

Oregon Health Policy Board**AGENDA****July 15, 2016**

OHSU Center for Health & Healing
 3303 SW Bond Ave, 3rd floor Rm. #4
 8:30 a.m. to 12:00 p.m.

#	Time	Item	Presenter	Action Item
1	8:30	Welcome	Zeke Smith, Chair	X
2	8:45	Director's Report	Lynne Saxton, Director OHA	
3	9:15	HB 3396 Legislative intent and guidance	Sen. Monnes Anderson, Sen. Bates and Rep. Nathanson	
4	9:45	HB 3396 draft findings & discussion	Robyn Dreibelbis, Healthcare Workforce Committee Vice-Chair Sebastion Negrusa & Paul Hogan, Lewin Group Gil Munoz, CEO Virginia Garcia Health Center	
5	10:45	Break		
6	11:00	SB 440 update and discussion	Mylia Christensen & Betsy Boyd-Flynn, Q Corp	
7	11:45	Public testimony	Chair	
8	12:00	Adjourn	Chair	

Next meeting:

August 2, 2016

OHSU Center for Health & Healing
 3303 SW Bond Ave, 3rd floor Rm. #4
 8:30 a.m. to 12:00 p.m.

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Oregon Health Policy Board
DRAFT June 7, 2016
OHSU Center for Health & Healing
3303 SW Bond Ave, 3rd floor Rm. #4
8:30 a.m. to 12:30 p.m.

Item

Welcome and Call To Order, Chair Zeke Smith

Present: Chair Zeke Smith called the Oregon Health Policy Board (OHPB) meeting to order. Board members present: Zeke Smith, Carla McKelvey, Karen Joplin, Joe Robertson, Carlos Crespo, Brenda Johnson, Stacey Dodson, Oscar Arana and Felisa Hagins

The Board approved the May '16 minutes unanimously.

Zeke introduced new Board members Oscar, Stacey and Brenda and each spoke for a moment regarding their background.

Zeke briefed his legislative day's testimony and relayed a request from Rep. Greenlick to look closely at the future of CCOs and provide guidance to the Legislature and OHA. He recalled the 2010 Action Plan for Health and requested the plan be updated. Zeke will relay a timeline for an update after consultation with the Governor's Office. Joe requested further thought about how the Board will engage during the legislative session. Lynne spoke about the coming July System Transformation Quarterly Report and its importance informing a refreshed action plan.

Director's Report, Lynne Saxton, OHA

Lynne relayed that OHA is engaged in a national search for a new Oregon State Hospital Superintendent. Oscar asked about communities of color and women as part of the hiring process and Lynne relayed her personal goal to increase diversity of leadership staff and resultant success, she welcomed members of the Board to be a part of the process. Leslie re-introduced Leanne Johnson, OHA's director of the Office of Equity. Lynne then gave a tribal update regarding access and specialty care, an agency budget update, a member services update and an 1115 Waiver update. Felisa requested a summary of submitted Waiver comments and changes as a result of comments. Commissioner Joplin requested more information about tribal access and federal medical assistance percentages (FMAP) and Oscar asked about external participants on the taskforce. OHA will prepare a briefing regarding tribal taskforce work and waiver comments. Lynne relayed Jackie Mercer's role, tribal participation and internal tribal staffing updates. Lynne briefed a reduction in state hospital referrals for misdemeanors as a result of collaboration and work with 6 Oregon counties, the judiciary and law enforcement. She then briefed Oregon's performance plan for Oregonians a result of USDOJ negotiations to support those with severe and persistent mental illness (SPMI) and the state's behavioral health collaborative. Felisa asked what might happen if metrics from the USDOJ plan aren't met and Leslie informed that USDOJ will be looking for progress and demonstrated effort in recognition that outcomes are aspirational.. Lynne spoke about the behavioral health mapping tool and statewide listening session as well. Felisa asked about structural issues and access in regards to the behavioral health system and Lynne cross-walked that issue with language in the collaborative charter. Karen asked which agency has responsibility for metrics in the coming USDOJ plan and Leslie relayed OHA is responsible.

Lillian Shirley briefed the Board regarding the Public Health Division work on Cleaner Air Oregon, lead in drinking water, childhood marijuana prevention pilot and Cascadia Rising. She emphasized the Division's is ensuring environmental issues are informed with a health lens and that rulemaking will continue; official public notice and comment period ended at the end of May. She relayed a second

release of monitoring information is coming and that this work will continue. She briefed communication structure codification and rapid responses designed to deal with emerging issues more quickly. OHA is working with local school districts, state education department and early childhood infrastructure regarding recommendations about lead in water. OHA will provide technical assistance and implementation support and show how to test, where to get tests analyzed, how to shut off the tap, how to communicate results and how to mitigate problems. Carla asked if Lillian had received reports showing elevated lead levels in children. Lillian replied that there is clinical evidence and reports to OHA of elevated lead. Lillian briefed a change in the benchmark for lead tests, 5 parts per billion versus 10. She reported paint dust is responsible for 80% of positive tests for lead. Carla asked for inclusion of local healthcare providers in the process and recommendations. Lillian will ensure local healthcare providers are included in the process and passed on that this is being addressed statewide. Lillian then briefed the childhood marijuana prevention pilot. Carla relayed her concern and Joe agreed regarding children and marijuana prevention. Zeke asked for a copy of the webinar prepared by Public Health for the Board regarding medical marijuana and Felisa asked that department of education and department of human services be included and that lessons learned from the anti-smoking campaign be adapted. Oscar asked about targeted education for specific communities and various language. Finally, Lillian briefed Cascadia Rising, a coordinated functional exercise simulating complex responses and procedures to an earthquake and/or tsunami and OHA's physical and mental health responsibilities.

Workforce Committee Update

Carla briefed HB 3396 2015 regarding Board recommendations for provider recruitment and retention and the progress to date. She relayed issues with related data and briefed listening session plans. Felisa asked if listening session information had been passed to licensing boards and OHA staff responded that it would be. Joe asked about recruitment and retention beyond incentives and Carla relayed the Board is responsible for recommendations as well.

Value Based Payments Discussion

Marge Houy of Bailit Health Purchasing presented on value based payments, the presentation is available in [meeting materials](#). Carla spoke about a risk determination system to identify medical and/or social risks and noted it hasn't been used in payment systems. She noted that bundled and integrated service's data should be captured and prioritized before setting a benchmark. Carlos noted population health metrics were important and asked how many CCOs have a comprehensive community health improvement plan and what stage they are at. Joe said he appreciated the review and need for continued innovation, he noted concern with provider burnout and how the provider should be supported in practice change. He mentioned the quadruple aim, the fourth element being provider satisfaction. Felisa relayed her surprise and concern with the lack of CCOs implementing VBPs, she noted where CCOs have the most flexibility to negotiate they have more VBPs but where they have less power to negotiate they have less VBPs. She mentioned hospital and pharmaceutical costs and need to empower CCOs to implement VBPs in that space. She recalled the Board's Medford trip and bifurcation in payment models where multiple CCOs exist. Brenda advocated for long term trajectory thinking to enable delivery system success, she asked about total cost of care issues around interventions and data as well as integrated plan design. Karen asked about how to use data as presented, she recalled 2 CCOs in supplemental payment design and asked what the obstacles were to the other CCOs. She asked for an analysis regarding why other CCOs are doing what they're doing to implement VBPs. She emphasized asking questions to find out what's producing presented data. Carla noted the industry standard is still fee-for-service and issues documenting VBPs as opposed to intervention codes. She asked if the state's data collection systems penalize VBPs. Lynne noted CCO infrastructure needs for a stable financial model and previous challenges with rate development and data challenges originating from data

systems. Zeke noted the sequence of VBPs as presented as a continuum and talked about making sense of data regarding CCOs and VBPs. He remarked on the role the state has to hold the right amount of tension regarding supporting continued movement towards VBPs. Marge noted the most challenging link is moving from fee-for-service to pay for performance and discussed models on the continuum which support advanced VBPs. She noted the number of providers and primary care providers incented to cooperate and collaborate is crucial. When discussing the role of the state she relayed the importance of the state collecting and analyzing data to help CCOs move forward with VBPs. She advocated for consistency across payers so benefits of transformation are clear and adequately financed. She spoke about technical assistance for CCOs from the Transformation Center for providers that aren't early adopters and who need assistance as well as the opportunity for alignment through the state's sizable purchasing power.

Value Based Payments Panel

Bill Guest & Dean Andretta of Willamette Valley Health CCO presented first, followed by Christi Siedlecki of Grants Pass Clinic and Will Brake of AllCare.

Dean presented on 4 risk groups and risk adjusted sub-capitation paid on rate group category as well as case rates they use. He shared info on embedded behaviorists and sub-capitation agreements with the local county mental health provider and 4 local dental care organizations (DCOs). Bill noted mental health access issues and legacy DCO agreements. Dean spoke about quality incentive alignment at the provider level and the challenge of using claims and encounter data to drive VBPs. Bill raised concerns with measures and lack of payment for improvement if benchmarks aren't reached. Dean said the big challenge is specialty care because their OHP book of business isn't large enough to motivate VBPs, he noted the opportunity with PEBB & OEBC and need for community wide health delivery system change.

Christi briefed VBPs used at Grant's Pass clinic to include supplemental payments, shared savings and risk and sub-capitation. The local CCO and patient centered primary care home (PCPCH) both helped drive the adoption of these VBPs. She noted challenges with payer alignment and the need for data to do VBPs. The number of patients and specific support offered by payers are key criteria used to decide which VBP to utilize. She relayed a key lesson learned is to not chase money but focus on improving care across the continuum. She noted the need for reduced administrative burden and payer alignment as well long term financial support to plan around as well as provider and staff recruitment. She advocates for enhanced primary care support as well as building relationships. Felisa asked if the clinic had reached out to payers and asked for alignment on metrics. Christi said they haven't done that; they have about a dozen direct payers.

Will briefed VBPs used by AllCare, his presentation and further material is available in the [meeting materials](#). Will relayed they have an adjusted capitated model similar to the state's methodology for Josephine county and use fee-for-service for the other two counties they serve. He noted specialty, oral and behavioral health VBPs were a challenge and they engaged heavily with the community. AllCare sub-capitates with four DCOs and contracts directly with one. He noted challenges with shared saving models for specialty care around selecting measures. He said everything outside primary care requires innovation to use VBPs and that more time should be allowed before standardization is pursued. He noted the value of community relationships. Felisa asked about provider contract retention and Will said they have had no provider drop out of VBPs. Brenda asked how focusing on social determinants of health will interface with VBPs and the CCO. Will responded with some examples of local programs and shared that there is ongoing internal and community discussion to bring forward measures based on social determinants of health.

Christi noted that screening for social determinants of health is a challenge because there's not a clear next step after the screening, and Carlos said they need to be measured. Karen asked Bill how WVCH is rewarding and incenting follow-up mental health screening and Bill replied that two members of the CCO board of directors are county mental health representatives. He spoke about a few process measures in place and continuing dialogue to make improvements. Karen asked Christi how she pays for behavioral health integration and Christi said they give space to the county mental health provider and the effort is supported by the local CCO. Carlos asked about sub-capitation and asked where community health improvement would fit in shared savings priorities. Bill said that model was the intent, but that's not what's being implemented given CMS' needs for actuarial soundness. Leslie will follow-up with a medical and social service spending report. Zeke asked the panel what one thing they'd like to see to create more space for VBP adoption. Bill said the state needs consistency and time for system change once an incentive is introduced. Dean spoke about the potential of CPC+ because of the improved alignment at the practice level beyond OHP. Christi advocated for CPC+ and supporting CCOs at the local level. Will noted when the state makes a decision about measures there's months' worth of work needed at the practice and provider level and asked for patience. Brenda asked Bill if the waiver has flexibility for a global budget to address the concerns he raised. He spoke about the need for local flexibility and innovation as well as spreading best practices through the Transformation Center. He noted concerns with the waiver which may force less integration and asked barriers be removed from true dental and mental health integration.

