive with their own health management.	Email Submitted: 3/15/2011	Janet L. Rueger
22	Defines, as well as outlines the duties and advantages of, a Patient Advocate, someone who assures that the patient's needs are attended to, that the patient's best interests are served, and that the patient's voice is heard.	Email Submitted: 3/15/2011	Charles Maclean
23	Advocates for the idea put forth in the film <i>Forks Over Knives</i> . The film posits that "diseases of affluence" can be prevented by a person's commitment to a healthy lifestyle. The meaning of the title is that healthy eating habits can be more effective than going under the knife. We should be using this type of health and wellness tool to empower and educate the public to help create a healthier society.	Email Submitted: 3/15/2011	Marc Corbett

From: "Sally Haffner" <corins@teleport.com>
To: <ohpb.info@state.or.us>
Date: 3/1/2011 3:03 PM
Subject: Sinus Surgery

My husband underwent sinus surgery 1-19-2011. He had a sinus surgery last year but it was unsuccessful. Shortly after his recent surgery he began to experience severe headaches and was not able to work. He obtained pain meds but the problem continued. The surgeon who did the sinus surgery said everything looked good and spent about 10 minutes at the most with my husband (he had a busy schedule).

My husband has been on numerous medications trying to ease the headache pain. The surgeons office failed to get back with him when he called to schedule an appointment. It seems as far as they were concerned they had done their job and he was no longer their problem.

My husband went to his regular doctor for help. He suggested another cat scan and possibly a visit to a neurologist. The headaches only started coming after the surgery.

My husband continues to be on several medications and feels terrible most of the time. His quality of life has diminished tremendously.

My frustration with all this is the lack of anyone overseeing the patient's welfare and looking at the bigger picture. It seems like the health care system is so fragmented.

I just hope I don't have a medical problem and have to seek help. That is a scary thought!

>>> "Margy Robinson" <margy@rexos.net> 3/1/2011 5:31 PM >>>
Thank you for creating the webinar format and making the discussion of the Health Systems Transformation Team so available to the public.

As I listened to the discussion regarding metrics I had a couple of thoughts:

1. Ensure that you are measuring what you might be able to change. Using the question of "what could/would we do differently if we knew this information?" might be a good guiding question
2. Also ensure that the metrics are readily understandable by the public. If they are too sophisticated, or involve too many caveats they will not be useful for the community.
3. I very much support the idea of trying to design measures of health, not just of disease and of paying attention to geography. These might include measuring elements that are markers of an environment that produces health e.g. number of grocery stores that sell fresh produce by zip code; presence of sidewalks/bike paths, or lighting.

Again, thank you very much for encouraging others to participate in this process.

-Margy Robinson

From: "Dick Noren" <dnoren@upwardaccess.com>
To: <ohpb.info@state.or.us>
Date: 3/2/2011 12:20 PM
Subject: Single payer universal health care system, paid for with a dedicated sales tax for Oregon

To The Health Care Transformation Team,

Question: Is a Single Payer Universal Health Care System, paid for with a dedicated sales tax, being considered by your team? I e-mailed Governor Kitzhaber with that suggestion yesterday. Consider what Vermont is doing, visit www.singlepayerforVermont.com, for all the details strongly supported by their Governor Peter Shumlin. Now that President Obama has given the green light, based on Senator Wyden's plan, to states to do their own thing, the time is ripe for really bold action in our state to initiate a plan that will provide access to health care for all citizens so that none will go broke due to health care expenses. The plan would be administered by a state agency that acts as the single payer for health expenses and no for profit health care insurance companies would be apart of this system, although those type of plans would also be still available.

I reading your mission statement, it says "The current fiscal climate calls for bold action to design a new, more sustainable platform by fundamentally restructuring our delivery system as an innovative model to deliver better care, better health and lower costs". Well gentlemen, a single payer system would accomplish those goals and I strongly believe the citizens and the business community of Oregon would support such a plan paid for with a dedicated sales tax. The reasons why are many and I'd be happy to testify to that in person.

Very Best Regards,

Dick Noren

Hillsboro, life long resident of Oregon

From: "Nasrin Rahatzad" <nrahatzad@impactnw.org>
To: <ohpb.info@state.or.us>
Date: 3/3/2011 10:13 AM
Subject: Care plan for low income seniors and people with disabilities

I am a case manager with Seniors Program at Impact Northwest. I have been assisting low income seniors to receive in-home services through Oregon Project Independence (OPI) and I have witnessed their happiness and satisfaction with this program. Knowing that OPI provides independence and supports our seniors' dignity which are the most important factor in their lives and knowing the fact that OPI would prevent spending much more money if these folks were to live in assisted living facilities, it just doesn't make sense to stop Oregon Project Independence. Right now the budget is on hold and we have a long waiting list. Please don't let these folks lose hope.

I strongly advocate for Oregon Project Independence and would appreciate it very much if you consider the huge need for it.

Sincerely,

Nasrin Rahatzad

Impact Northwest

Program Advocate

Seniors and Disabilities Services

503-988-3660 x22571

The attached memo from the Governor's Task Force on Traumatic Brain Injury requests the inclusion of individuals with traumatic brain injury in the current health care initiatives with three specific recommendations. Please see attached memo.

Thank you,

Don Hood
For the Governor's Task Force on Traumatic Brain Injury

Donald Hood
Project Coordinator
CBIRT-Center on Brain Injury Research and Training
The Teaching Research Institute
Western Oregon University
99 W. 10th Ave., Suite 370
Eugene, OR 97401
541-346-0535
hoodd@wou.edu

To the Oregon Health Policy Board:

March 3, 2011

The Governor's task force on traumatic brain injury (TBI) requests that the Oregon Health Policy Board as part of the Health System Transformation process, include services for people with brain injury and similar conditions. For individuals with brain injury to contribute fully to the community and society, an improved sustainable system would include prevention; the use of Medicare/Medicaid dollars to support a continuum of care from the acute stage through rehabilitation to long-term care; and appropriate supports for employment and independent living. Current Medicaid programs often lead inappropriately to more costly and restrictive nursing home services, which may deny community involvement to people with brain injury. Oregon currently offers services for persons with TBI in a variety of programs. At times, accessing this variety of programs proves challenging for people with brain injury and may cause duplicate efforts to assess and serve them. Survivors of brain injury in Oregon and similar conditions need a clear plan with a continuum of services and statewide leadership for these vulnerable populations.

The Governor's task force on brain injury recommends an integrated health system that:

- Provides a continuum of care available to people with brain injury in Oregon
- Fully integrates services for people with brain injury into the new Oregon Health Plan
- Includes continued oversight by a taskforce or commission on brain injury to assist in the prevention and treatment of brain injury

From: <advocate55@q.com>
To: <ohpb.info@state.or.us>
Date: 3/4/2011 8:24 AM
Subject: System Delivery from a clients perspective

Greetings,

I wanted to write about my personal experience with my TEAM at Mult. Co. Health dept. One of the greatest additions to my life was meeting Dr. Defontes from Mid County health dept and the team that would keep me alive.

I am considered extremely medically fragile and I am now spending the majority of my time trying to explain to others what I have seen and what I learned about Staying healthy. If I were on your team I would suggest that you start a Person Centered Pay as you Grow plan.

I believe that if you start offering Oregonians a Medical Savings Plan which would be a percentage of their income being contributed to Medical the day they start working, say around age 15. This Plan would accrue funds for the future of each individual going forward who paid into the plan. Similar to SSI deductions. Every working Oregonian would pay into the plan every month. That money could be an interest bearing account earning maximum return dollars.

Most citizens today have some health problem that will gain momentum as they age which will need attention sometime in life. Since most people remain relatively healthy throughout their childhood, simple maintenance plans would suffice. Prevention, Education and Family Supported services are keys to a healthy life.

Reward people who don't smoke, drink or eat excessively, Charge more for those who refuse to do what is better for their health. If I have learned one thing in life it is this,

Had I been given a team at Kaiser when I was paying almost \$200.00 per month in premiums through my job, I would have been healthier then I am now.

For the life of me, I cannot see how one X-ray machine visit can vary in price so much between providers . We are being duped believing that by paying more per visit, we are actually getting healthier. I bet that I will remain JUST as healthy going to my Community Health Clinic, then if I went to a private physician.

Reform who is charging excessively for the same service given elsewhere. Do research on the BASIC health visit costs per doctor or facility. Create a base of acceptable fees for regular health visits across the board. Start creating contracts between those doctors willing to reduce fees for service to line up with the average cost. Bid for agencies who offer Preventable Education modules for their clients. Financially support those who are willing to comply with the cost reductions.

ER visits and serious health conditions are always going to cost more, but the majority of citizens will never need those services. Refuse to do business with those not willing to change. This is still AMERICA, we have plenty of medical health providers to choose from, so we can create our MEDICAL HOME MODELS from those willing to be cooperative.

If I get more than 30 mins per visit I am having a GREAT day, most appointments are 15 minutes, so at \$200 or more per visit, YOU are being ROBBED. Do more studies on what would be included in basic health visits and charge accordingly.

Create a health visit plan by age group, As we age more health risks happen naturally, Do you really know how many Chronically sick citizens we really have to find coverage for?

Do a quick survey monkey to see just how sick people currently are and what those illnesses are. Without more accurate statistics it is hard to plan going forward.

