

**Oregon Health Policy Commission  
Quality & Transparency Work Group**

**2006 Meeting Notes**

**January 9, 2006 2-4pm, 800 NE Oregon St, Room120B, Portland**

**February 13, 2006 2-4pm, 800 NE Oregon St, Room 120B, Portland**

**March 13, 2006 2-4pm, 800 NE Oregon St, Room 120B, Portland**

**April 10, 2006 2-4pm, 800 NE Oregon St Room 120A, Portland**

**May 8, 2006 2-4pm, 800 NE Oregon St Room 120A, Portland**

**June 12, 2006 2-4pm, 800 NE Oregon St Room 120A, Portland**

**July 10, 2006 2-4pm, 800 NE Oregon St Room 120A, Portland**

**Quality & Transparency Work Group Meeting Notes**  
**Oregon Health Policy Commission**  
**January 9, 2006**  
**800 NE Oregon St, Room 120B, Portland, Oregon**

**Members Present:** Vickie Gates, Sherry Blaskowsky, Nancy Clarke, Gwen Dayton, Lisa Krois, Bill Kramer, Michael Leahy, John McConnell, Ron Potts, Ralph Prows, Brett Sheppard, Doug Walta

**Members Excused:** Jonathan Ater, Joel Ario, Keith Marton, Gil Muñoz, Glenn Rodriguez

**Staff:** Hanten Day, Research Analyst, Office for Oregon Health Policy & Research (OHPR)  
Tina Edlund, Data & Research Manager, OHPR  
Gretchen Morley, Director, Oregon Health Policy Commission  
Jessica van Diepen, Assistant, Oregon Health Policy Commission

Call to order: 2:12p.m.

**I. Recommendations from the Clinical Databases Subcommittee (Tina Edlund), Exhibit III**

***Discussion***

- Because DRG hospitals are reimbursed on a DRG basis; the excess cost of added care for post-surgery complications is incurred by the hospital itself.
- The American College of Surgeons (ACS) may be willing to consider a demonstration project for rural hospitals (Rural Health Quality Network should be a partner in this). Rural hospitals will be constrained by the cost of the database and by their information technology limitations
- Who processes the National Surgical Quality Improvement Program (NSQIP) data? The ACS has contracted with QMetrics to compile the data and send the product back to individual hospitals
- To make statewide NSQIP adoption a success we need to:
  - Start first with the 20 largest hospitals; work to form a rural collaborative to pool data to reach the minimum 900 cases and take random samples from the pool
  - Involve every player in the discussion, tailor the argument for adoption to each player's individual interests and anxieties, and ask each player take the calculated risk necessary to see the experiment through
  - Involve not only the payors but also the liability insurance companies who have a lot to gain from this
  - One option may be for hospitals to pool their resources for this effort and contract with an outside entity (ala the Ambulatory Records Certification (ARC) project of the OMA, perhaps involving the Oregon Medical Association (OMA) as ARC did; we may be able to use the ARC infrastructure for this as it becomes extinct): have a number of nurses working for the effort and not for individual hospitals who will collect the data in an objective way. The advantage of this would be that these nurses would never be diverted by a given hospital's more pressing concerns and they would lend a consistency and expertise to the data collection process that would not exist with in-house nurses.
  - Questions that need to be posed and answered for the benefit of purchasers:
    - Is this a standardized (efficient) approach (or will each payor have a unique process)?
    - Is this a tool that works (has it been proven to work elsewhere)?
    - Is it accepted by the medical community as the right approach?
    - Is this simply a data collection effort or is it indeed a quality improvement effort?
    - For the benefit of hospitals: What will be done with the data? Who will "own" it and have access to it? How will it be used (will it be used in a punitive way)?
- What was the buy-in process of surgeons like in Oregon for the hospitals (Oregon Health and Science University (OHSU), Kaiser) that have already decided to adopt NSQIP? OHSU adoption was driven by the surgeons themselves, predicated on the idea that the cost of avoidable complications was too high and that the NSQIP data made a convincing case for its efficacy in

quality improvement; the hospital administrators were ultimately persuaded by the surgeons and by the data that OHSU should participate. There was unanimous support for NSQIP from attendees at the June meeting of the Oregon chapter of the ACS; there is agreement that of the existing databases, it is the best and it is one by which they are willing to be measured. Most surgeons would and are championing NSQIP adoption at their own hospitals.