Felisa asked about next steps in this work. Leslie relayed that the Board has a couple legislative placeholders that may be used after a statutory barrier analysis is completed. Lynne noted the Agency's workplan is inclusive of this conversation and passed on the mission of the state behavioral health collaborative to make recommendations. She asked the Board to consider how oral health recommendations might be addressed. Zeke noted four opportunities for action for the Board including legislation regarding value based purchasing, SB 440 data plan, SB 231 recommendations regarding primary care spending and providing guidance to the legislature and OHA about the future of CCOs. Felisa spoke about local payment alignment and opportunities in local communities where the majority of payers are public and proposed the Board engage in helping enable pilots around local community payment type alignment. Carla asked if the Board can make recommendations to SB 231 collaborative or receive recommendations and Leslie said it's a partnership and the collaborative will report back. Lynne asked that Board members receive the SB 231 collaborative schedule.

OHPB Priorities Discussion

The Board discussed their priorities and the role they can play to engage and move those priorities forward. Felisa expressed a preference for a process that engages committees beforehand and Karen noted the coming priority briefings will inform the conversation. Dr. Robertson spoke about the coming legislative session and framing conversations and context for health policy issues likely to be legislated, like the future of CCOs. The Board's priorities are ongoing but the future of CCO conversation is timely. Zeke posited questions about what the Board can impact and influence in the next 6 months related to CCOs and the Board's priorities and noted the difference in roles developing policy between OHA and the OHPB. Felisa noted a role for the Board taking positions on coming legislation before September. Carlos spoke about SB 440 metrics which will inform gaps and priorities. Joe noted the Board could agree on principles and the "spirit" of transformation, e.g. common data set. The Board affirmed its role regarding defining what a CCO is as well as its legislative role. Zeke recalled the Board's responsibility to represent and listen to consumers and solicited future feedback from Board members regarding input and engagement in the legislative process and long term priority planning.

<u>Public Testimony</u>
John Mullin provided comments regarding the Board's charge and the 1115 Waiver. He supported Felisa's request to receive the waiver comments and OHA's responses.
OHPB video and audio recording To view the video, or listen to the audio link, of the OHPB meeting in its entirety click here .
Adjourn

Next meeting:

August 2, 2016

OHSU Center for Health & Healing

3303 SW Bond Ave, 3rd floor Rm. #4

8:30 a.m. to 12:30 p.m.

House Bill 3396

Oregon Provider Incentive Programs

July 15th, 2016



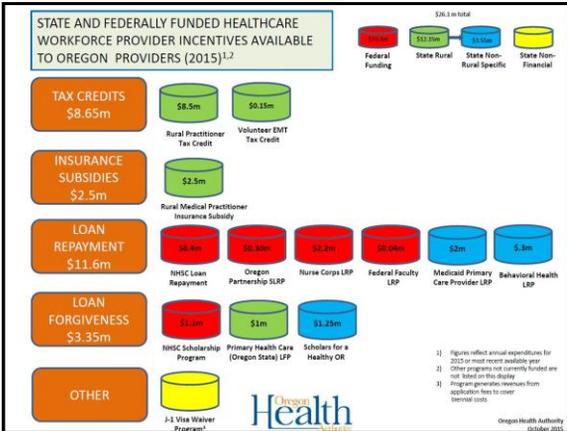
HB 3396 Background

- HB 3396 - Legislature's intent to "initiate a close look at how tax dollars are spent [on provider incentives] to ensure that taxpayers enjoy the best possible value..."
- Bill extends the sunset on the existing rural health care provider tax credits for two years and makes minor adjustments to the law concerning who may receive the credits.
- Bill repeals most existing other incentive programs and replaces with the Health Care Provider Incentives Fund; a single OHA-directed health care provider incentives program.



HB 3396 Background (cont.)

- Directs the Oregon Health Policy Board to study and evaluate the effectiveness of the financial incentives offered by the state to recruit and retain providers in "rural and medically underserved areas."
- Requires the Health Policy Board to make recommendations to the Legislature regarding:
 - Continuation, restructuring, consolidation or repeal of existing incentives
 - Priority for directing the incentives offered by Health Care Provider Incentive Fund
 - Establishment of new financial incentive programs
- The Health Policy Board is directed to make a final report to the Legislature by September 2016.

Oregon Programs Using State Funding

Programs in Oregon	Description
Rural Medical Practitioners Insurance Subsidy Program	<ul style="list-style-type: none"> Administered by OHA (since 2003) Provides subsidies to qualifying physicians and NPs in rural areas to offset cost of medical malpractice insurance Funding: \$2.5 million/year
Medicaid Primary Care Loan Repayment Program	<ul style="list-style-type: none"> Administered by OHA (since 2013) Provides loan repayment for providers serving Medicaid patients in Oregon Funding: \$4 million (2013-2015)
Scholars for a Healthy Oregon Program (Loan Forgiveness)	<ul style="list-style-type: none"> Administered by OHSU (established in 2013) Offers full tuition and fees to 21 OHSU medical, PA, Dental and APN students in exchange for obligation to serve in a OHSU approved underserved site for a stipulated period Funding: \$2.5 million (2013-2015)
The Oregon State Loan Forgiveness Program	<ul style="list-style-type: none"> Administered by Office of Rural Health (established in 2010) Provides loan repayment to 2nd/3rd year students who are enrolled in Oregon rural training track for funding up to 3 years Funding: \$700,000 (2013-2015); typical awards are \$35,000/year
Primary Care Services Loan Repayment Program	<ul style="list-style-type: none"> Administered by Office of Rural Health Provides loan repayment to providers offering primary care services in exchange for at least 3-years of service in underserved and rural areas (2-years for PA/NPs) Funding: currently unfunded
Rural Practitioner Tax Credit	<ul style="list-style-type: none"> Administered by Office of Rural Health and Oregon Department of Revenue (since 1989) Provides \$5,000 tax credit annually to eligible providers, optometrists, and dentists Funding: \$8.5 million/year
The Volunteer Rural Emergency Medical Service (EMS) Tax Credit	<ul style="list-style-type: none"> Administered by the Office of Rural Health and Oregon Department of Revenue (since 1989) Provides a \$250 tax credit for emergency medical respondents in rural areas (25 or more miles away from population centers) Funding: \$150,000/year
Behavioral Health Loan Repayment Program	<ul style="list-style-type: none"> Administered by the Office of Rural Health Offers loan repayment to behavioral health workers in exchange for at least 1 year of service in Mental Health Professional Shortage Areas Typical award is up to \$20,000 per participant per year of obligatory service

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Oregon Programs Using Federal Funding

Programs using Federal Funding	Description
Oregon State Partnership Loan Repayment Program (SLRP)	<ul style="list-style-type: none"> Provides loan repayment in exchange for a 2-year service obligation in Health Professional Shortage Areas Funding (HRSA): \$300,000/year and typical awards are up to \$35,000/year
National Health Service Corps (NHSC) Loan Repayment	<ul style="list-style-type: none"> Provides loan repayment to primary care providers in exchange for service obligation in Health Professional Shortage Areas Funding (HRSA): \$4.6 million/year and typical awards are up to \$50,000 for a 2-year commitment
National Health Service Corps (NHSC) Scholarship Program	<ul style="list-style-type: none"> Provides scholarship to pursue primary care and commit to serve in Health Professional Shortage Areas Funding (HRSA): \$1.1 million (2013)
Nursing Education (NELRP) Loan Repayment Program	<ul style="list-style-type: none"> Provides loan repayment to Registered Nurses and Advanced Nursing Practitioners in exchange for a minimum of a 2-year service in Health Professional Shortage Areas Funding (HRSA): \$1.2 million (2013)
Federal Faculty Loan Repayment Program	<ul style="list-style-type: none"> Provides loan repayment to health professions graduates from disadvantaged backgrounds who serve as faculty at an eligible health profession college or university Pays up to \$40,000 in exchange for at least 2-year service in Health Professional Shortage Areas Funding (HRSA): \$44,000 (2013)

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HB 3396 Stakeholder Engagement

Bill requires Health Policy Board, in developing recommendations, to consult with a number of organizations.

To fulfill stakeholder engagement requirement, OHA engaged in a comprehensive, multi-pronged engagement strategy:

- 3396 Steering Group: meets monthly, has guided the activity of Lewin by providing feedback and responses to Lewin's analyses and deliverables; reports back to HCWF Committee bi-monthly.
- Health Care Workforce Committee: meets bi-monthly, provides oversight for the completion of the work required for the Health Policy Board to fulfill its legislative obligations.
- Health Policy Board: develop and provide to the Legislature a set of recommendations with respect to Oregon's health care workforce incentive programs.
- Rural Listening Sessions: members of the Steering Group, Health Care Workforce Committee, and OHA staff convened 5 regional meetings across Oregon



Health Care Workforce Committee

- Health Care Workforce Committee established in 2009 by House Bill 2009
- Committee reports directly to the Oregon Health Policy Board
- Committee advises the Oregon Health Policy Board on Oregon's healthcare workforce including:
 - Regular analysis and reporting of workforce supply and demand in Oregon;
 - Develop recommendations and action plans for implementing the necessary changes to train, recruit and retain a dynamic health care work force scaled to meet the needs of new systems of care; and,
 - Identify resources, needs, and supply gaps, and works to ensure a culturally competent workforce reflective of Oregon's increasing diversity.
- Committee is comprised of 15 individuals from across Oregon intended to represent the diversity of the state



HEALTH CARE AND HUMAN SERVICES POLICY, RESEARCH, AND CONSULTING - WITH REAL-WORLD PERSPECTIVE

Evaluation of Health Care Workforce Incentives in Oregon

Prepared for Oregon Health Policy Board

July 15, 2016

Purpose of the Lewin Evaluation

Lewin Study Objectives:

- ▶ Estimate how effective current provider incentive programs are in attracting and retaining health workforce into rural and underserved areas in Oregon
- ▶ Consider new programs (if feasible and necessary), scale up or down current programs, and leverage resources to complement current programs
- ▶ Recommend ways to improve data collection for workforce policy-making in Oregon



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Project Overview

We completed the following steps to address the main objectives:

- ▶ Reviewed descriptive statistics on:
 - distribution of providers, program participation, patient population by target areas
- ▶ Conducted estimates of supply and demand by provider type (using Oregon APAC and national Provider-360 database of providers)
- ▶ Considered factors related to incentive programs:
 - funding, program design, literature review on the effectiveness of such programs
- ▶ Estimated program recruiting and retention effects
 - expressed in terms of additional FTE-years generated by the program
 - calculated cost of attracting an additional FTE-year, by program and provider type

▶ Formulated (preliminary) program and policy recommendations



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Evaluation Method of Oregon Incentive Programs

We measure the impact of the incentive programs in two related ways:

- A "recruiting effect" - attracting providers into a targeted area who otherwise would not be there
- A "retention effect" - inducing providers to stay in the targeted areas longer than they otherwise would

We combine these effects with an estimate of the program cost to form a measure of the cost of one additional FTE-year in targeted areas



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Key Findings

- ▶ We find that all of the programs have a positive effect on increasing FTE-years in rural and underserved areas
- ▶ Some programs have both a recruiting effect and a retention effect while others are largely limited to a retention effect
- ▶ The added cost of attracting an additional FTE-year, while it varies among programs, is of the same magnitude across programs

Summary of Positive Effects for Oregon Programs

	Providers	Recruiting Effect (FTE-years)	Retention Effect (FTE-years)	Total Effect due to Program (FTE-years)
Primary Care Physicians				
RPTC	827	0	736	736
RMPIS	459	0	459	459
SLRP	26	39	13	52
BHLRP
MCPLRP	8	15	4	19
NHSC	84	99	32	131
NHSC & RPTC	30	58	18	76
NPs and PAs				
RPTC	632	90	510	600
RMPIS	78	54	57	111
SLRP	20	56	7	63
BHLRP	14	39	5	44
MCPLRP	15	43	5	48
NHSC	108	301	40	349
NHSC & RPTC	74	250	28	278

- ▶ A program is effective if it increases number of FTE-years beyond the number of FTE-years in targeted areas without program
- ▶ All programs increase FTE-years in rural areas over and above the level without programs (last column)
- ▶ Estimates are based on the number of unique providers in each program (2011-2015)
- ▶ FTE-years are a function of:
 - the recruiting and retention effects
 - expected number of rural area

NOTE: Due to lack of data, calculations for the state LRPs assume the same retention rates and recruiting effects as in the case of the NHSC program.