Basic needs would be Dental, Physical, & Mental health. Bad teeth make you really sick, financially oppressed citizens will be more Depressed and be prone to other illnesses. I know from past experiences that many people DO NOT want to get well no matter what you offer for free.

Support MORE expansion of the Community Health Centers across our cities because THEY really do help the sick stay well. Financially support

those insurance companies like Care Oregon, who do a Very Professional job of service provision to so many different clients with marginalized incomes. Take the BEST of what Oregon already has and SUPPORT its growth, so they in turn can support more people.

Require more proof that the person is getting better before you pour more money into their care. Why pay for what does not work? Allow contractual partnerships between MHO's and Primary Care providers for combined service care to the same individual.

Create a simple Release of Information form that can be shared across the agencies who care for individuals.

Bring MORE patients to the round table discussions, to review what works and what needs improvement. Invite those like myself to testify on what works now, WE the Patient have the experiences. Survey a thousand patients from Private doctors to Community health centers and see what folks say about their current care.

Provide mini grants to rural area organizations to gather their input too. Remember MOST low income people cannot afford the luxury of computers and the internet to answer your online surveys. **YOU CAN DO THIS, I believe in you.**

Multnomah County Health dept is very good at gathering surveys and results from 2010 say 90% of current clients are healthy and happy because of the care they receive there. That really speaks to me and it should to you as well.

thanks for listening
Amy Anderson

Vice Chair-Multnomah county health council

3735 SE Sherman St

Portland, Or 97214

503-230-6936

From: Ari A ETTINGER
To: ohpb.info@state.or.us
Date: 3/4/2011 9:35 AM
Subject: Fwd: Re: Thank you for attending"Health Systems Transformation Team -- Wednesday, February 23rd"

>>> <davesherri56chevy@comcast.net> 3/4/2011 8:35 AM >>>

I have four questions and two comments ~

Is there a limit to the amount of time a family/individual can receive health care services? (Point - Is this a hand-up or hand-out? Suggestion - Limit 6 months to 2 years)

Is advertising of this socialized tax burden being done like I have seen on billboards for Healthy Kids and the OR Scholarship Commission? (Point - There should not be.)

Is citizenship required to receive government sponsored social services at all levels (housing, food stamps, medical, etc.)? (Point - It should be considered illegal and punishable for government to use citizen tax dollars to harbor fugitives. Also, anyone in the country legally but not a citizen should not be eligible for social services--if they are not self-supporting on their work/education visa, they need to return to their country of origin.)

Do the Legislative Committees ever ask themselves - Is this really any of our business? Should we suggest this program be cut? What is the limit of the program rather than what can we add to the bureaucracy?

Comment - One of the speakers (a lady) at the webinar suggested additional bureaucracy of a 'customer satisfaction survey'. Individuals receiving social services are not 'customers' of the state, they are dependents. To clearly understand our purpose and goal, we need to be fully aware that no one is buying anything from us. Individuals who apply for and accept social services are infant/toddler/youth/teen dependents who need to be taught good habits just like we do with our own children. They need to be lifted up and then set free to fly or fail as they choose.

Until we push the babies out of the nest, we will never have been good parents who prepared our children appropriately to stand on their own two feet and be working, contributing members of society. Anything less than pushing a baby out of the nest is enabling poor behavior. Our politicians and social program workers need to grasp and embrace this concept clearly. Raising a child up and then expecting them to be a part of lifting up the next person is truly loving that person completely. Allowing a child to wallow endlessly and never be expected to stand independently and even help another is the worst type of social oppression. Even if a parent must use tough love by cutting off benefits, that is true love to allow the individual to step up and be independent--just like children, they may not like it when it happens, but they will be truly grateful as their life progresses rather than stagnates.

Comment - I personally know an individual who moved from Nevada to Oregon 5 years ago, and she and her child have been in Section 8 Housing, receiving welfare, and been on the Oregon Health Plan since arriving here. She has never held a job, and has absolutely no intention of getting a job. The church encouraged her to get a job, she did actually go out and interview about 1-1/2 years ago, was offered and accepted a job, but then never started. That was the last of it. How many people like this are what is truly breaking the back and budget of our state?

Thank you.
Sherri Cartwright
2322 Mousebird Ave NW
Salem, OR 97304

From: "Lani Doser" <lani.doser@gmail.com>
To: <tina.d.edlund@state.or.us>
Date: 3/4/2011 1:06 PM
Subject: No Medicaid reimbursement for HI risk Home Birth
Attachments: Hlth Xfrm Team.2.pdf; Hlth Xfrm Team.pdf

Dear Ms. Edlund,

The attached letters are for the Oregon Health Authority. I heard you were the person to email with the contents of these letters. I hope you were the right contact.

Thanks so much for your work.

Lani Doser

Study Citation	Sample/ Subjects	Measurement/ Variables	Intervention	Outcomes	Analysis: i.e. Odds Ratio/Risk Ratio	Clinical Significance
<p>Bastian, H, Keirse, M, & Lancaster, P. (1998). Perinatal death associated with planned home birth in Australia: Population based study. <i>British Medical Journal</i>, 317: 384-8.</p>	<p>n = 50 perinatal deaths occurred among 7,002 planned home births during 1985-1990 (up to 28 days in age and > 500 g weight)</p> <p>Planned Australian home births reported to a national consumer organization called Homebirth Australia.</p> <p><i>Home birth practitioners</i> included midwives and medical practitioners both registered & nonregistered.</p>	<p>Perinatal mortality rates</p> <ul style="list-style-type: none"> • Antepartum (unexplained, IUGR, placental abruption) • Unknown ante/intrapartum • Intrapartum death (intrapartum asphyxia, birth asphyxia d/t shoulder dystocia, preterm twins, uterine infection, tear of umbilical cord), • Early neonatal death (intrapartum asphyxia, mec aspiration, shoulder dystocia, lethal malformation, neonatal sepsis, and unexplained. • Late neonatal death (intrapartum asphyxia, SIDS, postviral cardiomyopathy, chromo abnormality) 	<p>An audit form was given to practitioners who had reported deaths. Those that did not respond, information was taken from the state's perinatal data collections.</p> <ul style="list-style-type: none"> • Comparison was made between the national Australian perinatal deaths AND • Australian home birth perinatal deaths 	<p>Perinatal mortality rate:</p> <ul style="list-style-type: none"> • Home Birth = 7.1/1000 (n = 7002, 95% CI, 5.2 to 9.1) • All AU Birth = 10.8/1000, n=1,502,756/ 95% CI, 10.6 to 10.9) <p>NOTE*: the above results include all losses. The home birth population lacked severe pregnancy or fetal disorders.</p> <p>Calculating for intrapartum fetal deaths only:</p> <ul style="list-style-type: none"> • Home Birth = 2.7/1000 (n = 7002, 95% CI, 1.5 to 3.9) • All AU Birth = 0.9/1000, n=1,502,756/ 95% CI, .85 to .95) 	<p>OR (p value)</p> <p>OR of an intrapartum death for an infant without congenital malformations or extreme immaturity:</p> <ul style="list-style-type: none"> • OR =3.0 (95% CI 1.9 to 4.8) 	<ul style="list-style-type: none"> • 52% of the cases (26) were due to intrapartum asphyxia. • The <i>higher death rate</i> was due to inclusion of <i>predictably high-risk</i> birth and prolonged birth asphyxia with warning and without prompt action. • 36% were due to malposition (5 breech, 1 face), twins (2), and meconium (7). • Concern that continued high-risk practice is not only inadvisable but unethical & borders on clinical experimentation. • This data does not support Oregon's high-risk home birth practice. • The inclusion of <i>nonregistered</i> midwives mimics Oregon's legal status of licensed and <i>unlicensed</i> home birth attendants. • 1 of only few studies to review the outcomes of planned high risk home childbirth as compared to hospital birth (Mehl-Madrona et al., 1997)

Study Citation	Sample/Subjects	Measurement/Vari-ables	Intervention	Outcomes	Analysis: i.e. Odds Ratio/Risk Ratio	Clinical Significance
<p>de Jonge, A., van der Goes, B., Ravelli, A., Amelink-Verburg, M., Mol, B., Nijhuis, J., Bennebroek Gravenhorst, J., & Buitendijk, S. (2009). Perinatal mortality and morbidity in a nationwide cohort of 529,688 low-risk planned home and hospital birth. <i>British Journal of Gynaecology</i>. Doi:10.1111/j.1471-0528.2009.02175.x.</p>	<p>N = 529,688 women with midwife led care; n = 321,307 intended home birth (61% planned home births); n = 163,261 planned hospital birth.</p> <p>Data from a perinatal database of the Netherlands (2000 – 06) of <i>low risk</i> women.</p> <p>Excluded: > 1 fetus, mal-presentation (cephalic only), <37 weeks and >42 weeks gestation, previous cesarean birth, prolonged ruptured membranes, prolonged labor, presence of meconium, & insulin-dependent diabetics</p>	<ul style="list-style-type: none"> • Intrapartum death • Intrapartum and neonatal death within 24 hour of birth • Intrapartum and neonatal death within 7 days • NICU admission 	<p>No intervention but comparison (retrospective data collection)</p> <ul style="list-style-type: none"> • Midwife led planned home birth • Midwife led planned hospital birth 	<p>Perinatal mortality or morbidity rates:</p> <p>No significant difference</p>	<p>Planned home and hospital births for low risk mothers with with midwives (95% CI):</p> <ul style="list-style-type: none"> • intrapartum death .97 (0.69 – 1.37), • Intrapartum and neonatal death to first 24 hours 1.02 (0.77 – 1.36), • Intrapartum and neonatal death up to 7 days 1.00 (0.78 – 1.27), • Admit to NICU 1.00 (0.86 – 1.16) 	<p>Only 8.5% missing data on unknown place of birth</p> <p>Largest study on the safety of homebirth with midwives</p> <p>Netherland midwives are well trained with a three year degree (mimic Oregon training for licensed direct entry midwives, but more rigorous in birth experiences)</p> <p>The Netherlands possesses a collaborative referral system that does not exist in Oregon.</p> <p>Netherland midwives have mandatory licensure to practice unlike Oregon.</p> <p><i>Demonstrated LOW rate of perinatal mortality and severe morbidity with planned homebirths as compared to hospital births with midwives in women who are LOW risk</i></p>