- Are all 130 data elements useful/necessary for explaining quality or could we collect a subset of these elements in a less costly/faster way? Right now, we don't know which data elements are necessary and which are not (the statistical validity of NSQIP is based on all 130 data elements); there may be a point in future when we do know and some of them can be eliminated from the process and still maintain statistical validity. The Veterans Association (VA) measured with NSQIP's 130 elements and realized \$9.3million in savings and decreased mortality by 30%.
- Who "owns" the data that is submitted to ACS and who has control over its dissemination to outside audiences? The ACS keeps the data in a central location and also sends it back to individual hospitals with 1) that hospital's own data and 2) "de-identified" national benchmarks for measuring purposes. The ACS does not share data between hospitals or with outside entities; it is secure.
- Does NSQIP provide recommendations for improvements to hospitals whose data deviate from national benchmarks? It isn't automatic, but they have the capability. Most improvement measures are self-evident to a hospital once it has access to its Observed/Expected (O/E) ratios.
- Surgical Care Improvement Project (SCIP): put together cooperatively by Center for Medicare & Medicaid Services (CMS) and ACS; it nets process measure improvements that are easily actionable within a very short period of time (a year). NSQIP is a more robust database that is part of a longer-range plan that will not yield immediate improvement but is a sound investment for an ongoing quality-improvement system as adoption becomes more widespread and the process matures (NSQIP requires a year's worth of data before it yields a product for individual hospitals; likely would be 2-3 years before we see system-wide improvements).
- The subsequent step to NSQIP adoption would be quarterly meetings to convene hospitals and practitioners to share their results among themselves and share best practices/lessons learned in a closed (protected) setting.
- Why haven't hospitals already invested in NSQIP? Cost, limited information technology capabilities (small, rural hospitals); hospitals say they are already collecting a lot of data for too many databases and they are concerned that current data collection does not result in quality improvement.
- NSQIP results to date show that it nets measurable cost and mortality savings; we need to build a case for the database and publicly endorse it.
- If the business community and the public were aware of the human and financial cost of not implementing proven quality improvement programs like this, they would be outraged. Further, if the health care community does not address this issue voluntarily in the very near future, it is very likely that the State, whether through legislation or regulation at the agency level, will take matters into its own hands and mandate that the industry take steps to address it
- The Subcommittee did not come to agreement on how or when any of this data would be made public to further the "transparency" as well as the "quality" element of the workgroup's mission. Discussion yields general agreement that statewide adoption would have enough of a quality benefit to the public and to the health care system that it should not be hampered at this time by the larger public reporting issue; several make the point that participation (or lack thereof) would in itself be a hospital quality measure for consumers and purchasers. Further, NSQIP is a piece of the larger picture, and the public reporting conversation for the time-being can be focused on cost or on other quality measures. The SCIP process with CMS will be transparent (what, if anything, should we do with *that* data?).
- Proposal: if we got commitments from our 20 largest hospitals, could we take a proposal to ACS for some flexibility in the price of participation in the program as well as how it is administered (demonstration project with pooling of resources to pay for an independent contractor to gather Oregon data).
- Follow Michigan's lead?: oversample bariatric surgery (for example) to get faster results in the beginning.

- State's role? Purchaser role through Medicaid and PEBB; the State had a key role in founding the Purchaser's Coalition and still has a presence there, so it make sense to put a good case together for this effort and then communicate that to the appropriate players.

## **II. Next Steps & Questions to Be Answered for Statewide NSQIP & SCIP adoption**

- Who ought to be involved in the learning process (who is our audience) and what are the things we need to put together to make a good argument for this; who would be good partners to move this forward?
- What is the CMS/Joint Commission on Accreditation of Healthcare Organizations (JCAHO) timeline for SCIP, how does SCIP data compare with what we currently have, how would we display it, etc
- We will adopt the "vision" statement proposed by the Subcommittee as a starting point, to be amended as needed
- Workgroup co-chairs and staff will work together to draft a strategy for moving this forward.

Adjourned: 3:55p.m.

### **Assignments:**

- **Workgroup members – think about what questions we should pose to the OBC, PEBB, and the Purchaser's Coalition to shape and focus our discussion with them**
- **Tina Edlund – get in touch with ARC as soon as possible about salvaging their infrastructure for our NSQIP adoption effort**
- **Co-chairs & OHPC/OHPR staff: outline a proposal for statewide NSQIP adoption and lay out the questions that to be answered**

### **February/March Agenda Items:**

1. **Insurance Commissioner's cost transparency efforts**
2. **Presentation of NSQIP adoption plan??**
3. **Oregon Health Care Purchaser's Coalition (Barbara Prowe), the Oregon Business Council (Bill Kramer), & PEBB: What does transparency mean to them? What are their priorities for transparency? What are they willing to invest in the effort?**
4. **Review of extant quality reporting and P4P efforts in Oregon (Patient Safety Commission?)**

**Next Meeting: February 13, 2006**

### **Exhibits:**

- I. Agenda
- II. November 21 meeting notes DRAFT
- III. January 4 Subcommittee meeting notes
- IV. 2005-2006 work plan

**Quality & Transparency Work Group Meeting Notes**  
**Oregon Health Policy Commission**  
**February 13, 2006**  
**800 NE Oregon St, Room 120B, Portland, Oregon**

**Members Present:** Jonathan Ater, Sherry Blaskowsky, Nancy Clarke, Gwen Dayton, Lisa Krois, Bill Kramer, Michael Leahy, John McConnell, Glenn Rodriguez, Jim Schwarz, David Shute, Doug Walta

**Members Excused:** Vickie Gates, Joel Ario, Keith Marton, Gil Muñoz, Ron Potts, Ralph Prows, Brett Sheppard

**Staff:** Hanten Day, Research Analyst, Office for Oregon Health Policy & Research (OHPR)  
Tina Edlund, Data & Research Manager, OHPR  
Gretchen Morley, Director, Oregon Health Policy Commission  
Jessica van Diepen, Assistant, Oregon Health Policy Commission

**Guest:** Linnea Saris, Oregon Insurance Division

Call to order: 2:15p.m.