Marginal Cost per Additional FTE-Year

- ▶ The marginal cost per additional FTE-year is calculated as the ratio between:
 - The program cost to attract an additional provider FTE in the targeted area
 - FTE-years induced by the program (recruiting and retention effects)

	PC Physicians			NP/PAs		
	Average cost (\$)	Cumulative Cost (\$)	Marginal cost (\$)	Average cost (\$)	Cumulative cost (\$)	Marginal cost (\$)
RPTC	5,000	18,350	20,787	5,000	17,800	18,940
RMPIS	3,890	14,626	14,820	3,890	14,081	9,866
SLRP	25,000	65,000	31,756	25,000	65,000	20,587
BHLRP	25,000	65,000	31,756	25,000	65,000	20,587
MCPLRP	25,000	65,000	31,756	25,000	65,000	20,587
NHSC (No RPTC)	25,000	65,000	31,756	25,000	65,000	20,587
NHSC & RPTC	30,000	94,000	36,908	30,000	91,000	24,233

NOTE: Due to lack of data, calculations for the state LRPs assume the same retention rates and recruiting effects as in the case of the NHSC program.

A Projection of Demand and Supply of Providers in Oregon

Provider Type	Projected Demand						Projected Supply					
	2015	2016	2017	2018	2019	2020	2015	2016	2017	2018	2019	2020
Primary Care Physicians	7,094	7,146	7,250	7,358	7,469	7,580	6,883	6,917	6,952	6,987	7,022	7,057
Specialty Care Physicians	4,889	4,776	4,821	4,906	4,995	5,088	4,505	4,631	4,761	4,894	5,031	5,172
Behavioral Health	5,487	5,468	5,521	5,549	5,587	5,618	5,291	5,317	5,344	5,371	5,398	5,425
Dentist	2,963	2,985	3,028	3,068	3,115	3,156	2,856	2,857	2,858	2,859	2,859	2,860
Physician Asst.	1,495	1,512	1,535	1,557	1,582	1,608	1,455	1,497	1,541	1,585	1,631	1,679
Nurse Practitioner	2,337	2,348	2,376	2,407	2,439	2,465	2,241	2,381	2,507	2,640	2,780	2,927

- ▶ Demand for health care services and providers are projected to increase through 2020 (APAC data)
- ▶ Supply of primary care physicians is projected to increase slower than demand for primary care physicians
- ▶ If same trends, future supply and demand for PAs and NPs appear to be in balance and may, in fact, substitute for primary care physician shortfall
 - ▶ Caveat: visits are lower in rural areas; this may not reflect lower demand, but rather provider shortage
 - ▶ Taking this into account, results in a greater demand than supply
- ▶ The projected demand was constructed using Oregon's APAC data

Conclusions

- ▶ Evidence suggests that current loan repayment programs have an impact on:
 - Inducing providers into target areas and
 - Retaining them longer than in the absence of the program
- ▶ Oregon's Rural Medical Practitioners Insurance Subsidy Program (RMPIS) in combination with Rural Practice Tax Credits appear to have an impact on recruiting new nurse practitioners (PAs) in rural areas
- ▶ Oregon's Rural Practice Tax Credits and Rural Medical Practitioners Insurance Subsidy Program also appear to retain providers longer in rural areas, when compared to the retention of non-participating providers
- ▶ Programs appear to be more cost efficient in attracting and retaining NP/PAs in targeted areas relative to physicians
- ▶ Marginal costs per additional FTEs appear to be roughly of the same order of magnitude for all programs
- ▶ The "recruiting effect" offers greater leverage to increasing providers in targeted areas than the retention impact alone

Preliminary Recommendations

- ▶ For limited-funding programs, where qualified applicants exceed awards available, consider allowing eligible applicants to "bid" additional years of obligated service
- ▶ Offer larger awards to loan repayment program participants who obligate to serve additional years
- ▶ Attract more providers who serve in rural areas only as a result of the programs
 - It decreases the cost of additional FTE-years, since some providers stay beyond obligation
- ▶ Add program features that would induce providers to move to such an area
 - E.g., a moving expense stipend, or a cash bonus

Preliminary Recommendations (cont'd)

- ▶ Make award of state loan repayment program award conditional on moving to a qualified area
 - It increases the number of providers who are induced to serve by the program
- ▶ Increase awareness on the availability of programs
 - Some providers may be induced to serve in rural areas once they learn about them
- ▶ Allow providers to participate in multiple programs
 - E.g., Oregon's Rural Practice Tax Credits and Rural Medical Practitioners Insurance Subsidy Program has a larger recruiting impact than participation in only one program
- ▶ Increase award amounts overall, given the increasing amount of student debt
- ▶ If feasible, increase number of awards of state loan repayment programs

Preliminary Recommendations (cont'd)

- ▶ To maintain and increase retention:
 - Increase level of community support
 - Combine benefits (e.g., allow LRP to be combined with RPTC post-obligation)
 - Include obligation to serve one or more years for non-obligation programs
- ▶ Allow for different award amounts by provider type
 - Award amounts have more value for non-physicians compared to physicians

Preliminary Recommendations (cont'd)

- ▶ Track data on *all* program applicants over time, and add other provider characteristics
 - Such data is valuable in better assessing the impact of the program
 - Isolate impact of non-program factors on the providers' decision to move to target areas (such as rural upbringing, race/ethnicity, marital status, family size, compensation etc.)
- ▶ Combine APAC data with data on program participation over time
 - It will allow for a clear tracking of the volume and nature of services supplied by providers in general, and participating providers in particular, in target areas
- ▶ Field a survey to obtain more detailed information on providers' socio-demographic characteristics, their background and experiences

Key Qualifiers and Limitations

- ▶ Provider 360 (P360) database and Oregon administrative data do not include individual characteristics that are relevant for the analysis
- ▶ P360 counts of providers are larger, since they include all licensed providers—recognizing not all licensed providers are actively practicing
- ▶ A large fraction of participants have been identified in P360, but not all
- ▶ Program participants in SLRP, BHLRP and MCLRP are few due to "newness" or these state funded programs
 - We approximate recruiting and retention effects of the programs using NHSC LRP
- ▶ Short timeframe for the data: 2011-2015
 - Some of our recruiting and retention effects are potentially understated
- ▶ Retention effects are based on retention differences between participants and non-participants
 - With current data and current data fields, cannot determine if this difference is *entirely* due to program → potentially overstating some retention effects
- ▶ Without link to claims data, we cannot determine volume of services generated by the programs
- ▶ Geography level was "rural area"; smaller or different levels of aggregation are not feasible with current data

HB 3396: Oregon Provider Incentive Listening Sessions

Robyn Dreibelbis, Vice Chair,
Oregon Health Care Workforce Committee

Five Listening Sessions Held



Prineville
Pendleton
Roseburg
Lebanon
Astoria



Purpose of Listening Sessions

- Hear from community members, providers, clinics, and hospitals on what works and doesn't work
- Provide an opportunity to receive input and feedback on Lewin's data and preliminary findings across different rural communities
- Receive feedback on what are the unmet needs among rural communities and what else should be explored in terms of ensuring an adequate primary care work force



Summary of 3396 Rural Listening Sessions

- Heard from more than 100 Oregonians
- 24 counties represented
- 13 of 16 CCOs covered
- Range in number of people participating from 12 to more than 60
- Members of the Health Care Workforce who attend listening sessions:
 - Jeff Papke (Prineville)
 - Dan Saucy (Roseburg)
 - David Pollack (Lebanon and Astoria)
 - Jeff Clark (Astoria—by phone)



What Was Shared — Key Themes



Prineville (June 20th)

- We need to do a better job of "grow your own"
- Need more primary care residency programs/slots
- Retirement options needed
- Benefit from larger packages/solutions than just "loan repayment"
- Compensation important, but fit in the community important as well
- Need to distinguish between short-term and long-term solutions; need both in rural Oregon

"If loan repayment is it, you will simply have a revolving door—no retention...and it's more than compensation. It's family, quality of life and having a rewarding career..."

Rural Provider



What Was Shared — Key Themes



Pendleton (June 21st)

- Pharmacists are missing from eligibility for many programs and there's a need
- Loan repayment amounts are too low, tax credits too low. Better than nothing but need larger amounts to provide a bigger enticement
- Need more training, rural rotations, residency slots
- Workforce is aging; there's a crisis that is almost here
- J-1 program is working; tax credit helpful (although low); need to expand SLRP

"There's a very aging workforce among primary care docs, which is only going to exacerbate the shortage we're already facing..."

Hospital Executive



What Was Shared — Key Themes



Roseburg (June 27th)

- Federal resources available through federally funded incentive programs are not enough
- Preceptors and mentoring is costly
- Too much uncertainty with whether the incentive programs will continue to provide awards over multiple year period
- Offer a new kind of scholarship program for people willing to go rural
- Lots of burn-out in rural practices
- Recruitment and retention a full-time job

"If we didn't have J-1 we wouldn't be in business...J-1 is a lifesaver!"

Rural Practitioner and Clinic Owner



What Was Shared — Key Themes



Lebanon (June 28th)

- Not enough residency slots—need to invest lots more in Graduate Medical Education (GME)
- Rural tax credit very important
- Compensation a larger challenge in rural Oregon
- Incentive programs should be available to all, regardless of institution
- Within local communities, bidding wars for local health care providers a real problem
- Retirement an issue

"The real question is what's the impact if we don't invest in these incentive programs..."

Rural Provider, 30+ Years in Medicine



What Was Shared — Key Themes



Astoria (June 29th)

- Inadequate housing in the community for training or locating doctors
- Significant lack of behavioral health providers
- HPSA (Health Professional Shortage Areas) scores too volatile
- Allow individuals to request longer-term service commitments than 2-3 years.
- Provide paid continuing education for those in the incentive programs to deal with burnout and help inspire providers

"Administrative simplification of the programs would be a huge value-add."