Study Citation	Sample/Subjects	Measurement/Variables	Intervention	Outcomes	Analysis: i.e. Odds Ratio/Risk Ratio	Clinical Significance
<p>Mehl-Madrona, L., Mehl Madrona, M. (1997). Physician- and Midwife-attended home births: Effects of breech, twin, and post-dates outcome data on mortality rates. <i>Journal of Nurse-Midwifery</i>. 42(2): 91-98</p>	<p>N = 8,468 n = 4361 apprentice trained midwife –attended n = 4107 family physician attended Matched sets: n = 1000 apprentice trained midwife –attended n = 1000 family physician attended These were planned U.S. homebirths from 1969-1985 through convenience sampling with a 30% response rate.</p>	<p>Retrospective chart review of the effect of attending breech, twin, and post-date pregnancies on home birth outcomes</p> <ul style="list-style-type: none"> • Perinatal mortality rate • Babies with lethal congenital anomalies • Women with twins • Babies in breech presentation • Gestation > 42 weeks 	<ul style="list-style-type: none"> • Apprentice trained midwife (ATM) • Family practice physician (FP) 	<p>Perinatal mortality rate: ATM = 14 / 1000 FP = 3 / 1000</p> <p>Matched Groups* (removing breech, postdates, twins, and lethal anomalies)</p> <ul style="list-style-type: none"> • <u>Total Mortality</u> = Not significant at P < .05 <p><i>* Matched for age group, insurance status, parity, and medical risk (Popras scoring system) to compare numbers, then used t-test and logistic regressions</i></p>	<p>OR (p value) OR of death for an infant born at home with one or more of the 3 conditions:</p> <ul style="list-style-type: none"> • OR =3.1 (95% CI 2.1-12.3, P =.002) 	<p>Although this is only one study, there are no others like it in the U.S. that look specifically at high-risk outcomes. Current topics at the April 2009 Midwifery Today Conference in Eugene, Oregon included how to attend breech and twin births at home to direct entry midwives (similar to ATMs).</p> <p>This data does not support current Oregon home birth practice. Concern remains about planned high-risk home deliveries Until proven otherwise, it may be prudent for clinicians to avoid such deliveries despite the age of the study.</p>

February 4, 2011,

Dear Oregon **Health System Transformation Team**:

Thank you for your enormous efforts and service to lead our state in effective public policy. The message that, “*Care should be guided by evidence-based practice guidelines built on the best available research in order to reduce inconsistency, improve health outcomes, and eliminate unnecessary costs,*” is one I rally behind (Oregon Health Authority, 2010, p. 47). It is with this shared passion that I am writing to you. I am requesting that **Oregon Medicaid no longer reimburse licensed direct entry midwives for *high-risk* home births**. National and international research show **these births will result in preventable fetal death and illness** (American College of Obstetricians & Gynecologists, 2011; Bastian & Keirse, 1998; deJonge et al., 2009; Janssen et al., 2009; Mehl-Madrona & Mehl-Madrona, 1997).

As a brief review in a 2010 testimony from former Governor Barbara Roberts, she stated that licensing of Oregon direct-entry midwives was established in 1993 with a legislative intent for **publicly reimbursed professionals to attend *low-risk* home births** (OAR 332-015-120; Roberts, 2010, p.31). Over the past 17 years, the scope of practice has changed (OAR 332-025-0021) and since 2002 includes reimbursement for high-risk conditions such as multiple gestation, breech presentation, vaginal birth after cesarean, and post-dates pregnancies. It is concerning that **Oregon Medicaid is reimbursing for high-risk, unsafe, non-evidence based care**. Logically, taxpayers should not compensate individuals who are billing the state while simultaneously increasing the rate of preventable fetal morbidity and mortality and neonatal intensive care admissions. Moreover, by cutting this reimbursement, increased interaction would occur between direct entry midwives and physicians through a stronger referral and consultation system.

For further information, I am attaching a summary and brief table of evidence regarding high-risk versus low-risk home births. Also know that I support the recommendations to come from the Health System Transformation Team. As a nurse and doctoral nurse practitioner student, I understand the many complexities of health care reform and would willingly work with you on this issue as you candidly and rapidly address Oregon’s pressing health needs. I thank you for your time, concern, and action on these important issues of public wellness. I am including my contact information if you would like to discuss this matter further.

Respectfully,

Lani Doser, RNC, BSN, BSEd, FNP/DNP OHSU student
(503) 246-5542
doserl@ohsu.edu
lani.doser@gmail.com

References

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Table of Evidence: High-risk versus Low-risk Home Birth

Lani Doser, RNC, BSN, BSEd, FNP/DNP student

Question: Whether high risk mothers in developed countries with planned home birthing have higher rates of perinatal mortality and morbidity than hospital birthing?

Synopsis of Findings: Strong evidence demonstrates the safety of low risk home childbirth in developed countries with government provided healthcare. In places like Canada and the Netherlands, home birth midwifery care is well established with a clearly defined scope of practice and standards of care (de Jonge, van der Goes, Ravelli, Amelink-Verburg, Mol, Nijhuis, Bennebroek Gravenhorst, & Buitendijk, 2009; Hutton, Reitsma, Kaufman, 2009; Janssen, Saxell, Page, Klein, Liston, & Lee. 2009). Within these protocols is careful exclusion of higher risk conditions including but not limited to twins or greater, malpositioned fetus (breech), prolonged rupture of the membranes, prolonged labor, presence of meconium, and post-dates pregnancies (gestations > 42 weeks). In the largest study of its kind, de Jonge et al. (2009) retrospectively examined 529,688 low risk women from the Netherlands' perinatal birth registry. They compared infant morbidity and mortality rates of midwifery home births to midwifery hospital births from 2000-2006. No significant difference was found between the two groups.

Contrast this finding with the results of two studies observing higher risk home birth outcomes (Bastian, Keirse, & Lancaster, 1998; Mehl-Madrona & Mehl-Madrona, 1997). Mehl-Madrona and Mehl-Madrona had the largest retrospective analysis occurring in the United States (US) that utilized a preexisting, voluntary database of home births. When the authors compared the home birth outcomes of family practice doctors with apprentice-trained midwives, a 3.1 odds risk ratio of infant death was found for the neonate when born at home. This statistically significant difference was not found as twins, breech and post-dates births were removed from the sample. Supporting this finding, Bastian et al. studied 50 perinatal deaths associated with home birth in Australia. The authors found a similar odds risk ratio of 3.0 odds risk ratio of a fetal intrapartum death without congenital malformation or extreme immaturity if born at home. They attributed the higher death rate to the inclusion of predictably higher risk birth that included fetal malposition, presence of meconium, post-dates pregnancies, and twins gestation.

Credibility of Findings: Bastian et al. and de Jonge et al. used perinatal databases. This information was collected through voluntary registries but inclusion of the primary populations was thorough. Mehl-Madrona and her colleagues explored higher risk perinatal outcomes in the United States and their effects on fetal mortality. They too used a much smaller voluntary database. One would expect with the smaller size that bias would be in favor of the midwives (voluntary sharing of only good outcomes) rather than controvert the results. Remarkably, the two studies examining higher risk outcomes, though in different countries and with different data sets, concluded with similar odds risk ratios.

Clinical Significance of Findings: The Netherlands study demonstrates that low risk home birth with clear parameters for risk assessment is as safe as hospital birth. The U.S. and Australian data suggest that higher risk home childbirth has increased infant mortality.

Applicability of findings to practice or policy: These studies are particularly relevant in Oregon where higher risk home childbirth is legal (Oregon Board of Direct Entry Midwives Oregon Administrative Rules, 2010) and occurring without evidence or data to support its practice. With the push to practice evidence-based medicine (Ellwood, 2003; Oregon Health Authority, 2010, p. 47), Oregon public health policy needs reexamined with stricter inclusion factors and requiring true informed consent using Oregon data to consumers regarding possible damaging outcomes. While more study should be done to confirm or refute such numbers, until proven otherwise, it would be prudent for clinicians to avoid such deliveries despite the age of the U.S. and Australian studies.

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From: "Cheryl Donahoo" <sdonahoo@q.com>
To: <OHPB.Info@state.or.us>
CC: <OMA@theOMA.org>
Date: 3/4/2011 6:29 PM
Subject: Health System Transformation Team LC

Dear OHPB members;

I am a retired Oregon Orthopedic Surgeon (1971-2005), am a consumer of care only these days.