**I. Updates & Announcements**

- On the recommendation of the Electronic Health Records Subcommittee's March 2005 Report, the state has established a ½-time state health information technology coordinator. It has accepted Dr. Jody Pettit's contract for that position, and she will start work soon. The HISPC grant, if awarded to Oregon, will supplement the funding for this position and make it full time.
- Introduction of the Health Information Security & Privacy Collaboration (HISPC) Grant opportunity (Jeanene Smith), Exhibit III:
  - OHPR will apply on behalf of the state; it is a very prescribed project with an outline of specific data to be sent back to the federal government at several points along the way
  - This will be a public/private effort that capitalizes on existing collaborative projects underway in Oregon; the Quality & Transparency Workgroup will be asked to play a central role in fulfilling the project requirements.
  - Letters of support are not required, but they are welcome
- Price data reporting: Joel Ario, through the Insurance Division, is convening health insurers to discuss the possibility of their submitting price data for a variety of services which will then be aggregated and average cost data published. Participants are now in the process of submitting proposed plans and proposed lists of services (top 10 most expensive services, top 10 most frequent services, etc). Data would be collected at the Insurance Division, then aggregated and analyzed at OHPR. Statistical approaches to the analysis have yet to be determined

***Discussion***

- The point of collecting and disseminating this data is to allow the consumer to compare the average price for a given service hospital to hospital. What is the value to the uninsured consumer of publishing the average of what insurers have contracted to pay? Hospitals are being sued more and more over how patients are charged for services and over the transparency of those calculations. This is a step toward a good-faith response to this issue.
- This data is too far removed from actual prices to be helpful to consumers, though it may have beneficial effects within the system.
- Market-driven solutions intended to be facilitated by this kind of price information cannot succeed as long as only a small portion of the population is directly purchasing services. Market forces cannot work while the government is purchasing insurance for low-income people and public employees, employers and individuals are purchasing insurance through a myriad of companies who pay a variety of contractual prices to providers, and only a small portion of the population is paying cash for its care.
  - OHPR is looking to other states' models for analyzing these data
- Statewide NSQIP adoption: Tina Edlund and the subcommittee are in the process of drafting a white paper for review by the workgroup
  - Michigan is a good model for implementation

- Please be sure to explain, for the benefit of hospitals, how this database is different from others and how it adds value where others don't
- Patient Safety Alliance: has selected two SCIP measures to target 95% implementation in Oregon (this will be undertaken ahead of CMS' timeline for reporting). These data will initially be shared only with participants for internal process improvement; there is an expectation that this information will be made public at some point in the future.
- What do we mean by transparency? Two things: patient population data (trends in processes and outcomes) and patient-level data (helping the patient understand what care is being recommended to them as well as what happens to them along the course of that care.)

## **II. Short and Long-Term Direction of the Workgroup**

### ***Discussion***

- Conversations with clinicians about EHR and chronic case management; decide what to measure and how to measure it
- Look more at primary care initiatives; Dr. Rodriguez will help the co-chairs to develop future meeting agendas around this
- Patient safety & work force development issues
- Address public trust of health care providers/industry; how can we educate the public about what we and others are doing to address quality issues?
- Keep the end in mind, which is: improved quality and efficiency of the healthcare system. 1) Prioritize problems/opportunities, to make sure we are working on the most important things and the things that are ripe for action (is it chronic care management or something else?). 2) Transparency is a vehicle to measure of performance. We need to ask "what kind of measurement should we be doing?" Our work should be to assess different measurement systems and then get consensus on how to measure a given problem area (surgical quality, etc). 3) Publicize the appropriate information to the appropriate audiences. Consider what the different groups (consumers, group purchasers, and providers) need in the way of quality data.
- End of life issues and the allocation of resources; lack of patient trust here is very expensive. Patients and their families will insist on more diagnostics and more interventions than the clinician recommends if they do not trust their provider.
- We have to be content with the idea that improvement around quality and transparency will be accomplished with many small successes, not all at once, and not all one way.
- Important to keep in mind the human element of providing care which is harder to measure (though it is measured by way of patient and staff surveys). Non-clinical interventions can be as meaningful as measurable processes and procedures.
- Fostering trust between stakeholders

Adjourned: 4:05p.m.