Rural Hospital Executive



Next Steps for 3396

- Lewin Study: final report and recommendations to OHA – **August 1st**,
- OHA report from 3396 Rural Listening Sessions – **August 1st, 2016**
- Health Care Workforce Committee Meeting – **Mid-August** (TBD)
- Oregon Health Policy Board – **September 6th**
 - Review and approve formal recommendations for submission to the Oregon Legislature by September 30th.



Additional Information

- Oregon Health Care Workforce Committee
<http://www.oregon.gov/oha/OHPR/HCW/Pages/index.aspx>
- HB 3396 – Oregon Provider Incentive Programs
<http://www.oregon.gov/oha/OHPR/HCW/Pages/Current-Work.aspx>
- Provider Incentives Comment – public comment submission (through August 31st)
<http://www.oregon.gov/oha/OHPR/HCW/Pages/Current-Work.aspx>
- Marc Overbeck, Director, Oregon Primary Care Office
 - Email: Marc.Overbeck@state.or.us
 - Phone: 503.373.1791





MEMO

To: Oregon Health Policy Board
From: Oregon Health Authority
Date: June 6th, 2016

Subject: Update and Next Steps on HB 3396

This memo is intended to provide stakeholders in Oregon's health care workforce provider incentive programs an initial, written update on Oregon's progress in addressing House Bill (HB) 3396 -- including ongoing stakeholder engagement activities and upcoming opportunities to provide input. These activities, in sum, are to address the legislature's charge to the Oregon Health Policy Board (OHPB) to provide recommendations on the future of health care provider incentives in Oregon by *September 1, 2016*.

Members of the 3396 Steering Group would like to share with interested parties key next steps as we understand them at this point, including where we hope to engage your thinking in a focused way around this work.

Background

HB [3396](#) articulates and responds to the Legislature's intention to "initiate a close look at how tax dollars are spent [on provider incentives] to ensure that taxpayers enjoy the best possible value..." The bill extends the sunset on the existing rural health care provider tax credits for two years and makes minor adjustments to the law concerning who may receive the credits. Additionally, the bill establishes the Health Care Provider Incentives Fund, to fund an OHA-directed health care provider incentives program.

The bill also directs the Health Policy Board to study and evaluate the effectiveness of the financial incentives offered by the state to recruit and retain providers in "rural and medically underserved areas" and make recommendations to the Legislature regarding:

- Continuation, restructuring, consolidation or repeal of existing incentives;
- Priority for directing the incentives offered by Health Care Provider Incentive Fund; and
- The establishment of new financial incentive programs.

In July 2015, the Oregon Health Policy Board adopted a [charter](#) directing the Health Care Workforce Committee (HCWF) to deliver to the Board a study and report on the efficacy of Oregon's provider incentives and recommendations on improvements to the current incentive, principally HB 3396. Oregon's Health Care Workforce Committee serves as the primary forum for stakeholder engagement for HB 3396. In relation to HB 3396, the committee's roles are to:

- Support selection of vendor
- Provide key input in determining criteria for evaluating the effectiveness of incentive programs
- Assist vendor with stakeholder engagement
- Review progress over time and provide direction to vendor and OHA staff
- Review incentive provider study from vendor and companion report to Health Policy Board

3396 Provider Incentive Study: Lewin, LLC

In January 2016, through a competitive procurement process OHA contracted with the Lewin Group, LLC to perform a series of tasks designed to ensure OHA and Health Policy Board are able to fulfill the requirements specified in HB 3396. Summarized below are the tasks OHA contracted Lewin to complete by *August 1st, 2016*.

- Task 1—analysis of Oregon health care market, provider data and Oregon’s existing provider incentive programs; tentatively due, April 30th.
- Task 2— evaluation of program effectiveness and efficacy of Oregon’s existing provider incentive programs; due, May 31st.
- Task 3— Development of policy and program recommendations; due, June 30th.
- Task 4— stakeholder engagement, February-July.
- Tasks — 5-6: development of reports and presentations to key stakeholders; due, July 31st.

Stakeholder Engagement

HB 3396 requires the Oregon Health Policy Board, in developing recommendations, to consult with a number of organizations including Graduate Medical Education Consortium, the Oregon Healthcare Workforce Institute, the Oregon Office of Rural Health, and the Oregon Center for Nursing among other appropriate entities. Summarized below is a comprehensive, multi-pronged strategy developed with input and guidance from the Health Care Workforce Committee (HCWF) and key stakeholders that serve on an external advisory group (i.e. 3396 Steering Group).

- 3396 Steering Group: meets monthly, Jan-July; intended to inform and guide the activity of Lewin in fulfillment of the RFP including providing feedback and responses to Lewin’s analyses and deliverables; reports back to HCWF Committee bi-monthly.
- Health Care Workforce Committee: meets bi-monthly, provide oversight for the completion of the work required for the Health Policy Board to fulfill its legislative obligations under HB 3396.
- Oregon Health Policy Board: adopt and provide to the Oregon Legislature a set of recommendations with respect to health care workforce incentive programs.
- Regional Listening Sessions: members of the Steering Group, Health Care Workforce Committee and OHA staff will convene 4-5 regional meetings across Oregon to solicit feedback on the use of provider incentive programs; tentatively scheduled for June.

Progress to Date: February thru May 2016

Lewin Deliverables

- February: Lewin submitted a comprehensive work plan and analytic plan.
- March-April: Lewin engaged the 3396 Steering Group and HCWF Committee; completed complete Task 1 as of May 15th.

Stakeholder Engagement

- 3396 Steering Group: OHA has convened an external group to help inform Lewin in its work. The committee meets monthly and includes members of the Health Care Workforce Committee, Oregon Health Workforce Institute, Oregon Center for Nursing, Oregon Office of Rural Health and Oregon Association of Hospitals and Health Systems.

Next Steps: June through September 2016

Lewin Deliverables

- Task 2 – Findings from Program Effectiveness and Efficiency: written report and supporting documentation on assessment of Oregon’s provider incentive programs; due May 31st.
- Task 3 – Policy and Program Recommendations; due June 30th
- Task 4 – Stakeholder Engagement (see next section)
- Task 5 – Final report to Health Care Workforce Committee and Health Policy Board; July 31st.

Stakeholder Engagement

- Monthly meetings of the 3396 Steering Group (January through July)
- Report and discussion by the Health Care Workforce Committee on Lewin’s data analysis, recommendations and final report (July 6th) in which public comment will be accepted.
- Formal stakeholder engagement by OHA and Health Care Workforce Committee through in-person meetings in multiple regions of the state, aided through technology around the evaluation of programs and the preliminary recommendations (March, May -- July).
- Oregon Health Policy Board—present Lewin’s analysis and report along with recommendations from the Health Care Workforce Committee, July 15th and September 6th.

As noted above, the Health Care Workforce Committee will be conducting several in-person meetings in different parts of the state during the month of June (see next page for additional information). The goal of these meetings is to hear directly from health care clinicians, employers, local officials, and others impacted by the availability of health care provider, provide feedback on Lewin’s recommendations, and hear from communities that have a stake in Oregon’s provider incentive programs.

Feel free to contact us with your questions.

Marc Overbeck (Marc.Overbeck@state.or.us) and Oliver Droppers (Oliver.Droppers@state.or.us)

SB 440 Strategic Plan Overview

General Information

- [SB 440](#) directs the Oregon Health Policy Board ([OHPB](#)), in consultation with agencies including OHA, DHS and DCBS, to develop a strategic plan for health care data collection and use for submission to the legislature by Sept. 1, 2016.
- The plan is intended to support the health care transformation goals and vision articulated by the OHPB and the health care community, and can serve as a resource for the OHPB and internal agencies to help shape their implementation strategies in further support of health care transformation.
- SB 440 also calls for the convening of a committee in 2017 to select a set of metrics for use in state measurement efforts. The selection of that committee and the setting of its work plan are separate processes from the creation of this Strategic Plan.

Plan requirements

The final plan must:

- Outline a five-year vision and implementation timeline, including clear objectives for how health care data will be collected and used to support health system transformation in alignment with the Triple Aim.
- Identify what gaps would need to be filled in order to help the community know they have achieved transformation goals in the future.
- Provide critical information to support the work of the Health Plan Quality Metrics Committee (to be convened in 2017), though it will not serve to direct the work of the committee.
- Include strategies to ensure that the State's collection, use and measurement of health care data advances payment reform and supports implementing, measuring and reporting on alternative payment methodologies.

Stakeholder engagement requirements:

- Beyond state agencies, the plan is intended to reflect the input and needs of health care community stakeholders including patients, providers, employers and health plans.
- Wherever possible, Q Corp will engage with groups that can reflect input from a broad community of stakeholders, including patient advocates, providers, employers, community-based service organizations and health plans; the Collaborative for Health Information Technology in Oregon, which is comprised of Oregon Association of Hospitals and Health Systems, Oregon Health Leadership Council, OCHIN and Q Corp, is one such group.

Q Corp's engagement process:

- Q Corp will engage with stakeholders to understand their perspectives on data available or needed to support health system transformation; this work will be conducted using a variety of channels including individual and group interviews, listening-session type meetings, and an electronic survey.
- Q Corp will synthesize the information and feedback collected, and ensure it is appropriately represented in the resulting work.
- Q Corp will work with OHA and key stakeholders to facilitate review checkpoints throughout the project, to ensure stakeholder reflection and input throughout.

OHA's role:

- As staff to OHPB, OHA will facilitate and manage the project throughout, keeping the OHPB and agency leadership informed about ongoing progress.
- OHA will help Q Corp connect with the appropriate agency key informants for the purposes of gathering feedback.
- OHA will also help to assemble and provide relevant source documentation regarding strategy and goals for health care transformation from across the Authority.
- OHA staff will provide feedback to Q Corp on key deliverables throughout the project.

Major Deliverables:

1. Statewide Strategic Plan for the collection & use of health care data.

OHA contracted with Q Corp to manage this scope of work.

- May 13th 2016: complete progress report.
- June 17th: complete final Data Gap Analysis and a Report on Survey Activities.
- July 1st: complete summary of stakeholder feedback.
- July 15th: present status of stakeholder process to the Oregon Health Policy Board.
- July 15th: submit first draft of Plan for review.
- August 2nd: present proposed Plan to the Oregon Health Policy Board.
- August 5th: complete Stakeholder Summary with Board's feedback.
- August 12th: complete final draft of Plan, reflecting Board's feedback.
- August 26th: finalize report.

- September 1st: OHPB submits plan to Legislative Assembly.

2. Establish the Health Plan Quality Metrics Committee

Governor appoints members as prescribed in statute.

- February 1st 2017: members appointed; work begins as described in statute.

- January 1st 2018: implement health outcome & quality measures

The first weeks of the project will be spent working closely with OHA, DHS and Q Corp to finalize project plans and assess opportunities to leverage existing agency inventory and analysis work.