Any consideration of health care reform with an aim at cost management without serious tort reform is disingenuous or ignorant. It is time for all elements having negative impact to be considered. It wont be easy, surely will cost campaign funds but it is the right thing to do.

Sincerely, Stanley E. Donahoo, MD

From: "Michael G Saslow" <saslowm@exchangenet.net>
To: <ohpb.info@state.or.us>
Date: 3/7/2011 10:40 AM
Subject: feedback for inclusion Wed Mar 9 handout

(The ohp web site feedback system isn't working)

The low hanging fruit is excess hospital admissions, readmissions, lengths of stay, and ER utilization of seniors and disabled. The most easily instituted structural reform: a 24/7/365 corps of nurse practitioners associated with each Area Agency on Aging and Disabled alongside or within an Accountable Entity; main practice sites, nursing facilities and other long term care.

(Don't throw the baby out with the bathwater. Oregon's LTC system of Area Agencies already exists and the system, statewide, produces better continuity and coordination of care than any other state has, or any boutique recipe, ramped up, could. There are obvious issues of dispatching, mobility, recruitment, supervision, and continuing education, but this appears simpler, less costly, more rapidly put in place, than something similar associated with multiple medical homes within an area).

Michael G. Saslow, Ph.D., retired assistant administrator of state Senior Services and former manager of Research and Development; writer of the 1979 Medicaid Waiver.

From: "fred abbe" <fabbe@charter.net>
To: <ohpb.info@state.or.us>
Date: 3/7/2011 11:36 AM
Subject: to healthcare services transformation team

please fund peer wellness coaching,there is no substitute for
experience,those who have solved there own health issues should be given
a chance to help others qnd their efforts should be funded.

**State Independent Living Council (SILC)
Position Paper on Health System Transformation
March 7, 2011**

Oregon's long-term care system has been/IS a model for many states, due to its:

- High level of consumer choice, independence and dignity to seniors and people with disabilities;
- Effectiveness at serving people in the setting of their choice - most often their home, with Oregon's having the highest percentage in the nation of LTC recipients living in their home or other community based setting;
- Flexibility that meet the individualized needs of consumers;
- High accountability and quality, which are natural results when the direction and control of services are vested in the person that uses them – the consumer;
- Cost-efficiency by utilizing the lowest, most appropriate level of "care" needed – resulting in a shift *years ago* from institutional to home and community-based services. This has provided unprecedented savings in the state budgets.

Acknowledging the budgetary challenges on both the federal and state levels, the dramatic increase in the aging population and the ever-present goal of improved care, the position of the State Independent Living Council (SILC) is as follows:

Health Services Transformation MUST use as its foundation, the principles and structures demonstrated as effective, efficient and cost-saving, in Oregon's current long-term care system, including:

- The Consumer is the nucleus: individualized services are designed around the person, using a holistic view of the individual- their strengths and needs;
- The Consumer controls/directs their own services; Hires, directs/manages and dismisses their own personal care providers
- Services are delivered in the least restrictive and most appropriate setting;
- Foster/support coordination between social services, human services and acute medical care;
- Utilize and value consumer, case manager and home care worker's expertise

Health Services Transformation MUST NOT:

- Dismantle an effective and highly regarded system - LTC/HCBS system to rescue a dysfunctional system (acute and primary care);
- Implement a wholesale, system-wide, expensive, and speculative conversion of a system without first, identifying the set of drivers making change necessary, and examining/piloting less disruptive best practices;
- Disrupt the relationship between consumers and their providers;
- Expect huge cost savings by adding, through managed care, another layer of bureaucracy between the state and LTC/HCBS providers. *Many states having implemented MMLTC, may have realized savings through deinstitutionalization, which Oregon already leads the nation on and has for years. Other cost-effectiveness outcomes seem to be mixed and inconclusive, as cited by Ingrid McDonald, Advocacy Director, AARP*
- Jeopardize the balance/supply of various care options in the community by reducing reimbursement rates so greatly, the system we have would be weakened to the point of eliminating choice, access in many rural areas, and the high quality realized through current competition.
- Allow providers of services through managed care, to reduce options or lessen the quality or amount of services provided to meet a capitation rate. *In a capitation rate system, there are natural occurring incentives that make these actions probable.*

To move toward the goal of AIM 3; Better Care; Better Health and Lower Costs, we too believe Oregon can be the trailblazer it has been in the past and offer to join with others also willing to actively engage, in *thoughtful planning and implementation* for system improvement. There exist several options, now becoming available through the Affordable Care Act of 2010, that could enhance the coordination of care without making such an extensive change to a capitated program for LTC/HCBS systems. Many of these focus on providing flexibility and use of best practices to address many cost drivers being faced. Some of these less drastic, more thoughtful approaches to improving the system and lowering cost need to be given serious consideration BEFORE we even consider what viewed by many, as the likely destruction of the current system with there not being a sound, tested nor proven better model to implement. There are simply too many unknowns in the current proposal. Coupled with the unbelievably short time line for implementation, could easily result in unintended catastrophic consequences - not acceptable to Oregonians. Our system, build over several decades and the envy of most states, needs improved, not replaced!!

Thanks for the opportunity to comment. Feel free to contact Ann Balzell, SILC Chair @ balzell@aol.com or 503.945.5857 or Tina Treasure, SILC Executive Director @ Tina.M.Treasure@state.or.us or 503-945-6621.

From: "Anne Morrill" <anne@prochoiceoregon.org>
To: <ohpb.info@state.or.us>
CC: "Michele Stranger-Hunter" <michele@prochoiceoregon.org>
Date: 3/8/2011 3:13 PM
Subject: Transformation Team input
Attachments: Cost Savings.pdf

Dear Health Policy Board,

Every dollar spent on comprehensive access to contraception will save \$9.25 in health care costs!

Please see the attached fact sheet for more information.

If you have any questions please contact Michele Stranger Hunter at (503) 223-4510 ext 11, michele@prochoiceoregon.org.

Thank you for your time and consideration.

Sincerely,
Anne

Anne Morrill
Access Coordinator
Oregon Foundation for Reproductive Health
NARAL Pro-Choice Oregon
(503)-223-4510 ext 18
<<http://www.accessebc.org>> www.accessebc.org
<<http://www.prochoiceoregon.org>> www.prochoiceoregon.org



Reproductive Health Core Outcomes

Every dollar spent on comprehensive access to contraception will save \$9.25 in health care costs!

Achieving better health, higher quality care, and lower costs for Oregon families

Evidence-based reproductive health preventive care services are critical to health care reform in Oregon. Reproductive health prevention efforts save money, improve health and increase the quality of health care services.

An investment in reproductive health care is returned many times over in improved outcomes and a decreased reliance on limited public resources.

- According to the Institute of Medicine states that preterm birth before 37 weeks of pregnancies costs the United States more than \$26 billion annually.
- **The average first year medical cost for premature/low birth-weight baby is \$49,033 compared to \$4,551 for a baby without complications.**
- **Medicaid costs are reduced on average between \$12,000 and \$15,000 for every very low birth-weight incident prevented (National WIC Association).**
- Research indicates that 58,600 women in Oregon were at risk of unintended pregnancy in Oregon, and that number would **decline by 90%** to 5,900 if all those women had **access to contraception services**. While Title X is crucial, it is not enough to meet the needs of Oregon women, and primary care clinicians must be routinely involved.
- Title X saved Oregon \$18.2 million in public funds in 2008 by preventing unintended pregnancy. However, if all reproductive-age women had access to contraception, **Oregon would save \$75.5 million per year.**
- **Complete contraception access for a population results in a Return on Investment of \$9.25 for every dollar spent.**

The state of Oregon Department of Human Services, Public Health Division tracks data on postpartum women in our state through Oregon PRAMS, the Pregnancy Risk Assessment Monitoring System. PRAMS is a project of the Office of Family Health with support from the national Centers for Disease Control and Prevention (CDC). PRAMS collects data on maternal attitudes and experiences prior to, during, and immediately after pregnancy for a sample of Oregon women. The sample data are analyzed in a way that allows findings to be applied to all Oregon women who have recently had a baby. **PRAMS data, which has been collected following CDC protocol since 2002, can be used to evaluate the impact of including reproductive health goals in primary care.**

Reproductive Health Core Outcomes:

→Reduce costs in the next year by:

- Reduce complications due to unintended pregnancies, including preterm births paid for by Medicaid by increasing the number of women who receive prenatal care during their first trimester of pregnancy from 35.5% to 50%.
- Reduce expenditures on maternity care services paid for by Medicaid by reducing the number of unintended pregnancies from 49% to 35%.
- Reduce expenditures on social services and supports needed by families pushed into poverty by unintended pregnancy.

CALL TO ACTION:

Decision-makers in Oregon's Health Care reform process could make a substantial reduction in the state's overall costs by ensuring that:

1. State purchasers of health care, including OHP plans, PEBB and OEBC should incentivize clinicians to integrate reproductive health into physical health assessment by routinely screening for pregnancy intention through pay for performance incentives.
2. Participation in the Title X program is (at a minimum) preserved, and ideally increased in order to maximize receipt of federal funds and save taxpayer money by preventing unintended pregnancies and the health care and social costs they incur.
3. Data systems such as PRAMS should be utilized to evaluate the impact of reproductive health goals in primary care.