**Next Meeting: March 13, 2006**

#### **Exhibits:**

- I. Agenda
- II. January 17 meeting notes DRAFT
- III. HISPC summary
- IV. 2005-2006 work plan

**Quality & Transparency Work Group Meeting Notes**  
**Oregon Health Policy Commission**  
**March 13, 2006**  
**800 NE Oregon St, Room 120B, Portland, Oregon**

**Present:** Vickie Gates, Sherry Blaskowsky, Nancy Clarke, Gwen Dayton, Lisa Krois, David Labby, Michael Leahy, Gil Muñoz, Ron Potts, Ralph Prows, Linnea Saris (for Joel Ario), Brett Sheppard, David Shute, Doug Walta

**Excused:** Jonathan Ater, Joel Ario, Geoff Brown, Bill Kramer, Keith Marton, John McConnell, Glenn Rodriguez, Jim Schwarz

**Staff:** Hanten Day, Research Analyst, Office for Oregon Health Policy & Research (OHPR)  
Tina Edlund, Data & Research Manager, OHPR  
Gretchen Morley, Director, Oregon Health Policy Commission  
Jessica van Diepen, Assistant, Oregon Health Policy Commission

**Call to order - 2:15p.m.**

- ▶ **Announcement:** Dr. Sheppard invites workgroup members to be his guests at the Portland Surgical Society's dinner entitled "The NSQIP: An Imperative that Surgeons Can No Longer Ignore" on Monday, April 3 at 6:30 p.m. at the Governor Hotel (see flyer provided). Call 503-494-7145 to reserve your seat and tell them you will be a guest of Dr. Sheppard. The keynote speaker will be Dr. Shukri Khuri who led the NSQIP adoption at the Veteran's Association.

## **Quality Improvement in Ambulatory Care – What Is Underway in Oregon?**

### **CareOregon (David Labby)**

CareOregon serves 100,000 members (6,000 of those are new dual-eligibles). It is undertaking QI on two fronts:

**Grant Program for Quality Improvement** supports quality improvement projects in its major clinics. First year had 42 projects; the only stipulation was to have a good idea. Year 2 had more than 50 projects; dedicated staff to run the program, an outside advisory board to review proposals, and now stipulates that project proposals include measurable outcomes for best practices. Currently, there are two pilot payment mechanisms for case management.

### **Complex care case management program development:**

- Moving from benefit management to population management.
- Deals with bio-psycho-social and environmental issues; identifies those who need help in a proactive way. Many are also dealing with chronic pain and cognitive impairment.
- Plan began in 1993 with dedicated nursing staff to deal with patient issues as they came up. In the last 3 years, CareOregon has added specialized staff (e.g. substance-abuse specialists, medical assistants and social workers) and implemented Adjusted Clinical Groupings (Johns Hopkins software) which uses demographic, ICD9 and pharmacy information to flag those at highest risk; members identified by the software as having a 50% or greater probability of hospitalization in the coming year and those who have other risk factors such as a recent hospitalization, are eligible for complex case management. CareOregon will contact as many of these members as it can to initiate case management.
- Initially, program seems to net cost savings, though the data are still being analyzed. Other similar programs have shown a 3-to-1 return on investment.
- Defining specific roles nursing staff and identifying interventions that are most effective. Goal is to manage the top 3-5% and ultimately the top 12%.
- CareOregon is partnering with Kaiser to measure patients' functional improvement called "Health Utilities Index" (vision, pain, mood, activities of daily living).
- Ultimate goal is for members to have a medical home based with their primary care provider, not CareOregon.

## Regence BlueCross BlueShield (Ralph Prows)

- In-house, Web-based care management for the “walking well”; allows members to see provider utilization and cost information and to seek advice; rewards and incentives for personal health management
- Health coaching program with personal trainer to help build personal wellness plan
- 24-hour nurse advice line
- Condition management program: pre-natal coaches, disease management (“predictive modeling“ uses software to identify members at high risk who are then proactively contacted by Regence)
- 2006 Initiatives: self-management (navigation of pharmacy needs, etc), medical home, evidence-based care, service integration, improving infrastructure, managing for quality at the physician level, and transparency
- Pilot Projects:
  - EHR & Connectivity: Web-based login to access hospital, lab, pharmacy and other physicians’ records. Regence will pay for interface between LaGrande Hospital and local physicians’ offices and for setup costs for 50 physicians
  - Clinical performance improvement project tracks 40 claims-based measures of ambulatory care quality; 1<sup>st</sup> set of physician-specific reports will be sent to them late next month. (Both primary and specialty care measures.)
  - Pay-for-condition (diabetes) at OHSU
  - Perinatal Quality Improvement: formation of teams with consistent training and rapid-response processes at NW Physicians Mutual
  - RFP to several Oregon clinics for infrastructure improvement for chronic condition management (similar to CareOregon grant program; this one asks clinics to build on their existing infrastructure)

## Oregon Clinic (Doug Walta)

Quality improvement efforts are specialty specific. They began at the direction of the CEO and the board; planning and implementation at the department level with the support of physicians.

- Cardiologists have adopted “Get with the Guidelines”
- Cardiac-thoracic-oncology service: a team approach to care, in which patient is seen by all three specialists who then confer on a coordinated treatment plan
- Gastroenterologists came together to decide how to measure themselves for quality (difficult to measure because complication rates are so low). Decided to start with colonoscopy, by 1) measuring withdraw times against the number of polyps identified during the procedure (slower withdraw times have shown to improve the number of abnormalities identified) and 2) with Providence Health Plan, measure the clinic’s rate of testing against the national guidelines. These data are collected and analyzed by Providence and sent back to physicians. *The challenge is EMR software compatibility.*
- Patients in need of cardiac surgery can consult the clinic website to check potential cardiologists’ records on stroke rate, death rate, and complication rate in comparison to national guidelines

## Oregon Community Health Information Network’s Support of QI at FQHC’s and the Safety Net (Mike Leahy) Handout #3

- Pilot project begins with verifiable information; it is a common community record that will be uniform across clinics. Starting with ambulatory care (100 primary care conditions) with the ultimate goal that it will be available to hospitals emergency departments and specialists.
- Applying for federal grants with OHSU and Kaiser Center for Health Research to build web portal to look at best practice (clinical, health alerts, billing, etc) for safety net organizations.
- Partnering with the Office of Rural Health to set up EMR within a rural community between its hospital and the local providers.