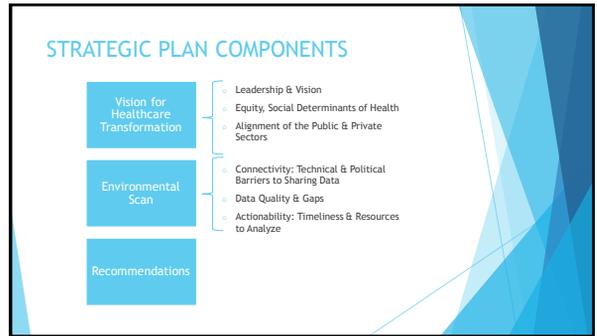
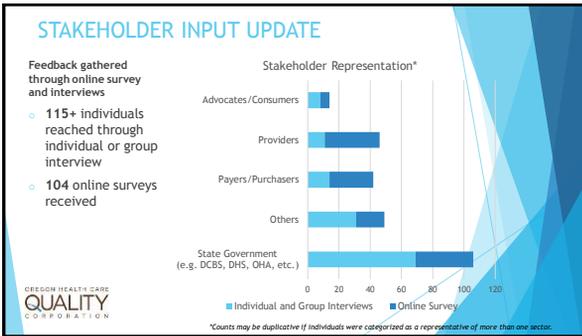
OHBP Priority Areas:

The Oregon Health Policy Board (OHPB) is responsible for monitoring, oversight, and policy development in the following priority areas:

1. Health System Transformation (including Coordinated Care Organizations)
2. Healthcare workforce issues (Healthcare Workforce Committee)
3. Health Information Technology (Health Information Oversight Committee)
4. Public Health system & Modernization efforts (Public Health Advisory Board)

Additionally, the OHPB has identified the following timely priority areas, each examined and developed through a Health Equity lens:

1. Behavioral Health System
2. System integration: physical, behavioral and oral health.
3. SB 440: metrics alignment
4. High-cost pharmacy issues
5. Value-based payment/Payment reform



- ### TRENDS: Key Themes
- #### Leadership and Vision
- Data, measurement and metrics must be tied to clear goals
 - Collective vision and goals must be kept up-to-date
 - Resources needed implement
 - Priority areas are not goals
 - Data and metrics cannot lead the vision
 - Bold leadership is required
 - Sense of urgency about where HST is going next
 - Need focus on improving health and reducing costs

- ### TRENDS: Key Themes
- #### Equity and SDoH
- Must have an equity lens
 - Common data collection = limited spectrum to fully identify disparities
 - Notable gaps and data quality issues
 - Populations we are trying to serve should have a voice in the data
 - Survey and self-reported data is under-utilized
 - Consider how data is analyzed to focus on disparities and outcomes
 - “State” may need to be more prescriptive to simplify and align
 - Divergent and nuanced views about racial equity as a primary focus

- ### TRENDS: Key Themes & Discussion Alignment
- Need multi-stakeholder and multi-payer participation to be successful
 - Focus on all of Oregon, not just one payer or system
 - State should encourage the democratization of data
 - Alignment among state agencies would be a good first step
- Questions for Discussion
- Questions about Key Themes?
 - What does the OHPB want to see in the strategic plan?

SB 440 Strategic Plan

Stakeholder Input Summary

Submitted to the Oregon Health Authority by the Oregon Health Care Quality Corporation

Date: July 1, 2016

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Oregon Health Care Quality Corporation (Q Corp) is an independent, nonprofit organization dedicated to improving the quality and affordability of health care in Oregon. Q Corp leads community collaboration and produces unbiased information to support health care transformation efforts across the state and nationally. Stakeholder engagement for this report was conducted by Q Corp staff in consultation with the Oregon Health Authority.

Introduction and Project Overview

This Stakeholder Input Summary serves as an important foundational element to the final Senate Bill 440 (SB 440) strategic plan, to be completed in August 2016. It is an overview and synthesis of results from a series of community engagement strategies, including individual and group interviews that solicited feedback from more than 115 people, and online survey responses from 104 individuals. The section on **Methods** describes the creation and distribution of the online survey, as well as the interview protocol developed by Q Corp in partnership with the Oregon Health Authority. Feedback collected is summarized in the **Findings** section, distilled into key themes organized into six categories. A **Conclusion** section briefly describes how the Stakeholder Input Summary fits into the strategic plan.

SB 440 directs the Oregon Health Policy Board (OHPB), in consultation with state agencies including the Oregon Health Authority (OHA), the Department of Human Services (DHS) and the Department of Consumer and Business Services (DCBS), to deliver a strategic plan for the collection and use of health care data to the legislature by September 1, 2016. The strategic plan will support the health care transformation vision and goals articulated by the OHPB on behalf of the state, as well as the broader health care community, and serve as a resource for both the OHPB and state agencies as they shape transformation implementation.

The OHPB is responsible for the final strategic plan. As staff to OHPB, OHA's role is to facilitate and manage the development of the plan. The OHA contracted with Oregon Health Care Quality Corporation (Q Corp) to produce the plan in coordination with OHPB, OHA and other state agencies. A project team consisting of Q Corp and OHA staff members scoped the strategic plan to meet OHA specifications; it includes a broad community engagement process, summarized in this report, and an inventory of existing data infrastructure. These and other relevant background and environmental scan pieces will inform a series of recommendations for next steps. These elements will be brought together to form the final strategic plan.

Stakeholder engagement was conducted in three phases:

- **Phase 1:** Q Corp staff worked closely with staff from OHA, DCBS, DHS to identify a list of key health care data stakeholders, which included both internal state agency data users, as well as non-state agency data users representing a variety of perspectives relevant to the collection and use of health care data. Project staff then developed a robust survey tool and interview protocol to capture feedback around the key components to be included in the strategic plan. Focus areas for the survey and interviews were identified based upon current and previous OHPB priority areas, as well as priority areas in the State Health Improvement Plan (SHIP).
- **Phase 2:** Q Corp collected feedback via survey response, individual interview and group discussion. While only select individuals were invited to participate in an interview or focus group, all individuals on the list were sent the survey, and the survey was forwarded to other interested parties.
- **Phase 3:** Q Corp summarized, analyzed and synthesized stakeholder input to produce the Stakeholder Input Summary.

Methods

Survey

Q Corp worked with OHA staff, through four rounds of feedback and edits, to develop a robust survey tool to capture the insight and experience of a broad cross-section of health care data owners and users. To reduce duplication of effort, the OHA Public Health Division's Program Development and Evaluation Services (PDES) team helped to shape the survey, as they are conducting a similar public health-focused feedback effort directed at some of the same stakeholders on a similar timeline.

The survey included six major sections, seeking information from respondents about Oregon's data related to:

1. Past and current Oregon Health Policy Board priority areas
 - Health System Transformation, including Coordinated Care Organizations
 - Healthcare workforce issues
 - Health Information Technology (HIT)
 - Health equity
 - Behavioral health system and integrated care
 - Public Health System & Modernization efforts
 - Oral health issues and integration with the physical health system
 - High-cost pharmacy
 - Value-based payment/Alternative Payment Models
2. Oregon's State Health Improvement Plan (SHIP) priorities
 - Prevent and reduce tobacco use
 - Slow the increase of obesity
 - Improve oral health
 - Reduce harms associated with alcohol and substance use
 - Prevent deaths from suicide
 - Improve immunization rates
 - Protect the population from communicable diseases
3. Data used most often by respondents
4. How respondents use data
5. Access barriers and gaps
6. Open-ended reflections on the use of data in health system transformation efforts

Questions were either matrix Likert-scale, or open-ended so respondents could answer questions most relevant to their area of expertise and needs.

Survey Outreach

On May 17 a link to the survey was emailed to the 93 individuals on the stakeholder engagement list developed by OHA, DHS and Q Corp, with a reminder email sent on June 1. All OHA staff were invited to complete the survey via an internal staff email, while non-OHA recipients were contacted by Q Corp. The email language indicated the survey should be shared widely with colleagues. Additionally, the survey link was sent in the follow-up correspondence to interviewees and discussion group participants. Within OHA the survey link was forwarded beyond staff to the Metrics Technical Advisory Group (TAG), the All Payer All Claims Technical Advisory Group (APAC TAG), the Behavioral Health Mapping Tool Technical Advisory Committee (TAC), as well as other groups affiliated with health care transformation. Although it is difficult to determine how many total individuals were forwarded the survey, it is likely a minimum of 250 individuals received the survey link.

Survey Responses

The survey opened on Monday, May 16 and closed on Friday, June 3 allowing three weeks for responses. There were 104 respondents in total; 42 respondents completed the survey and 62 provided partial responses. Survey completion is defined as a respondent answering all questions and clicking “done” on the last page, while incomplete surveys are defined as respondents entering at least one answer and clicking “next” on at least one survey page. Responses to open-ended questions towards the end of the survey were answered less completely than questions posed earlier in the survey. Additionally, there were fewer responses to the open-ended SHIP questions than there were to the open-ended OHPB priority questions, potentially due to the sector-specific expertise of survey respondents.

Interviews

In addition to the survey, Q Corp conducted a combination of one-on-one interviews and group discussions to gather feedback from key stakeholders. Q Corp worked with OHA staff to develop an individual interview protocol and a group discussion protocol to ensure feedback was gathered consistently and focused on OHA priority areas. The individual interview protocol included questions about data use, the best outcome for the strategic plan, data needs, value of existing state data, and barriers to using data. Additionally, there were sub-sets of questions developed for respondents from specific sectors including:

- State agency data owners (e.g. OHA, DHS, DCBS)
- External data owners (e.g. Oregon Association of Hospitals and Health Systems, health plans)
- Data users (e.g. researchers, state policy analysts)
- State agency staff (e.g. Early Learning Division, Office of Health Information Technology)
- External policy stakeholders (e.g. professional associations)

The group discussion guide protocol included broader questions about data needed for OHPB and SHIP priorities, how to acquire the needed data, the value of existing data, barriers to using existing data, and examples of other data repositories or access systems for reference.

Interview Outreach

Outreach to stakeholders for scheduling began on Wednesday, May 4 and continued through Wednesday, June 15 allowing seven weeks for scheduling. Invitations were sent via email with a follow-up email or phone call when appropriate to approximately 102 individuals including contacts on the stakeholder engagement list developed by OHA, DHS and Q Corp as well as additional contacts added later in the process.

Interview Responses

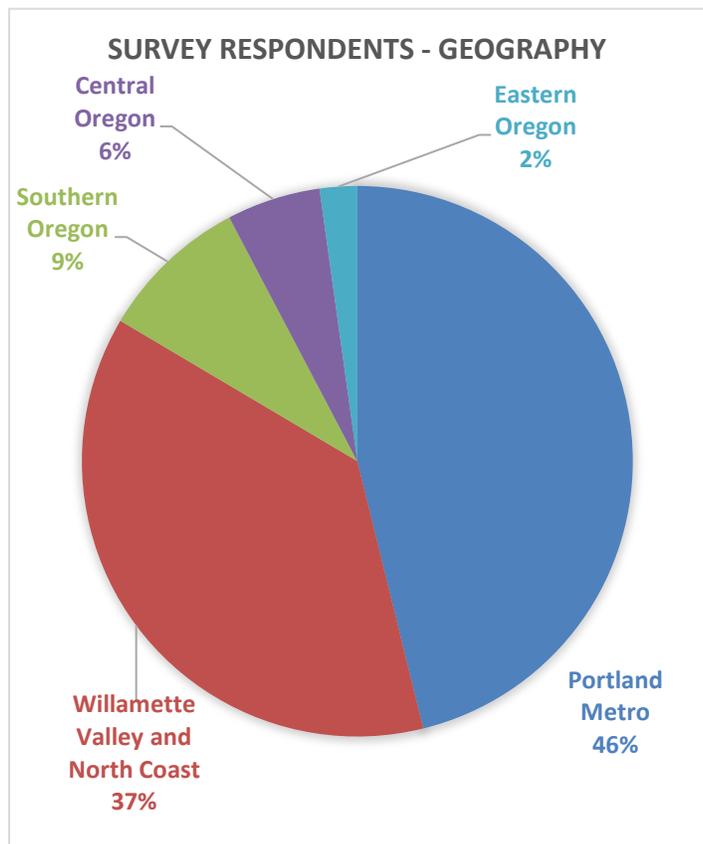
There were close to 115 respondents counted from the stakeholder engagement list and possibly closer to 130 respondents in total including additional group discussion members. Interviews were conducted in person or by phone depending on respondent preference or logistical feasibility. As an exception, staff decided to send an electronic version of the interview protocol to a small group of individuals after the interview scheduling deadline was past, due to low response rates from some sectors.