Please contact the Oregon Foundation for Reproductive Health with any questions:

Michele Stranger Hunter, Executive Director
(503) 223-4510
Michele@prochoiceoregon.org

From: "Terry Dethrow" <Terryd@npc.mvbcn.org>
To: <ohpb.info@state.or.us>
Date: 3/8/2011 9:49 AM
Subject: Opportunity for Rule Input - Regulatory Barriers to Efficiency

We would like to take this opportunity to give some input to the committee for Regulatory Barriers to Efficiency regarding some of the rules that affect Behavioral Health services.

Thank you for this opportunity.

Sincerely,
Tim Markwell, MSW
New Perspectives Center for Counseling and Therapy
1675 Winter Street NE
Salem, OR 97301
(503) 316-6770

OPPORTUNITY FOR RULE INPUT

1. Form Standardization-Since both the OWITS project and the MTM consultation process (in some counties) is taking place, and is attempting to standardize forms, it only makes sense to wait to make changes until a decision and/or compromise is reached. It costs providers a lot of money and creates a lot of confusion when you are getting mixed and sometimes contradictory mandates regarding how clinical records need to look in order to be in compliance.

Suggestion-Put rule implementation and changes on hold.

2. ISSR Language-while we are attempting to integrate the physical and behavioral health disciplines it makes no sense to use the language mandated by the ISSR. People know what a patient or client is and they don't necessarily know or understand the terms consumer or individual. Also, people understand what a treatment plan is and not an ISSP. While these changes were made to supposedly be more "client friendly/client centered" they have only served to raise costs and confusion and it takes us further away from our goal of integration.

Suggestion-Remove language change requirements or at least allow

language (old and new) to be used interchangeably.

3. Unfunded required case management services-Don't require providers to provide case management services that aren't billable. This is an unfunded mandate.

Suggestion-Change language to state that the offering of these services are highly recommended, but not required.

4. Clinical supervision requirements for Licensed master level practitioners-we are in agreement with the monthly group supervision requirement, but feel the face to face requirement is a little excessive. Unlike un-licensed master level practitioners, state licensed practitioners have served a two year licensing supervision process, have taken and passed a test and have a mandatory continuing education requirement in order to keep and maintain their license. Due to the aforementioned previous oversight and training as well as the continuing education requirement, we believe the face supervision requirement for these licensed practitioners is excessive and that the time commitment should be lowered.

Suggestion-For licensed master level practitioners, have the face to face requirement be quarterly as opposed to monthly.

5. Assessment billing-Requiring a complete assessment by the end of the first session is unrealistic, especially with children. If we could return to the time when you could develop (and bill) and finish your assessment between the 1st to 3rd sessions. It would also be helpful to be able to bill assessment more than once.

Suggestion-Increase allowable time for developing and billing for assessments. Also allow the assessment code to be billed twice.

6. Treatment plans or ISSP's-As mentioned in #5 for assessments, it would be beneficial to have a longer time period to complete treatment plans/ISSP due to the time it takes to form a diagnosis, again, especially with children. Also, giving the client/individual the treatment plan/ISSP should be optional and not mandatory. Finally, the treatment plan/ISSP review timetable should be less prescriptive and more individual.

Suggestion-Increase allowable time for treatment plan/ISSP development.

Make giving the client/individual the treatment plan/ISSR optional. Allow treatment plan/ISSP review timetable to be flexible.

7. Group and family counseling-Currently, if two practitioners are in a supportive group setting (examples: New Solutions or school ISP where there may be multiple providers such as individual and/or family counselor and prescriber from the same agency that would want to attend to give a different perspective) or are meeting jointly with family members who see different counselors in that agency, only one person may bill for their time. We believe that in this age of collaboration and with a focus on managing the whole person/family, it only makes sense for both to be able to bill for their services (if the service or the perspective offered (PMHNP versus LCSW) is different and benefits in increasing the overall understanding or planning in the case). We believe more collaboration would take place if both could bill for their services. An example of this is in couples therapy where you might have the individual therapist of the husband and the individual therapist of the wife have a family session with both parties so that there could be support for both parties in communicating their issues. This could also happen with a child and parents where they may want to have both the therapist and prescriber meet together so that a joint plan can be formed to make sure everyone is on the same page to help the shared client.

Suggestion-Allow for two practitioners in a therapy group setting to be able to individually bill for the group and also for a conjoint therapeutic family service offering.

8. Public client no shows-We cannot currently charge a public funded client for a no-show. We would like to be able to levy a nominal no-show charge against publicly funded clients/individuals. We believe that to be able to impose a charge provides for more of a buy in from the client/individual while stressing the importance of attendance while also reflecting the real world consequences for not showing up and/or not following through.

Suggestion-Be able to levy a \$10 to 15 charge for no-shows for publicly funded clients/individuals.

From: "Willi, Scott" <SWilli@roguecc.edu>
To: "OHPB.Info@state.or.us" <OHPB.Info@state.or.us>
Date: 3/9/2011 3:44 PM
Subject: inefficient mental health treatment/documentation

I've worked for a county mental health agency for 28 years. The necessary documentation to stay in compliance and eliminate liability claims continues to increase dramatically. Very inefficient. It's crazy looking at all the paperwork hoops that we put clients through, before they get any amelioration of the pain for which they are seeking help.

In an intake, I believe the prospective client must sign his name 13 times. I recommend that you try and sign up for some therapy at a OHP clinic like ours, and see how the process goes for you. For instance, on our "Authorization to Release Information" form alone, we have the consumer sign his name, sign his initials 7 times, and check off 7 additional boxes. Certainly, this prevents lawsuits, but is so inefficient and time consuming for all parties concerned. Reformation is needed.

Scott

Comments are my own and do not represent my agency.

This e-mail may contain information that is privileged, confidential, or otherwise exempt from disclosure under applicable law. This e-mail was sent in good faith to the address you provided to Rogue Community College. We trust that you have password-protected access to this e-mail account and that any transmitted confidential information is secure. If you are not the named addressee, you should not disseminate, distribute, or copy this e-mail. Please notify the sender immediately by e-mail if you have received this e-mail message by mistake, and then delete this e-mail and any attachments from your system. If you are not the intended recipient, you are notified that disclosing, copying, distributing, or taking any action in reliance on the contents of this information is strictly prohibited.

From: "Darvel Lloyd" <darvlloyd@gmail.com>
Date: 3/10/2011 12:25 AM
Subject: Preserve Oregon's model of a long-term care system!

March 9, 2011

Dear Dr. Goldberg and your Oregon Health Authority's Transformation Team:

Our Southeast (Portland) District Senior Advisory Council and volunteers at Impact Northwest, Inc., applaud your exceptionally hard and intense work on radically improving the healthcare system in Oregon! We will be closely following your progress and the evolving legislation in Salem. We strongly support House Bill 3037--expanding the highly popular Oregon Project Independence program--and the Health Care for All Oregon Act (HB 3510 and SB 888), which will result in much better health benefits for everyone and huge reductions in state costs.

Given the extremely short timeline to complete your plan and the Draconian human service budget cuts looming ahead, we are greatly concerned about the long-term care and well-being of our most vulnerable citizens: the frail elderly and disabled people of all ages. There is very real and widespread fear among our senior clients (including those on long waiting lists for services) of increased suffering, even greater poverty, inability to stay in their own homes, forced institutionalization, and loss of independence. In Multnomah County alone, many hundreds of poverty-stricken, disabled people under 60 years of age face imminent reductions in the quantity and quality of their services. We advocates for these Oregon citizens are equally worried about the future of human services and healthcare delivery in the face of the rapidly growing demand.

*We implore you and your team to always keep this in mind that Oregon continues to have one of the most desired and cost-effective long-term care systems in the nation, so you MUST retain it's most important values: preservation of **choice, independence, and dignity! *You owe it to Oregonians to carefully balance and retain the best aspects our current systems. But if it ain't broke, don't fix it!

**Thank you so very much for tackling the huge job ahead with empathy, compassion, dedication and sacrifice.

Best regards and good luck,

Darvel Lloyd
Chair, SEDSAC and volunteer,
Impact Northwest's Program for Seniors and People With Disabilities
Portland, Oregon
Office phone: 503-988-3660

From: "Michael G Saslow" <saslowm@exchangenet.net>
To: <ohpb.info@state.or.us>
Date: 3/10/2011 11:51 AM
Subject: suggested added language for lc draft

Ari, this is the idea we looked at Wed. evening: language that would reassure many potential supporters of health system transformation, who are concerned that the gains they have achieved will be thrown out with the bathwater in the accelerated rush to restructuring the less effective or only potentially effective components of the new system.

This is a proposed addition to 414.025 (10), 2/28/11, starting with "Accountable care organization" or "ACO" means.....in accordance with ORS 414.725"; add the following:

"Specifically, an ACO may coordinate and/or supplement the case management services of an Area Agency on Aging, or a comprehensive community disability, mental health or substance program, with the operations of multiple person-centered primary care homes, so as to avoid duplication of effort and more rapidly implement effective and efficient continuity of care."