## **Virginia García Medical Center (Gil Muñoz)**

Virginia Garcia has participated since 1999 in the national diabetes collaborative (best practices in diabetes care: registry, process infrastructure development). The first step was information technology infrastructure development; now, they are working on using the data to actively effect case management.

## **Oregon Health Care Quality Corporation (Nancy Clarke)**

4 learnings from the state clearinghouse project "Barriers to Integrating Disease Management into Physician Practices"

- These collaborative approaches are badly needed
- There is high very high interest in collaboration
- Technical challenges are a significant issue (specifically, physician attribution)
- Infrastructure and money for this effort are badly needed
  - **Next steps:**
    - formation of regional health information organizations
    - identification of some short-term victories (sponsored by Regence, Providence, CareOregon and OHSU)

## **Oregon Medical Professional Review Organization (David Shute)**

- new AHRQ website (aggregate state-level measures) will go live Friday
- Recommendations for the workgroup and the State:
  - Align disparate reporting initiatives (several CMS projects, Q-Corp, etc); wherever possible, collaborate or combine
  - Foster alignment of quality improvement initiatives underway across the state
  - Address the financial structure/environment, especially with regard to the uninsured/under-insured. Ask:
    - Does it support the formation of medical homes and care management?
    - Does it support the development of an EHR infrastructure?
  - Look at competitive advantage issues: with EHR, with disease-management infrastructure. Does pay-for-performance discourage cooperation?

### **Discussion Summary:**

- Concern among group members that EHR is becoming or may become a competitive business tool instead of cooperative effort for efficiency and patient safety. RTI grant (if it is awarded to Oregon; we will know by mid-April) will convene many of these competitors and allow them to decide as a group if and how to cooperate on EHR adoption
- What can we do to ensure that, as physician groups and clinics adopt quality measures and tracking infrastructure, there is uniformity and compatibility?

### **Next agenda:**

- **Nancy Clarke will report on Q-Corp's common measures project**
- **Ron Potts and Sherry Blaskowski will report on Kaiser's local and national QI efforts**
- **What can the workgroup do and how can it influence players in Oregon to bring consistency, efficiency, and compatibility to emerging quality improvement and EHR infrastructure development?**

Adjourned: 4:05p.m.

**Next Meeting: April 10, 2006**

### Exhibits:

- I. Agenda
- II. February 13 meeting notes DRAFT
- III. FQHC & Safety Net handout (Mike Leahy)

**Quality & Transparency Workgroup  
Oregon Health Policy Commission  
800 NE Oregon St, Room 120  
April 10, 2006**

**Present:** Jonathan Ater, Vickie Gates, Nancy Clarke, Gwen Dayton, Bill Kramer, David Labby, Keith Marton, John McConnell, Ron Potts, Ralph Prows, Glenn Rodríguez, James Schwarz, Brett Sheppard, David Shute, Doug Walta

**Excused:** Joel Ario, Sherry Blaskowski, Geoff Brown, Lisa Krois, Michael Leahy, Gil Muñoz

**Staff:** Gretchen Morley, Director, Oregon Health Policy Commission (OHPC)  
Tina Edlund, Research & Data Manager, Office for Oregon Health Policy & Research  
Jessica van Diepen, Communications, OHPC

**Call to order: 2:16 p.m.**

**Announcement:** Dr. Sheppard will provide the workgroup with the keynote presentation from the Portland Surgical Society's April 3 dinner which makes a strong business case for the National Surgical Quality Improvement Project (NSQIP). *Staff will distribute copies of the slide presentation at the May 8 meeting.*

**Quality Improvement in Ambulatory Care: What is Underway in Oregon?**

**Providence Health System, Oregon (Glenn Rodríguez) – Tools for better population management and point-of-care coordination**

- Uses GE Centricity for outpatient EMR to keep 3 registries: diabetes, stroke prevention (anti-coagulation management, and cardiovascular disease).
- Sophisticated software tracks specific data points directly from patient charts and alerts to patients whose data indicates high risk for these conditions. Patients can be sorted by physician to measure that set against the whole clinic. These tools are most effective at the point of care, 1) especially for patients with co-morbidities, and 2) for the future financial viability of primary care.
- Changes to disease management in response to the output of this software have resulted in significant, measurable improvement (e.g. patient hemoglobin A1c levels.)
- **Practical complications to expansion/improvement of EMR:** how can multiple providers accurately track patient prescription medication list and then how can individual providers and institutions measure their own adherence to best practice in this area?
- Clinical pharmacists' involvement in the development of Virginia Garcia's EMR infrastructure demonstrates how a multi-disciplinary involvement can drive innovation and its implementation.