Most interviews were audio recorded to supplement the detailed notes captured by the interview facilitator or partnered scribe. Interview notes were then compiled, coded and summarized into this report.

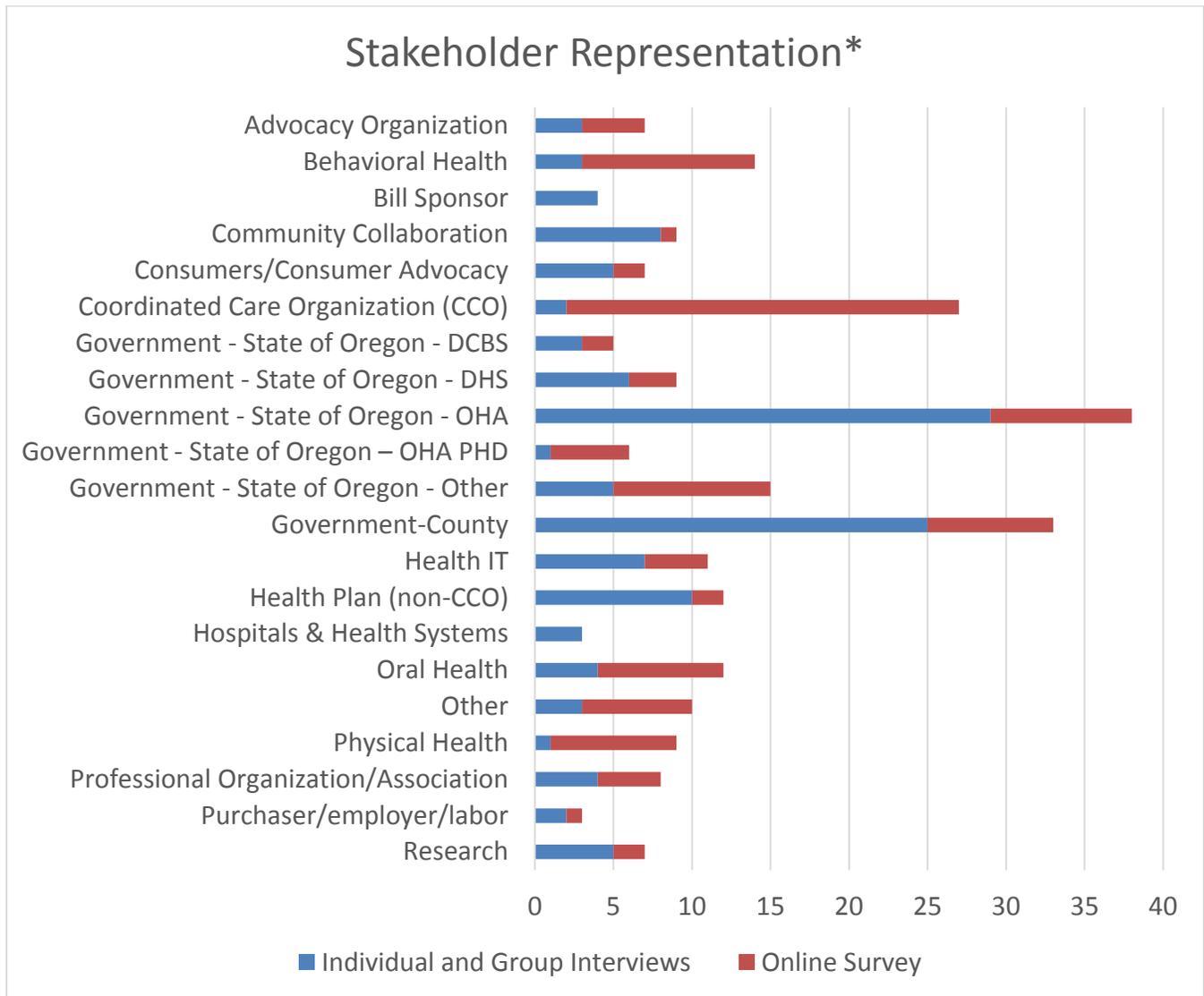
Survey Respondent and Interviewee Demographics

In order to ensure survey responses adequately represented key data stakeholders, the surveys and interviews included several demographic questions about the respondents' employer and geographic location. While there was an unsurprising abundance of survey responses from the Portland Metropolitan and Willamette Valley regions, there was representation from all parts of the state. Ninety-one (91) respondents entered their zip code for analysis; regions were divided according to the Oregon Department of Transportation Region Map. Staff did not record the geographic location for each interview respondent, although a majority were from the Portland Metropolitan and Willamette Valley regions.

In regard to the stakeholder types who responded to the survey, project staff agreed there was an appropriate diversity of respondents with respect to employer types,



except for the limited number of responses from county employees and private health insurers. In response, Q Corp worked to ensure those perspectives were adequately represented through the other engagement activities. Similar to the survey efforts, Q Corp staff categorized key interview stakeholders by employer type using the same categories as the survey. Stakeholder representation for the combined community engagement effort is included in the chart below. Stakeholders identified as “Other” included federal government employees, non-healthcare nonprofit organizations, and consultants with no stated specialty focus.



*Counts may be duplicative if individuals were categorized as a representative of more than one sector.

Survey and Interview Analysis

Throughout the project, Q Corp staff held weekly internal meetings to discuss emerging themes to inform the development of a data classification taxonomy, captured in a codebook used to categorize responses for qualitative analysis. Using necessary elements of the strategic plan laid out by the Oregon Legislature as a guide, staff developed the following high-level codes:

- **Uses** – How are respondents currently using data?
- **Gaps** – Where are there gaps in data that stakeholders need to conduct their transformation work effectively?
- **Barriers** – Where do stakeholders identify barriers to collecting and using data needed for health system transformation work?
- **Strengths** – What aspects of Oregon’s current data systems are strengths?
- **Opportunities** – Where are opportunities to improve Oregon’s health-related data collection and reporting efforts?

Topic specific sub-codes were developed within each of these overarching codes; examples include: U-PROG (Use, Program Evaluation); G-OUT (Gap, Outcomes); B-INT (Barrier, Interoperability); S-MEA (Strength, Measures); O-SIMP (Opportunity, Administrative Simplification). Where there was no appropriate code, staff coded responses as “miscellaneous” for further review. Through this iterative process, additional codes were developed to capture common themes among stakeholder responses. Each interview and group discussion was catalogued in an excel spreadsheet where counts of each code and germane quotes were noted. Survey responses to the open-ended questions were likewise coded using this schema and combined with the interview and group discussion codes.

The coding process was the foundation for synthesizing comments into themes, and the themes into categories as they are presented in the Key Findings. Codes used more than 25 times across all surveys and interviews were prioritized for further analysis to determine the thematic essence of feedback from stakeholders. Gaps, barriers and opportunities were often used inter-changeably among coders, so these codes were combined for some areas even though they did not individually appear more than 25 times. Representative quotes for each of the most frequently occurring codes are highlighted among the six theme categories.

Limitations

In order to align this information collection effort with the Public Health Division’s similar feedback needs, the survey was longer than originally scoped. In addition, project staff opted to include many open-ended questions in order to capture narrative feedback from stakeholders unable to be reached through the interview process. The length of the survey, along with the multiple open-ended response options may have deterred some respondents from completing all questions and finishing the survey.

Although great efforts were made to invite an array of stakeholders, representation from some sectors was less than anticipated. Furthermore, representation from outside of the Portland Metropolitan and Willamette Valley regions was limited. Overall, the short timeframe for this project should be noted as a limitation.

Findings

In both interviews and surveys, stakeholders were asked to reflect on how current data systems in Oregon support efforts related to each of these focus areas:

- Health System Transformation (including Coordinated Care Organizations)
- Healthcare workforce issues
- Health Information Technology
- Public Health system & Modernization efforts
- Health Equity
- Behavioral health issues and integration with the physical health system
- Oral health issues and integration with the physical health system
- High-cost pharmacy issues
- Value-based payment/Payment reform

This range of focus areas resulted in a wide-ranging assortment of feedback on high-level considerations, as well as very detailed, specialized or niche perspectives specific to data collection and reporting. Many respondents did not limit their feedback to the collection and use of data, but also offered feedback on the inextricable link between data collection and reporting, and the broader context of health care transformation. Interviewees and survey respondents represent a wide variety of perspectives – public and private sector, health plans, policymakers, and health care purchasers and consumers. Within those categories were those who collect and organize data, as well as data users and those who serve more as intermediaries, facilitating the sharing of data. Familiarity with data technology and infrastructure, within the state and in general, was also variable and included those with a high degree of technological sophistication, as well as others with more expertise in policy development and implementation.

Despite the diversity of perspectives, the interviews and surveys surfaced a number of repeated observations, conclusions and recommendations, which have been summarized into themes, organized into six categories. These categories represent the most frequent observations and comments of interviewees. The order of the categories is intentional. Many of those interviewed and surveyed believe any data strategy should be grounded in a clear vision, with consistent and visible leadership, a focus on equity and the social determinants of health, and aligned within the public sector and with the private sector. Themes on these topics are captured in the first three categories (1 – 3). More data-specific themes related to the sharing, timeliness, quality and transparency of data are captured in categories three through six (3 – 6).

1. Leadership and Vision
2. Equity and Social Determinants of Health
3. Alignment within the Public Sector and between Public and Private Sectors
4. Lack of Data Connectivity: Technical and Political Barriers to Sharing Data
5. Actionability: Data Timeliness, Quality, Transparency and Analysis
6. Data Gaps

Leadership and Vision

Data, measurement and metrics must be tied to clear collective goals. The OHPB and greater community must decide where to go, how to get there, and which measures will incentivize people and organizations to move forward collectively. Continued health care transformation needs a refreshed, invigorating vision and strong leadership.

Collective vision and goals must be kept up-to-date – people want to know “where are we going now?” and “how are we doing?” Once a broad statewide vision and goals are set, measurement activities should align and be shared widely. Without the vision, goals and regular updates, metrics become “box checking.” Most agree we are at a pivotal juncture, and if Oregon wants to continue to lead the nation in this area, our shared vision needs a visible update.

Vision and leadership also require securing the resources to implement. It is reasonable for policymakers and leadership to focus on high-level priorities, but the infrastructure and data needed to impact those priorities is part of ensuring success. This includes infrastructure needed to analyze data at the policy level, but also the system-building and coordination needed to sustainably improve the delivery system.

Priorities are not goals. Survey participants and interviewees were generally aware of existing OHPB and OHA priority areas, but were less aware of any specific goals related to each area. We can only know we improve if there are goals towards which we measure our progress.