From: "Suzanne Huffman" <suzanne97205@gmail.com>
To: <ohpb.info@state.or.us>
Date: 3/10/2011 5:32 PM
Subject: Community First Choice and the Health System TransformationTeam

Recently CMS published proposed rules for the Community First Choice plan under ACA. As team members probably know, there will be a 6% incentive on the table. Oregon is doing much of what's required under these rules; in fact, it is likely that CMS looked at our state's model, given our historic leadership in Home and Community Based Services.

My questions are these: (1) When the team gets down to specifics on the place of long term care in the transformation process, what part will the proposed rules play in the discussion? (2) Since funds will be available much sooner than the target date for transformation, will our state be applying for this waiver under the current structure?

My comment: A 6% increase in Oregon's waiver may not balance the budget, but the Community First Choice plan, with additional provisions for supports to transition individuals from more costly nursing facilities back into the community, appears very much in line with the Triple Aim.

Thank you for consideration of my questions and comment.

Suzanne Huffman
1570 Cottage St SE
Salem, OR 97302
(503) 875-5999

From: "MICHAEL VOLPE" <volpemr@msn.com>
To: <ohpb.info@state.or.us>
Date: 3/14/2011 3:16 PM
Subject: Consumer Input to Health System Transformation Team

To whom it may concern,
Attached an below is my input. Thank you for your invitation for input to the Health Transformation team.

Health Transformation for the consumer
3/14/11

I have been a consumer of community based long-term care services in my home for 16 years and I would like to voice some thoughts and concerns over the health transformation process. Though I have no voluntary movement below my neck due to multiple sclerosis, my overall health since I have been receiving long-term care services has been good. I've only had 3 short hospital visits during those 16 years. I had 2 longer hospital stays followed by nursing home rehabilitations. The long term care services have stabilized my physical health. This stabilization of not only my health, but the peace of mind that my physical needs will be met has also enhanced my mental health. As a result I have become more involved in my local community and advocacy programs for people with disabilities.

I am concerned about the transformation process interrupting my well-established routine, which has taken me a great deal of time and effort to establish. This routine is comprised of home-care workers, support staff at the local Senior and Disability Services office, food stamps, and a stable home which I maintain through the home-care workers. As you can see, it takes a network which I have been fortunate enough to establish, to keep me safe in my own home. I am aware that there will be cuts to the services that I receive, but I feel that the basic integrity of Oregon's community based long term care system must be preserved. For almost 30 years this system has been nationally acknowledge for the quality of services delivered and simultaneously the cost savings that have been achieved.

I feel that the quality of services that I have experience has been in large part due to the services that I have received from home-care workers and the support that I and the home-care workers have received from the local administrative office. Due to the extend of my disability I rely upon home-

care workers for most of the acts of daily living, which include eating, mobility, grooming, bathing, toileting, bowel and bladder management, shopping and transportation. A rotation of home-care workers supply the assistance that I need. I manage the hiring, training and rotation of the home-care workers, but I also need the freedom to hire the person of my choice and when necessary fire the home-care worker. The support of the local administrative office in conjunction with the state administrative office is essential to make timely payments to the home-care workers, manage the application process of new home-care workers as well as conduct background check on these workers. The local office is also responsible for allowing me the flexibility to change home-care worker schedules as long as I stay within the mandatory maximum hours that I am eligible for.

I know that the future of long term care services is uncertain, but I am hoping that the basic qualities of the current system such as locally administered services, my freedom to choose home-care workers and my ability to live in my own home will be preserved.

Thank you for your attention to this matter.

Mike Volpe
1975 S.E. Crystal Lake Dr. #131
Corvallis, OR 97333
volpemr@msn.com

From: "Don Fries" <crestview2@comcast.net>
To: <ohpb.info@state.or.us>
Date: 3/14/2011 7:03 PM
Subject: HSTT Input RE: Proposed OHA/DHS Split

Dear HST Team:

With the Governor's Focus on developing a fully integrated health care system all the way from acute hospital inpatient care, down through long term care, to basic in-home support, I am very surprised that he has yet to lobby for keeping the Department of Human Services whole and as one complete agency.

Given that the Oregon Health Authority is becoming the new single state Medicaid agency, it only makes sense that the whole department, encompassing the totality of Medicare and Medicaid functions, be operated under one roof. This is critical to operating a truly "lean" program - all players and policy staff working in concert with Oregon's Federal partners, not to mention state, local.

Thus, I heartily recommend that you add to the draft Legislation a provision that will keep OHA/DHS whole under the new "capitated" OHA umbrella.

As a fallback, keep at least all of the Medicaid and Medicare policy functions under one OHA roof.

Otherwise, Oregon will hamstring itself with duplicative additional layers of bureaucracy, trying to run lines of communication via interagency agreements that could have naturally existed in one unified agency.

Go Lean.

Oregon Citizen

From: "Marc Corbett" <marccorbett@gmail.com>
To: <ohpb.info@state.or.us>, <Tina.d.edlund@state.or.us>
Date: 3/15/2011 4:51 PM
Subject: Freedom of Health Care

Hi Tina and Transformation Team,
I have been asked to forward this to you from Janet L Rueger, DC, of Ashland, OR. Please include this action stimulus resource in background for discussion and legislation input.

Oregon Health Transformation Team
Epidemic of Health

* *

Freedom of Health Care – I suggest we have this as a slogan, or incorporated in some way. Especially, here in the United States, if we are to be required, by law, to pay for health care, that must include methods of treatment that we each choose. I am unwilling to pay a percentage of my income for treatments that I will likely never use, unless I also have coverage for BodyTalk, for chiropractic, for acupuncture, for naturopathy, for homeopathy, for cranial work done by a chiropractor, for craniosacral.

All of these with any licensed provider of my choice.

No more “preferred provider” networks.

If medications are to be paid for by health care insurance, then it is only fair that *nutritional supplements*, herbs, essential oils and homeopathic remedies recommended by a licensed chiropractor, acupuncturist or naturopath or homeopath would also be paid for by the insurance. This may need some boundaries, but we also need boundaries on the amount of medications that are paid for.

Reward those people who are proactive with taking care of their own health

(The above paragraphs do that). The current proposed US federal health care plan penalizes those who take care of their own health. We spend our own money on health club memberships, yoga, tai chi, and qi gong classes, on nutritional supplements, on chiropractic care, BodyTalk sessions,

acupuncture and massage, stay healthy and then we have to pay another huge chunk of money to fund health care for people who eat junk and do little to maintain their health?

Our Health Care is not working; we must *look outside of our current beliefs and our current “box”. *This means going against the plans and desires of the pharmaceutical industry.

The definition of a healthy person includes not requiring medication. A person who is “managed” with their meds is NOT healthy.

BEFORE any person is given medications, that would likely be long term medicating, or has surgery, unless their condition is life threatening or in the view point of a chiropractor, a naturopath and an acupuncturist, they do need the meds, *they must be evaluated and treated, by at least two “alternative” methods. *They would have an amount of treatment that the practitioner feels is a reasonable amount to try, prior to medications or surgery.

If a person has an acute bacterial infection, yes, antibiotics would be given if that is their choice and that would not require an evaluation by an alternative practitioner, unless the patient wants to try other methods.

Evaluations of all patients should be done not only by allopathic trained personnel, but also or prior to allopathic, by a trained licensed Wellness practitioner, such as a chiropractor, a naturopath, an acupuncturist, a homeopath.

*Include, in health care, Alternative Therapies that may not yet be “Evidence Based” *and also some therapies that may not be licensed. With those that are not licensed, require a reasonable certification such as BodyTalk offers.

Therapies to include:

BodyTalk

Acupuncture

Chiropractic

Cranial work done by Chiropractors

CranioSacral

Visceral Manipulation done by Chiropractors or other licensed practitioners

who have training in it

Many NON-evidence based therapies have helped many people to become well.

I'll give you an example:

I saw as a new patient, a woman who has Oregon Health Care. She is disabled, possibly temporarily, more likely permanently, unless she receives significant help from outside of the allopathic system. She consulted me for back and neck pain. She has an extensive history of injuries, surgeries and labeled diseases. She's on several medications. She wants to be well. She chose to see me because I do BodyTalk and Cranial work, rather than see other chiropractors. I accepted her as a patient, knowing it's unlikely I'll get paid anywhere near my reasonable fee, for seeing her (Oregon Health Pan pays horribly)

As I evaluated this woman, I felt, intuitively that there were abuse issues. I did not ask about that in the first visit, because first she needed help with the acute low back pain. On the second visit, after doing chiropractic treatment with her, I told her, "I'm going to use your arm to ask your body if it wants anything else." I had been "drawn" to pelvic area and lower abdomen. With BodyTalk testing, I found "Active Memory, sexual abuse with first husband" in her pelvic floor and lower abdomen. She had given NO information on the history form to suggest a history of abuse.

I told the woman what I found – the Active Memory and she proceeded to tell me about sexual abuse, as a child, with her step father, then following that, with her husband of 8 years, including verbal and non-sexual physical abuse, and his abuse of their children.

I feel strongly that this woman will only become well after she has help with healing from the abuses. She has had many years of psychotherapy and that has certainly helped her, emotionally and mentally, however, it has not helped her to become well physically.

This woman may very well become well, get off most, if not all, of her meds and become a functioning member of society if she continues with BodyTalk as a therapy. She does not have an income. Currently the State of Oregon is paying for meds for her every month and for medical doctor visits. She could be a ward of the State for the next 30+ years.