**Kaiser Permanente (Ron Potts)**

- The Kaiser system was founded on single patient records from which chart-abstracted (rather than claims-based) quality data is collected.
- EMR implementation is nearing universal adoption within Kaiser nationwide. Although there is an initial decrease in physician productivity at the time of implementation, in the long term efficiency is increased and physicians are pleased.
- The next step is to bring this data together in a national registry to make population research possible.

- Kaiser EMR system creates an “After-Visit Summary” which patients find valuable, especially those with co-morbidities or a need for follow-up action. “Pre-visit summaries” are provided to clinicians to remind them what to watch for with a given patient.
- Patients are able to log in online to a portion of their data (particularly lab results); soon, there will be a mechanism in place for patients to review and correct errors in their chart.
- There is still no definitive answer on the return on investment. There is unquestionably a “societal ROI”, though, and we should flesh that out at some point as a tool for communicating with providers and the public about EMR.

### **Oregon Health Care Quality Corporation (Nancy Clarke)**

- **2 projects:**
  - “Accelerator Group” meeting weekly on Tuesday nights to define the best first step for sharing electronic health information across institutions; due date is May 15. Privacy and security workgroup (dependent on grant award) will research the laws and propose policies around sharing electronic health information in time for the legislative session in January.
  - “Community conversation” with clinicians, health plans, quality experts, and government officials to agree on a common set of quality measures in the outpatient setting. 1) Basic set (claims-based), 2) Expanded set (electronic medical records for real intermediate outcome measures).
- Primary care doctors feel are anxious about changes to the payment system; they need to be integrally involved in the planning and implementation these outpatient quality measures. The question of the day is: who will own/manage the data that is generated?
- *Staff will distribute an electronic copy of QCorp’s survey of quality measures currently in use across the industry*

### **Future Agenda Items:**

- Glenn Rodriguez present Providence’s online quality tools (laptop, Web connection, InFocus)
- Payment system reform for better prevention and management
  - financial issues around pay-for-performance
  - how to incent providers to take the lead in realigning the payment system
  - being sensitive to unintended consequences to low-income patients and to doctors in depressed communities
  - Payment/delivery systems need to be reformed simultaneously; neither reform will be sustainable in isolation.

### **Exhibits:**

1. Agenda
2. March draft meeting notes
3. Q-Corp: “Measuring Health Care Value in Oregon: Ambulatory Care” (Nancy Clarke)

DRAFT

**Quality & Transparency Workgroup  
Oregon Health Policy Commission  
800 NE Oregon St, Room 120  
May 8, 2006**

**Present:** Jonathan Ater, Vickie Gates, Sherry Blaskowsky, Nancy Clarke, Bill Kramer, Lisa Krois (by phone), David Labby, Mike Leahy, John McConnell, Glenn Rodriguez, Linnea Saris (for Joel Ario), James Schwarz, Brett Sheppard, David Shute (by phone)

**Excused:** Geoff Brown, Gwen Dayton, Keith Marton, Gil Muñoz, Ron Potts, Ralph Prows, Doug Walta

**Staff:** Gretchen Morley, Director, Oregon Health Policy Commission (OHPC)  
Tina Edlund, Research & Data Manager, Office for Oregon Health Policy & Research  
Jessica van Diepen, Communications, OHPC

**Call to order: 2:14 p.m.**

**Announcement:** Welcome new commissioner, Steve Sharp

**I. Online Tour of Providence's Electronic Quality Improvement Tools (Glenn Rodriguez)**

- CareManager software features: Performance Feedback, Disease Identification, Treatment, Drug Safety, Services Due, Resources. Outpatient medical record interfaces with lab records but is not integrated into the hospital database.
- For point-of-care use
- Dramatic improvement in blood pressure control across the cohort, LDL levels, and others
- Clinical pharmacists took the lead in motivating adoption at the beginning
- Creates patient summaries and email notifications
- Tipping point for widespread use by practitioners was the development of this user-friendly tool.
- Economics: the effort has paid for itself by reminding doctors and patients to make regular visits/diagnostics that would have otherwise been forgotten or overlooked

**II. Recommendations for the OHPC Reform Plan (Updates to the September 2004 Quality Workgroup Recommendations, Handout #3)**

- Encourage participation of EVERY hospital in the Institute for Healthcare Improvement (IHI)'s Saving 100, 000 Lives Campaign (WA's version of OMPRO did this through a voluntary process).
- There is now a national standard on what an EMR is; the next step is interoperability & data sharing. This is most challenging in metro areas or communities where there is more than one hospital (single hospital communities are often well coordinated between the hospital, local providers, and pharmacies). *What can the state do in interoperability, what are the other states doing, what can our state government do in the next leg session to accelerate this?* (agenda item June)
- PEBB is already moving on this; Medicaid is the next state purchasing area that needs consideration
- *State certification "bond rating" of providers who do quality measurement and contribute those data to a transparent database?* Renewed yearly to keep parameters fresh. Concern: would set up an environment where "rich get richer, poor get poorer". Subsidies, or something, to ameliorate this?
- *Define qualitative, measurable outcomes for our recommendations*
- *Take Leapfrog off the table? What do we recommend now?*