Data and metrics cannot lead the vision. Data and metrics inform and measure goals, but they do not shape them. Driving with measurement is problematic, especially since existing CCO measures are heavily influenced by stakeholder groups. Incentive metrics worked – people serving Medicaid patients focused on them intently and significant improvement occurred. However, when people get focused on data, and not the broader context surrounding it, some doubt whether we are following through on improving health overall and reducing cost. Others question whether the incentive measures are the “right measures.”

“...In Oregon we take a backwards approach [to transformation] and look at what [data] we want to collect, rather than what we want to achieve. Data should be a tool as opposed to [an] end.”

“I feel like we [in Oregon] start with the data, and as a result we have 265 measures that primary care physicians have to report on... I think we need to start with ‘What are we trying to achieve?’”

“[Health care transformation] is bigger than one group, it is a community effort. We need to aim for a win-win, but also get past self-interest and be willing to invest... This is no small challenge, and the most worrisome concern is the lack of bold leadership.”

“There’s a sense that Oregon is a leader [in transformation] and we’re moving in the right direction so we just need to keep pushing. I would say it’s a lot more urgent than that... there’s potential for a real crisis point... we haven’t changed health systems the way we said we were going to...”

“We gravitate to the solution of one single data system... and this hope for a universal, integrated data system has almost been an impediment to progress... We need the global vision... Conversations about data systems are sometimes a distraction.”

Bold leadership is required. Taking health system transformation to the next level requires leadership from the state in strong partnership with other parts of the health and health care community.

There is a sense of urgency about where health system transformation is going next. Many praised the success of the CCO model, but cautioned that what comes next is uncharted territory and plotting the next course is critically important.

Oregon has focused on improving care, but less on improving health and reducing costs. Outcomes and cost savings are both important to many stakeholders who hope the next phase of transformation efforts directs attention toward these and other pieces that have been less front-and-center.

“The range of measures being used in the CCO program are pretty good – nothing stands out or is glaring – one of the great things about the ways the CCOs have been structured is that it’s an integrated approach – behavioral and oral health is integrated – this is important in thinking about system transformation – thinking about whole-person care.”

“There is great potential, but data collection efforts seem fragmented and aren’t always consulting with or engaging communities of interest to develop the right questions or combinations of questions.”

“[There are] many other [behavioral health] metrics [I’d] love to have – but can we afford to wait until we can collect them? No, so what can we measure now – what are measures that can be aggregated and used at provider, plan, and system oversight levels as a way to drive improvement?”

“Less focus on metrics, more focus on the systems infrastructure and policy that will help us un-clunk our system.”

Equity and Social Determinants of Health

Health system transformation leadership and vision must have an equity lens. All commenters on this issue would like to see more robust and re-envisioned data sets to inform both a deeper understanding of the issues and how to affect meaningful change in health for all Oregonians.

Common data collection practices do not capture a wide enough spectrum to fully identify disparities. Existing methods limit the full spectrum of information needed to examine health disparities and advance equity; as an example: race, ethnicity and language data need to go beyond traditional categories. The limitations of the binary data collection system, and its impact on the data available, isn't an accurate reflection of either categorical diversity or the issues that affect many individuals. This is a result of the paradigms in which the data is collected.

Notable gaps and data quality issues must be addressed. Collection of demographic and social determinants data is highly inconsistent. Multiple stakeholders expressed concern that those responsible for collecting this information may be uncomfortable asking the right questions and/or may not be able to ask the questions in such a way that the respondents understand why it's being asked. Inadequate training and implicit bias impact the accuracy of the data collected.

Populations we are trying to serve should have a voice in the data that is collected and an influence on how we collect it. If populations don't have a voice – because our data methods hide them – it's impossible to either track them or make an impact on their lives.

Survey and self-reported data is under-utilized. Both are sometimes perceived as inaccurate, but are essential for advancing equity and impacting social determinants of health. Some stakeholders expressed a need for both more survey data and for more access to survey data that is collected. Education and training on how to use survey data is needed to address perceptions that this data is inherently inaccurate or less useful than data collected through claims or medical records.

“Social determinants of physical health are poorly understood by health care providers.”

“If CCOs are to push the boundaries and address social determinants of health and health outcomes, it would be helpful to give them access to broader data systems in a trusting way.”

“We have person centered planning but we don't have that in data collection.”

“Survey data has a bad rap, people don't buy into it as readily as they do claims data, which is a mistake since claims data probably has as many problems.... Perhaps combine some of the survey data we have with the claims data?”

“We need more community-based participatory and intergenerational storytelling, strengths-based approaches [to data collection].”

“For existing data sources, we need better methods to collect and disaggregate data by race and ethnicity, beyond standard census categories, in order to truly address racial disparities.”

“Public reporting of incentive metrics and other data are not stratified to identify disparities.”

Carefully consider how data is analyzed to focus on disparities and outcomes. More consumer-focused analysis and the ability to analyze data across a wide variety of demographic, social, geographic and other contexts are essential tools for health care and other stakeholders seeking to address health disparities. Current data systems are used for data capture and collation, but could be leveraged for broader purposes if such information was available.

The state may need to be more prescriptive, specifically in regards to simplification and alignment of internal data resources. The ability to share data between state divisions through interoperability and/or a centralized, up-to-date, state data repository with access for analysis would help state agencies address social determinants of health more holistically.

There are divergent and nuanced views about racial equity as a primary focus. Many believe the focus on race and ethnicity leaves out communities experiencing inequities for different reasons, while others believe the focus on race and ethnicity is the best way to address disparities on a large scale.

“We need more data about patient views and preferences. Most data is derived from a provider’s point of view.”

“The Oregon Health Authority needs to utilize a health equity lens that looks at all populations experiencing significant health disparities based on systemic and historical trauma... race and ethnicity are important and have remained a focus for OHA, but limiting the lens to just these data points of identity is missing a lot of what may be going on in our community.”

“The intersectionality of identities should be captured in data sets so we can make informed decisions that ensure health equity in Oregon.”

“State level efforts need to have people impacted by health disparities at the table... We need to understand why we’re addressing health equity and what we want to accomplish before we can effectively monitor, oversee and develop policies that actually move the dial... Current monitoring of CCO performance, public health efforts, etc. remain largely focused on whole population improvement instead of from an equity approach.”

Alignment of Public and Private Sectors

The focus on primary care and Medicaid must expand; we need multi-stakeholder and multi-payer participation to be successful and sustain efforts. We are at an important crossroads – lack of alignment could weaken current progress. Providers and others are experiencing burnout when faced with more patients and rapid change. The sustainability of measurement and other activities that have been funded using grant or other temporary funding is in question.

The state’s role in health system transformation is key, but the state cannot lead alone. There are times the state should lead, and times it should partner or follow. The role of the state and others in “utility models” like the Emergency Department Information Exchange (EDIE) are good examples of alignment. The state could do more to engage health IT and other stakeholders to solve common challenges.

Any strategic plan for transformation needs to be for all of Oregon, not just one payer or system. Health system transformation will be advanced by a strategic plan for all of Oregon. If OHPB has a responsibility for the state as a whole, not just OHA population, alignment with the Public Employees and Oregon Educators Benefits Boards (PEBB and OEGB), as well as commercial payers across state is a priority, and requires new strategies and approaches.

State should encourage the democratization of data. Health systems, health plans and providers should compete on outcomes, not data ownership. Competition and turf issues are huge challenges. It is important to acknowledge the real and perceived financial risks posed by transformation; those must be addressed for the private sector to fully support transformation efforts.

Alignment among state agencies would be a good first step. OHA has physical health data for OHA covered lives; DHS has additional data on many of the same individuals and families. Combining these data sources would support the aims of both agencies. DCBS, PEBB and OEGB could serve as a bridge to commercial health plans, but they must be connected to the strategy to do that effectively.

“Primary care funding is increasingly plowed back into the health care system; seeing an increase in ancillary services to teams, not necessarily to clinicians. Re-distribution of a fixed pool of money, or a reduction of the pool is going to hurt some or all parties involved.”

“One of the best outcomes of this strategic plan would be a more progressive data sharing lens. Especially for Medicaid and Medicare, these are public dollars and we are not using the money effectively across systems.”

[About Health IT] “How do you have people [across sectors] pay into it, and sustain it over time?”

“Transformation needs to include more about whether transformative efforts change healthcare outcomes across multiple populations.”

[About the biggest barrier to effectively use data to support transformation] “Politics, frankly, and the power of certain players in the industry who... aren’t comfortable with different ways of measure what they’re doing and making more information about their practices public. The state will have to make some choices about how far we are willing to push powerful interests in the health care industry... data should be about what is happening, and everyone should support broader availability, but there is going to be opposition because the data we collect will influence policy choices and there will be some sensitivities about that.”

Lack of Data Connectivity: Technical and Political Barriers to Sharing Data

Outdated infrastructure is a technical barrier to data sharing.

OHA is working with legacy systems, but there is hesitancy to discuss upgrades because of the price tag associated with technology investments. Fallout from CoverOregon may be contributing to fear and apprehension related to radical changes in technology.

Technical barriers to connecting data can be remedied, but data blocking and turf issues are more formidable barriers to data sharing.

Some health systems view data as an asset, and are reluctant or unwilling to share it for the greater good. Transformation poses real or perceived financial risks to payers, hospitals and others in the system, so it is unlikely data will be shared until those concerns are addressed.

Difficulty gathering centralized clinical data from Electronic Medical Records (EMRs) is a critical interoperability issue.

Clinical data is essential for measuring outcomes, but it is more difficult to collect on a broad scale. Access to EMR data is called out as one of the biggest challenges for people across organizations and sectors.

Better data sharing between DHS and OHA is essential to addressing social determinants of health and interventions to go beyond the medical model. In particular, data related to housing, corrections, schools and foster care are essential to addressing population health.

Privacy concerns are a barrier. While there is some concern about certain types of information being misunderstood or used to discriminate, the protections in place to maintain privacy are perceived as a nuisance and overly restrictive rather than as appropriate safeguards for patients.

Behavioral and oral health data is difficult to access and incorporate into other data. Privacy and discrimination concerns are notable barriers for behavioral health data, while oral health data is completely separate from physical health data and difficult to integrate. Neither behavioral health nor oral health providers were incentivized to adopt EMRs like physical health providers were, so many still use paper records.

“No one is quite comfortable with what you are allowed to do, even with the data use agreements...”

“Cover Oregon was a symptom of a broader problem in Oregon. We do a lot very well, but we don’t have centrally-focused IT design or system of sharing data. I think that’s something that needs to be thought through for the whole state and not left to regions or geographic areas or hospitals to determine.”

“Information sharing between parties is less a data problem than it is a systems and governance problem.”

“We are talking about *hundreds* of independent data systems that do not talk to each other – they do not cross and are not integrated”

“It’s difficult to connect public health and private providers when there’s so much being asked of providers... [It is] difficult to get that [clinical] information, so if you don’t have an ‘in’ to what’s being included in the HER, or if the EHR doesn’t run de-identified data to give you trends, that’s kind of difficult.”

[About health information exchange (HIE)], “There isn’t the political will to do it, and if we can’t get there [politically], then we won’t make it.”

“[Oregon is an] Epic-centric state and we were hoping the vendor would fix things...it takes care of the big counties and health systems, but it doesn’t take care of long-term care, community addictions providers, etc. because they are not the big players.”