This is one example of many people who could likely become self supporting, rather than being supported by the State, but if and only if they receive NON-allopathic Mind Body care, such as BodyTalk.

The State may spend a few thousand dollars on non-Allopathic care for this woman, to help her to become self supporting OR the State can continue to support this woman for 30+ years.

It seems it would be a prudent business decision for the State of Oregon to pay reasonable fees to experienced certified BodyTalk practitioners for a reasonable number of sessions for some people such as the above woman and then evaluate the results at the end of a one year period and a two year period.

Privacy of information will be necessary with BodyTalk and perhaps some other disciplines. People will not be honest with us about some of the things that have happened to them if that information could be available to government agencies or other health care staff or providers. We must not be required to give our session notes to insurance companies or government agencies, etc.

*Payment for services done by Non-Allopathic Providers *must be reasonable. What Medicare and Oregon Health Plan currently pay for chiropractic services is NOT reasonable and is not a level of payment that practitioners will be able to survive on unless they give poor quality service.
**

Medications are ending up in our water. I don't need to spell out the devastating effects of that. We must decrease, astronomically, the amount of medications taken by people, if we are to have a healthy planet to live on.

Janet L Rueger, DC
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Note: This draft version replaced an earlier version that was submitted on March 15, 2011.

Confidential Draft

Patient Advocacy – A Conversation Starter for Health & Health Care Transformation

“From Provider-Centric Fee for Service Sickness Care to Patient-Centric Wellness Outcomes Partnership Care Supported By Patient Advocacy as a Shared Right and Responsibility”

By Charles B. Maclean, PhD www.philanthropy.com

Version 2.6, March 25, 2011 (This is a draft conversation starter in process)

Summary of Outcomes of Patient Advocacy

- Safety during treatment
 - Self-empowerment
 - Cost reduction
 - Better health

Context

The pressing need to transform wellness in the US as well as our health care system, has given immediacy to the creation of innovations that advance prevention and care quality while reducing costs.

It is a worthy challenge to migrate from a largely fee for service delivery-reimbursement model to a more outcome based model. Since health outcomes are determined in large part by patient choices, behaviors and decisions, the need for early and ongoing patient engagement in their care is self-evident. Yet it is not widely sanctioned, practiced, underwritten or reimbursed.

Reality is that every health care cost saving in one sector is a revenue loss to another. Hence payment strategies lobbied for by governmental entities, providers, hospitals, and technology and pharmaceutical companies have competing economic interests as drivers. These stakeholders vying for shrinking health care dollars have impeded or ignored consideration and adoption of viable patient centered and non-traditional innovations in self-care and wellness. It is these innovations that hold the promise of reducing traditional medical care expenditures that account for only about 10% of overall population health yet capture the majority of health care dollars.*

Patient Advocacy as a possible transformation solution, has received increased interest by the Department of Health and Human Services; the Institute for Health Care Improvement; the Cautious Patient Foundation and other formal and informal professional and lay groups.

As with any rapidly evolving service sector, there is a range of Patient Advocacy players: self-advocates, spouse-family advocates, independent volunteer advocates, hospital employed advocates, and

independent paid advocates. The competencies, role, efficacy, and liability of each approach remain largely undefined and unknown. Rigorous outcome and process research is urgently needed. This conversation starter, while incomplete, is intended as a step in that direction.

Definition of Patient Advocate

A readily available, economically independent, intimately familiar go-between who assures that the patient's needs are attended to; that the patient's best interests are met and served; and that the patient's voice is heard and understood.

Patient Advocate Functions

The Patient Advocate acts as a liaison and coordinator between the patient, the patient's family and health care providers and insurers to help improve or maintain safety and a high quality of health care for the patient. Patient Advocates may act on the patient's behalf, often serving as an information finder and translator, spokesman or decision maker when so authorized. This includes the capacity to communicate with the patient in his/her own language.

Patient Advocates are the consistent conveyers of the patient's history, needs and preferences especially when there is no primary care provider or where rotating hospitalists are delivering care. In doing so they minimize and mitigate risk, recognizing and effectively voicing concerns before it is too late.

Patient Self-Advocacy

A patient, whenever possible and with assistance from the Patient Advocate when needed, is responsible for carrying out self-monitoring, agreed upon care regimens and preventive/wellness care behaviors. They are also responsible for communicating their concerns, questions, and wishes to the Patient Advocate and providers.

Patient Self-Education

Patient advocacy is about interacting with providers and insurers. Patient self-education via pursuing on-line education at vetted sites and participation in credible support groups is what precedes, follows and enhances patient advocacy interventions.

Framing Questions for Readers

1. How can educating and empowering savvy consumers, in ways that improve health and safety and reduce costs, measurably contribute to the wellbeing of both the patient and the health care delivery system?
2. What will it take for this question to be continuously raised during negotiations between various economic interests: "How will this treatment, billing, regulation, premium, legislation or policy decision impact the patient that is my spouse/mother/child/me?"

Desired Outcomes of Patient Advocacy

Below is a range of desirable and possible results produced by competent Patient Advocates and the patients they represent. (Existing data to be compiled and other outcomes to be studied)

- 1) Reduction in medical errors and improved patient safety
- 2) Improvement in the patient-provider partnership enhanced by respectful communication
- 3) Better patient healing, whether or not a cure is possible
- 4) Improvement in life quality and/or longevity
- 5) Reduction in defensive medicine, its costs and side effects
- 6) Reduction in the frequency, financial and emotional costs of medical malpractice suits
- 7) Patients being more responsible for their health
- 8) Overall reduction in health care costs
- 9) Greater ease and flow of patients through the health care system
- 10) Increase in patient and patient's family engagement and satisfaction
- 11) Reduction in the duress providers experience as a result of undesired outcomes
- 12) Increase in patients' wishes being respected and honored

What Benefits Might Accrue to Health Care Providers by Utilizing Patient Advocates?

- 1) Better patient outcomes
- 2) Greater compliance with agreed upon home-care, self-care
- 3) Fewer medication, infection and other side effect occurrences
- 4) Fewer unnecessary disruptive midnight emergency department admissions
- 5) Fewer avoidable re-admissions and shorter hospital stays
- 6) Fewer first time admissions without adequate workups

(This question stimulated in part by informal comments at the March 23, 2011 Oregon Health Care Transformation Team meeting in Salem, Oregon)

Guiding Principles for Patient Advocacy

Core Principle

People have a right and a personal responsibility to identify and use a competent 1:1 Patient Advocate-System Navigator that assists them to make better decisions and to take responsibility for ongoing self-care and a behavior change plan.

Supportive Principles and Blended Actions

- 1) Wherever patients and regulations/issues that affect patients are being discussed, patients (and/or their designee or Patient Advocate) will be present.
- 2) Patient Advocates and select family members have a right to be with hospitalized patients 24/7/365. They are not to be treated just as “visitors” but rather as liaisons, advisors and proxies, with one or more designated as the Medical Durable Power of Attorney.
- 3) Provide Patient Advocate-System Navigators with effectiveness training and compensation to attend necessary meetings and consultation visits whenever possible.
- 4) People become savvy consumers of health care and prevention education before they become patients.
- 5) People become responsible partners in care with their providers of care and participate in decision making at the level they choose.
- 6) Care is available and affordable for all when and where they need it and is delivered in a safe effective manner that emphasizes prevention and wellness.
- 7) The treatment process is not worse than the disease itself, especially at end of life when palliative, compassionate care and dignity are needed most.
- 8) Improve health and fund necessary change by reducing waste, errors, under-service and over-service.
- 9) When there is a medical error, make a prompt course correction, explanation and apology that decouples the communication from restitution.
- 10) Revisit the current malpractice environment and create alternative dispute resolution practices like mediation-arbitration 2.0 that address all stakeholder needs and lead to equitable restitution.
- 11) People have a right and a personal responsibility to craft “end of life directives” before they are needed.
- 12) People have access to and are compensated for a wider range of complementary, holistic care options provided by licensed providers.
- 13) Care incorporates the core values and needs of patients, their families and of care givers and the outcomes are evaluated for quality of care and quality of caring.

- 14) People have a right to retain their primary care provider of choice over time and continuation of coverage regardless of which health insurance plan they choose.
- 15) To assure that all people have a primary care provider, the definition of PCP is expanded to include a wider range of qualified, licensed professional providers.
- 16) Recognizing that only about 10% of health status is directly attributable to traditional medical care (providers, hospitals, technology and pharmaceuticals) and that about 90% is attributable to lifestyle and behavior; human biology; environmental factors and social factors, it is time to shift more dollars that are currently devoted to “sickness care” to interventions and education that promote prevention and wellness.*
- 17) Attention and resources are focused on both traditional and complimentary-holistic care delivery systems and interventions anchored in evidence-based outcomes and care benchmarks regardless of where they come from or what they are called.
- 18) All people have a human right to basic health care and the nation [State] has a moral obligation to collaborate in providing basic care for all.**

*McGinnis J.M., Williams-Russo, P., Knickman, J.R. (2002). *Health Affairs*, 21(2), 83 (In reviewing a number of prior studies this analysis showed that of all the factors that influence an individual's overall lifetime health status, interaction with the medical system accounts for around 10%.)

**“Once a nation decides that it has a moral obligation to provide health care for everybody, then it can build a system to meet that obligation.”