## DRAFT

- *Microsystem changes?* Pharmacists managing blood pressure instead of physicians, etc.
- *Recommendations for payors?, for consumers?* (empowering consumers to demand QI)
- Research Triangle International (RTI) Grant (if awarded to Oregon) will need some work from this group on the policy portion of the EHR study
- *We should recommend the state to support participation in IHI by leveraging its purchasing power and by noting, e.g. on OHPR's Hospital Quality Indicators Webpage, which hospitals are participating*
- *Broaden category on "health information infrastructure" to read just "infrastructure"; what kind of tools and support do you need to support quality? Particularly with regard to disclosure and measurement.*

**Adjourn: 3:59 p.m.**

**Next Meeting: June 12, 2006**

### Handouts:

1. Agenda
2. April draft meeting notes
3. September 2004 Quality Workgroup Recommendations
4. NSQIP Slide Presentation, Portland Surgical Society Dinner, Dr. Shukri Khuri
5. "Does Volume Help Predict Outcome in Surgical Disease?", Dr. Shukri Khuri

**Quality & Transparency Workgroup  
Oregon Health Policy Commission  
800 NE Oregon St, Room 120  
June 12, 2006**

**Present:** Jonathan Ater, Vickie Gates, Nancy Clarke, Gwen Dayton, Lisa Krois, David Labby, Mike Leahy, Ralph Prows, Linnea Saris (for Joel Ario), Brett Sheppard, David Shute

**Excused:** Sherry Blaskowsky, Geoff Brown, Bill Kramer, Keith Marton, John McConnell, Gil Muñoz, Ron Potts, Glenn Rodríguez, James Schwarz, Doug Walta

**Staff:** Gretchen Morley, Director, Oregon Health Policy Commission (OHPC)  
Tina Edlund, Research & Data Manager, Office for Oregon Health Policy & Research  
Jody Pettit, MD, State Health Information Technology Coordinator, Office for Oregon Health Policy & Research  
Jessica van Diepen, Communications Coordinator, OHPC

**Guests:** Holly Mercer, Workers Compensation Division

**Call to order: 2:22 p.m.**

**I. Tiger Team (health information exchange options workgroup) Update on Electronic Health Records and Data Systems Interoperability (Handout #3), Dr. Jody Pettit**

***Discussion***

- Tiger Team initial report will be available in the next few weeks as well as a decision on funding for next steps
- What will be the largest cost for implementation of this plan? The patient match issue (correctly matching records from multiple providers to the same person)
- Privacy and security. The OHPC and the work of Oregon's Research Triangle International workgroup can serve as venues for elevating the public discussion of the pros and cons of security vs. accessibility to begin to find where in the continuum between the two the public is comfortable with landing.
  - One solution to acclimating people to the idea of digital health records might be offering a reduced premium to health plan members who opt in to an EHR.
- Inventory of current EHR infrastructure across the state is nearly complete; Jody Pettit will share that with the workgroup soon.
- American Health Information Management Association is funding educational outreach to the public about personal health records ([www.myphr.com](http://www.myphr.com))

**II. Recommendations from the Tiger Team to the OHPC**

- 1) Elevate a constructive public discussion of the trade-offs between conflicting needs to make health information available where and when it is needed while also assuring maximum privacy and security. Focus on principles, such as those promoted by the Markle Foundation's Personal Health Technology Council. (This should work in concert with the new HISPC grant.)
- 2) Provide support for efforts that will jumpstart and organize the flow of clinical information into an individual's health record (like a utility). A results viewing and retrieval system for lab results, image reports and hospital and emergency department summaries is the place to begin. This is not meant to compete with the numerous organizations that are creating personal health records; rather it is to prevent them from becoming even more silos.

- 3) Advocate for a strong state leadership role for health information exchange and EHR adoption. For example, maintenance of the State HIT Coordinator role to allow a sustained relationship and resource to educate providers and coordinate statewide adoption. (In the context of OHPR's need for resources in multiple areas.)
- 4) Support adoption of electronic health records, especially in small and rural practices, through incentives, loans and other types of assistance. (Consider the recommendations for federal support provided by the eHealth Initiative in its May 23<sup>rd</sup> letter to the Joint Finance Committee.)

**Adjourn: 4:01 p.m.**

**Assignments:**

- Jody Pettit, Gretchen Morley and workgroup co-chairs will work together before the July 10 meeting to put a recommendations proposal together for review by the workgroup
  - Consider:
    - What do we want to say to the 2007 Legislature? Do we have any legislative proposals around EHR or other quality/transparency issues and/or do we have consensus that the state should not take any action in specific areas.
    - How can the OHPC be helpful to OMAP/PEBB with implementation of incentives to providers/members for EHR adoption?
    - Flesh out the case for starting with results and reports as the initial components of the personal health record.