Uwe Reinhardt,

The Essence of the Patient Advocate Relationship

“You are my informed trusted ally, loyal to me. I know you will put my health and well-being first. I rest and heal better knowing that.”

Supportive Resources

AHRQ recommends patients use health advocates. Pattillo RE., Nurse Educ. 2011 Jan-Feb;36(1):30. PMID: 21135681 [PubMed - in process]

Assessing patient safety in the United States: challenges and opportunities. Zhan C, Kelley E, Yang HP, Keyes M, Battles J, Borotkanics RJ, Stryer D. Med Care. 2005 Mar;43(3 Suppl):I42-7. Center for Quality Improvement and Patient Safety, Agency for Healthcare Research and Quality, US Department of Health and Human Services

AHRQ underfunded: advocates. Current funding won't help safety, quality, they say. DerGurahian J. Mod Healthc. 2009 Jan 5;39(1):8-9. PMID: 19230086 [PubMed - indexed for MEDLINE]

Advocates deserve room at the decision-making table. Sheehy J. Nat Med. 2010 Oct;16(10):1070. PMID: 20930740 [PubMed - indexed for MEDLINE]

Empowering the patient. Private advocates help patients navigate complexities of the health system. McKinney M. Mod Healthc. 2011 Jan 31;41(5):32-3, 35. PMID: 21370635 [PubMed - in process]

Many of the definitions, outcomes and principles are compilations drawn from conversations, interviews, conference presentations, anonymous comments, reading and searches. Specific references are provided where possible.

Acknowledgment of Contributors and Reviewers

With thanks to: Tricia Pil, MD, Pediatrician and Patient Advocate; Bart Windrum, Author, Speaker and Patient Advocate, www.HospitalPatientAdvocate.com; Marc Corbett, Patient Advocate; Betsy Kusin, Administrative Director and Bill Thatcher, Executive Director www.CautiousPatient.org; Rose Winters, Executive Director, www.mcgareyfoundation.org; Susan Walenza, Patient and Patient Advocate and Author and other anonymous reviewers. Listing does not necessarily indicate full agreement with the content of this resource.

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Also available: "Prevention of Marketplace Created Non-Diseases & Low/No Value Treatments". (Proposed language submitted to the draft of the "Oregon Sample Legislative Language to Reduce Unnecessary Health Care Costs and Eliminate Unnecessary/Harmful Interventions")

Opportunity to Contribute to Help Continue the Work

This resource is the result of self-funded research and development. To support continuation of this work, please consider making a contribution (not tax deductible) via PayPal at www.philanthropynow.com Click on “donate”. Thank you.

Charles Maclean

Appreciative Inquiry Action Stimulus Questions

What has been your best Patient Advocate experience and what would make it even better?

If you don't currently have a satisfactory Patient Advocate, what are the competencies and traits you'd want in your Patient Advocate and what will you do by when to find your PA before you need one?

If you could enact nationwide Patient Advocate legislation and insurance coverage, what would you want to see in place for you and your loved ones?

Your other follow-up actions:

“It is possible to create an epidemic of health,” - Jonas Salk Interviewed by Bill Moyers, in The World of Ideas)

From: "Marc Corbett" <marccorbett@gmail.com>
To: "tina.d.edlund" <tina.d.edlund@state.or.us>
Date: 3/15/2011 5:35 PM
Subject: Lost cost solution for lowering Health Care costs

Hi Tina, this is background for the HSTT.

Bruce Goldberg wanted me to send this to you for the next Team meeting.

A creative idea for helping to lower health care costs, it's a new feature film "Forks Over Knives". It examines the profound claim that most, if not all, of the so-called "diseases of affluence" that afflict us can be controlled, or even reversed. Throughout the film it follows success after success of people getting healthy and in many cases remaining healthy for decades later. One of the subjects in the film was a heart patient in her eighties, twenty years earlier she was told to go home and die, After working with Dr. Caldwell Esselstynin MD, in his clinical study at the Cleveland Heart Institute, today she is happy, very healthy and never had any surgery. That is the meaning of the title of the film, Forks Over Knives, you can use a fork to eat your way to health rather than a knife for surgery. The film also presents evidence based medicine along with comprehensive scientific studies in a way that is easy to understand.

As I told Dr Goldberg, I really like this film, when it was playing in Portland during a special preview (to many sold out shows), I sent some patients to see the movie, the feature film tells a story of success, that it is possible for them to be healthy and they can improve the quality of their life. My patients felt hopeful after listening to stories of easily achieving good health and reversing disease, including cancer.

The movie helps me give a dream and vision to a patient that they can survive and get healthy, they can do it, they be that way too, just like in the movie. They can work out a plan to change their lifestyle, eat better, exercise and work with a PCP to reduce medication over a period of time. It shows they can win and take control of their own health and wellness. I have worked with many patients over the past thirty years using this protocol, I have had successes in reversing cancer, ending diabetes, clearing many inflammatory diseases. I just had a patient who was too weak for a bypass and was sent home from St Vincent hospital, I asked him to see the film, he saw the film and immediately and enthusiastically agreed to follow

the protocol. I saw him last week, he looks much stronger and he says he feels much better, this in just weeks, he is also seeing Richard Heitsch MD in Portland who is working to reduce his meds as his health improves, he probably won't need any surgery.

The film inspires the public that they can win too, with a message of hope. I talked with one gentleman in his late sixties after he watched the movie and he told me he going straight home to clean out the crap in his refrigerator. Just making small changes can make a big difference in ones health, in the movie they provide many examples for better living, along with the science, and with many successful role models including healthy doctors (some in their late seventies), for the public and patient to transform into and get to good health.

This is a new kind of health and wellness tool, using new methods helping to create a smarter public and helping cut over-all health care costs.

I just spoke with the films producer and he is willing to loan a DVD for a one time preview showing to see the film (now), for key members of the Team.

(The film makes it's National opening this May).

See you Wednesday.

Regards,

Marc

Marc Corbett
MarcCorbett@gmail.com

503-449-7077

Below is background information for you.

<http://www.forksoverknives.com/>

Synopsis of the film:

What has happened to us? Despite the most advanced medical technology in the world, we are sicker than ever by nearly every measure.

Two out of every three of us are overweight. Cases of diabetes are exploding, especially amongst our younger population. About half of us are taking at least one prescription drug. Major medical operations have become routine, helping to drive health care costs to astronomical levels. Heart disease, cancer and stroke are the country's three leading causes of death, even though billions are spent each year to "battle" these very conditions. Millions suffer from a host of other degenerative diseases.

Could it be there's a single solution to all of these problems? A solution so comprehensive yet so straightforward, that it's mind-boggling that more of us haven't taken it seriously?

FORKS OVER KNIVES examines the profound claim that most, if not all, of the so-called "diseases of affluence" that afflict us can be controlled, or even reversed, by rejecting our present menu of animal-based and processed foods. The major storyline in the film traces the personal journeys of a pair of pioneering yet under-appreciated researchers, Dr. T. Colin Campbell and Dr. Caldwell Esselstyn.

Dr. Campbell, a nutritional scientist at Cornell University, was concerned in the late 1960's with producing "high quality" animal protein to bring to the poor and malnourished areas of the third world. While in the Philippines, he made a life-changing discovery: the country's wealthier children, who were consuming relatively high amounts of animal-based foods, were much more likely to get liver cancer. Dr. Esselstyn, a top surgeon and head of the Breast Cancer Task Force at the world-renowned Cleveland Clinic, found that many of the diseases he routinely treated were virtually unknown in parts of the world where animal-based foods were rarely consumed.

These discoveries inspired Campbell and Esselstyn, who didn't know each other yet, to conduct several groundbreaking studies. One of them took place

in China and is still among the most comprehensive health-related investigations ever undertaken. Their research led them to a startling conclusion: degenerative diseases like heart disease, type 2 diabetes, and even several forms of cancer, could almost always be prevented—and in many cases reversed—by adopting a whole foods, plant-based diet. Despite the profound implications of their findings, their work has remained relatively unknown to the public.

The filmmakers travel with Drs. Campbell and Esselstyn on their separate but similar paths, from their childhood farms where they both produced “nature’s perfect food”; to China and Cleveland, where they explored ideas that challenged the established thinking and shook their own core beliefs.

The idea of food as medicine is put to the test. Throughout the film, cameras follow “reality patients” who have chronic conditions from heart disease to diabetes. Doctors teach these patients how to adopt a whole foods plant-based diet as the primary approach to treat their ailments—while the challenges and triumphs of their journeys are revealed.

FORKS OVER KNIVESutilizes state of the art 3-D graphics and rare archival footage. The film features leading experts on health, examines the question “why we don’t know”, and tackles the issue of diet and disease in a way that will have people talking for years.

***FORKS OVER KNIVES** *was filmed all over the United States, and in Canada and China.

Additional Video info...

Caldwell Esselstyn, MD -- "No More Heart Attacks -- Ever"

<http://www.youtube.com/watch?v=YNeWCvLZaFM&NR=1&feature=fvwp>

Evelyn Oswick, one of Dr. Caldwell Esselstyn's original heart disease patients

http://www.youtube.com/watch?v=k__7dRk5Ss8

Dr. T. Colin Campbell's: The China Study: Reducing Risk of Disease through a Vegan Diet- 2

<http://www.youtube.com/watch?v=HvA55xj8iMI>