**Next Meeting: July 10, 2006**

**Handouts:**

1. Agenda
2. May 8 draft meeting notes
3. Slide presentation, Dr. Jody Pettit, Electronic Health Records & Interoperability and Personal Health Records, Proposed Next Steps
4. 2004 Quality Workgroup Recommendations
5. Executive Summary, March 2005 Report to the 73<sup>rd</sup> Legislative Assembly: Electronic Health Records & Data Connectivity

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**Quality & Transparency Workgroup  
Oregon Health Policy Commission  
800 NE Oregon St, Room 120  
July 10, 2006**

**Present:** Jonathan Ater, Vickie Gates, Joel Ario, Nancy Clarke, Gwen Dayton, Bill Kramer, Lisa Krois, David Labby, Mike Leahy, Keith Marton, Holly Mercer, Sherry McClure, Gil Muñoz, Ron Potts, Ralph Prows, Brett Sheppard, David Shute, Doug Walta

**Excused:** John McConnell, Glenn Rodríguez, James Schwarz

**Staff:** Gretchen Morley, Director, Oregon Health Policy Commission (OHPC)  
Tina Edlund, Research & Data Manager, Office for Oregon Health Policy & Research  
Jody Pettit, MD, Health Information Technology Coordinator, Office for Oregon Health Policy & Research  
Jessica van Diepen, Communications Coordinator, OHPC

**Guests:** Jim Dameron, Administrator, Oregon Patient Safety Commission

**Call to order: 2:17 p.m.**

**I. Discussion: Draft Recommendations to the OHPC on Electronic Health Records (EHR) and Data Systems Interoperability (Handout #3), Dr. Jody Pettit**

- The State should apply for the federal “transformation grant” for Medicaid
- Consider recommendation that the State address issue regarding ownership of patient data, t
- Consider the problems with proprietary interest as barrier to health information exchange
- State could have a role in adoption of standards
- Increase efficiencies in claims processing, perhaps as Washington and Utah have done
- Committee would like to see the interim report from the workgroups of Oregon’s Health Information Security and Privacy subcontract – this is expected to be in October.
- Consider funding a cost/benefit analysis of HIT for the State. If benefits are too difficult to capture, should still estimate statewide costs.
- Committee supports the collection of data on EHR adoption and would like to see the results as soon as available – importance of monitoring was underscored
- Consider adding the role of State as a regulator in the recommendations
- Consider State as a source for (or connector to) low-interest loans to clinics for EHR development in the tradition of the federal student loan program
- State could incentivize EHR adoption through Pay for Play – direct incentive – like California
- Committee suggested building on community initiatives e.g. OCHIN, MVIPA etc.
- Committee suggested partnership with private sector
- Public Trust is an important consideration in health information exchange and public money could be used to assure the representation of the public in the decision-making processes around health data exchange
- The work of the Markle Foundation ‘Connecting for Health Common Framework’ were referenced in the discussion about ensuring consumer participation
- The suggestion was made to focus on short-term objectives that are bold yet realistic while continuing to keep an eye on a long term vision.
- Committee would like to prioritize these recommendations into tiers or phases, for example Phase I, II, III
- In our EHR discussion, we need to always keep in mind that we are not simply converting paper-based data to an electronic medium; we need to rethink the data itself and how it is formatted to ensure that what we collect is useful for multiple goals (continuity of

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care/practice management, quality measurement, population management & research, etc.) and is portable between systems

### II. Discussion: Other Recommendations (Handout #4)

#### A. Patient Safety Commission

##### 1. Update from Jim Dameron

- 48 of 57 hospitals have already signed on to participate in the voluntary and confidential reporting program for serious adverse events. Two more are likely to sign up very soon.
- The Patient Safety Commission is also working with nursing facilities, retail pharmacies, and ambulatory surgery centers to build adverse event reporting programs appropriate to those settings
- The Patient Safety Commission is working closely with OAHHS, OMA and Acumentra Health to champion IHI's 100,000 Lives Campaign in Oregon. The four organizations represent Oregon's 100K "Node."
- The Patient Safety Commission is planning a policy summit on healthcare-acquired infections, tentatively scheduled for January 2007.

##### 2. Proposed updates to Q&T Workgroup Recommendations

- These proposed recommendations are good; add a bullet recommending state dollars for permanent staff position(s) at the OPSC. It is currently entirely dependent on industry donations; this undermines the confidence of stakeholders in the program's longevity and in the State's commitment to patient safety.
- Amend recommendation on "a surgical errors reporting program..." to read "surgical events reporting program." Also, make it clear that the surgical reporting program refers to the National Surgical Quality Improvement Program (NSQIP)

**Adjourn: 4:04 p.m.**

#### Next Meeting Agenda:

- Consider more fully the idea for a single claims processing system
- Continue to develop recommendations. First up on August agenda: discussion of the proposed recommendation entitled "Addressing the lack of information, measurement & statewide coordination" (Handout #4, page 1)

**Next Meeting: August 14, 2006**

#### Handouts:

1. Agenda
2. June 12 draft meeting notes
3. Draft Recommendations on Electronic Health Records & Interoperability
4. 2004 Quality Workgroup Recommendations & Proposed Updates