Actionability: Data Timeliness, Quality, Transparency and Analysis

There are distinct data needs for different stakeholders.

Providers need support to use their EMR and other data to focus and improve health care quality. Health plans need multi-payer data that shows a larger picture. The state needs data to inform and monitor policy decisions, and to ensure the quality of care delivered by CCOs. These diverse needs require an array of solutions.

Many existing data sources are not widely shared, and potential users do not know how to gain access to many data sets. Many stakeholders are convinced there is more or better data out there, but they do not know how to find it. State agencies may not even be aware of the data collected by other state agencies. Some good examples of accessible data exist, including the Oregon Prescribing and Drug Overdose Data Dashboard.

Data is often not timely enough for use in program evaluation and planning. Stakeholders across sectors identify slow turnaround as one of the most significant barriers to using the data that is shared with them. While yearly or twice-yearly data is good enough to track very broadly, many data users seek data that can be used for ongoing monitoring and improvement.

Resources to analyze and interpret data are desperately needed and underfunded. Within the OHA and in organizations across all sectors, people have access to a lot of data that goes unused because they do not have the time or analytic skills to use it effectively. There is a perception that Oregon has focused more on *collection* than *using* data; the All Payer All Claims (APAC) database was cited as an example. This extends to providers who have been incentivized to collect and report data rather than use it effectively, so staff time is allocated more to collection and less to using data.

Broaden ‘lenses’ used to analyze and report. Overall there is a collective need to strengthen the lenses through which we view data – understanding the nuances between urban versus rural populations, and discouraging oversimplification, generalizations and across-the-board solutions.

“The biggest fear is that we get analysis paralysis and Oregon’s health sector has exceptional data with bad results.”

“We also have a lot of data we don’t have the staffing and analytic capacity to do as much with. It is one thing to have data, but handing someone a massive spreadsheet doesn’t really help them. Some of the opportunities are about increasing resources to help people use and think about the data already available.”

“The focus has been on collecting data, not what we are going to do with it.”

“We get caught in the weeds, asking very detailed questions – we have a harder time using data to indicate meta-changes.”

“...We’re required to do all of this reporting to the state and then the data we get back is very limited, and sometimes we don’t get it very frequently... for example the family planning data gives us a nice picture of where we are once every three years, and I know that it’s not changing very rapidly, but sometimes when you’re trying to do planning and program development, working with community partners, that’s a long time.”

Quality of data is vital. There are both widely agreed upon and often debated, and real and perceived, issues related to the accuracy of data that have to be addressed. People will dismiss data they do not believe in, which underscores the importance of how data is shared and communicated to data users.

Translation of data for consumers has been out of focus. Digestible information for consumers, especially for financial informed consent and understanding of cost sharing, is largely absent. There is little transparency about things like the cost drivers that lead to commercial health plan rate increases.

There are varying opinions on the value of different types of data. Some question the value of claims data, while others identify it as the most reliable source of data that can be collected across payers, health systems and geographies. Clinical data is highly valued, but centralized collection is challenging on a number of fronts. Self-reported and survey data are held in the highest regard by some, but are under-utilized.

Resources are needed to train the people who input data. Within OHA and health systems, training for those collecting data is an essential but underfunded piece of data strategy. This is particularly important when it comes to collecting patient-reported information, especially information that may be sensitive or easily misunderstood or misrepresented.

The same level of transparency in provider-level data should be applied to payer performance. Existing efforts (e.g. star ratings) are not enough. There are questions about how much commercial payers are contributing to health care transformation goals, and how the state and public can examine and monitor the contributions of private industry.

“Avenues must be found for requiring detailed reporting, at a local level (such as by zip code), on insurance enrollment, plan design, premiums, and medical loss ratios for every commercial health plan. This reporting would ideally include self-insured plans, as more than half of the privately insured are enrolled in these types of plans. With these data, policymakers, researchers, and regulators would be able to monitor market developments and to intervene, if necessary, based on better and timelier information.”

“Staffing and training [are the biggest barrier]. If staff receive a high-utilizer report they aren’t able to do much proactively because their caseloads are so high. Training and retention of employees is key to effective case management and medical cost containment.”

“I actually do not know what data is available on the state website, so that should tell you how well it is advertised for use.”

“For individual consumers, getting the value data – ‘bang-for-your-buck’ data – is really critical...getting it out there in ways people can use. It is a consumer protection issue – we have this available for almost all other consumer products.”

Data Gaps

Outcome data. Administrative data has high value and always will, but clinical data will help us move to assessing health outcomes. Stakeholders want to know – are people healthier?

Cost. More robust cost of care data would help each part of the system identify how it can contribute to overall cost savings. Without this information many are skeptical about whether health system transformation efforts have or will bend the cost curve.

Data on individuals. Client-level data is overlooked because of the focus on system level reform. Tracking individuals through the system is difficult using existing data. Additional demographic data such as income level, education, and disability status would complement efforts around collecting race, ethnicity, language, sexual orientation and other data.

Self-reported and patient experience data. Along with clinical data, these are an important complement to claims-based measurement. Existing survey data is underutilized and poorly coordinated. Aligning resources could save costs related to fielding surveys, and those resources could be reallocated to analysis. Many practices and other organizations receive survey data they cannot use because they cannot analyze it. Better access to culturally appropriate survey tools would ensure everyone’s experience is captured.

Provider directory that includes specialty providers and non-physician care team members. As opposed to primary care providers, there is less information about specialists. There is a similar lack of information about behavioral and oral health providers. In addition, the transition to team-based models within primary care has prompted the proliferation of many new care team roles (care coordinators, care managers, scribes, etc.) but there is no way to know who these professionals are and where they work. Overall, more detailed information about clinicians, clinics, health systems would support a number of programs and purposes.

[On data gaps] “Quality of life data – a Health-Related Quality of Life screener exists and comes in 59 languages. If we are going to be a *health* system rather than a *sick* system, we should be looking at quality of life.”

“As we’re moving into value-based payment and subcapitation we’re potentially losing info we have under the current system – financial info we pick up in claims isn’t nearly as complete as those reforms are being implemented.”

“There has been a major push to increase developmental screening for young children, driven by the basic logic model of the early learning and health transformation systems – earlier identification of problems allows you to invest upstream, preventively, rather than larger downstream investments... but the post-screening processes haven’t been built. What happens afterwards? How is information shared...Screening data is not that meaningful in the long run if we don’t know the consequence of the screening, the follow-up for the child and family.”

“Are we improving quality of life for the population? Not how many SBIRTs did we administer, but by virtue of having had an intervention, has it resulted in sustained improvement?”

Provider satisfaction data. The pace of change has had a deep impact on the satisfaction of health care workers. Data from surveys of providers could inform programs to combat burnout. Improving the work life of physician and other care team members is considered to be an important addition to the Triple Aim, making it the Quadruple Aim.

More granular data. Granular data, including data at a zip code level as opposed to county level, is important for rural providers. A lot of data reported at the county level is too general to be helpful in rural communities. More disaggregated data would help communities monitor local improvement efforts.

Process data. Health care providers are being encouraged to coordinate care in ways that may not be captured in claims data. As a result, important transformation aims like care coordination and integration are hard to measure.

Innovation. CCOs have engaged in a multitude of transformation projects over the past few years, but there is no central resource to know what is being tried where, and the impact of these efforts. CCO metrics are improving, but it isn't clear what is causing those improvements. Stakeholders know we've tried a lot, but wonder what's working best?

Data gaps are an unintended consequence of the move toward value-based payment. A number of important data points are not captured in claims. In many cases these activities and services are not captured at all, and in other circumstances it means health care providers must invest effort in collecting data in a consistent and reportable format. Value-based payment work may result in even more holes in claims data. There are so many value-based payment models; would some alignment simplify?

Behavioral health, oral health and pharmacy data. There is a great deal of focus on these areas, but many organizations are unsure about how to get data to improve care in these areas. When data is available, relevant metrics or specific benchmarks are not easily available.

"We don't have a good way of getting [pharmacy data]. I know that from the commercial [and Medicaid] side pharmacy was the biggest spend... bigger than inpatient hospitalization, yet we aren't able to get a lot of data on it. We're just told 'Oh, it's those designer drugs...'"

"Interpreters and/or language issues exists but we don't have information about it. [It would be helpful to] see practitioner information and their ability to speak different languages, etc. so people could wisely choose a practitioner who meet their needs."

"In [some areas] it is hard to know capacity – we pay for some services, but there is not a psychologist that will take Medicare patients."

"We need to emphasize...process measures. Are people getting help in a timely manner when they reach out – referrals, access to visits and follow-ups?"

Next Steps

Q Corp will coordinate with OHA to review the Stakeholder Input Summary and identify any gaps in feedback or perspective that can be addressed before the final strategic plan is submitted in late August. A final version of the Stakeholder Input Summary will be included in the final strategic plan, with any additional feedback added.

Q Corp will develop a series of recommendations for OHA and OHPB to consider, organized by the six categories of Key Findings, and corresponding to the major themes from stakeholder input. In addition, a number of stakeholders offered specific recommendations in their survey or interview responses; those will be compiled for inclusion in the final strategic plan.

ELIZABETH STEINER HAYWARD MD
STATE SENATOR



OREGON STATE SENATE
DISTRICT 17

July 15, 2016

To: Zeke Smith

Chair, Oregon Health Policy Board

From: Senator Elizabeth Steiner Hayward MD

Re: HB 3396 - Provider Incentives & SB 440 - Standardized Metrics

Dear Mr. Smith,

Please accept my comments to the Oregon Health Policy Board regarding the legislative intent behind HB 3396 (2015) and SB 440 (2015). I would be happy to answer any questions the Board has after reading my comments.

HB 3396 - Provider Incentives

Oregon has long offered a wide range of incentives intended to increase the supply of necessary healthcare provider incentives in underserved areas. Some, such as the Rural Scholars Loan Forgiveness Program, established by the 2011 Legislature, specifically target MD, DO, NP, and PA students who pursue a rural training track and plan to practice in rural areas. Others, such as the State's loan repayment program (in existence for over 20 years), offer direct payment of student loans for providers in both rural and urban underserved areas. In addition, the State offers a Rural Provider Tax Credit of varying amounts to physicians, NP's, and other providers including Emergency Medical Services volunteers. The final major incentive program is the Malpractice Premium Subsidy, initially established at the height of the malpractice crisis in 2003 and subsequently narrowed to a more target population in the 2007 legislative session.

While each of these programs affects some unique provider populations, many of them overlap, such that some providers benefit from two or three of the incentives. While the funds for the various incentive programs can come from different sources, and thus are not completely fungible, this overlap ultimately results in a decreased number of providers receiving incentives, which is not necessarily in the State's best interest. Furthermore, while the Office of Rural Health, which administers all of the incentive programs, has compiled good data about the loan repayment program, it has been difficult to assess the efficacy of the other programs in attracting and retaining healthcare providers in communities of need.

HB 3396 seeks to address the core goal of the State to leverage its financial resources in the most effective ways to attract and retain qualified healthcare professionals in areas of greatest need. The Legislature seeks information that will allow it to target funds used for incentive programs toward those that offer "the best bang for the buck," to use the vernacular. Questions include but are not limited to:

- 1) Under what circumstances should providers receive more than one incentive simultaneously?
- 2) How can we accurately measure the efficacy of the programs and continue to track their effects?
- 3) Could/should existing programs be restructured to increase their efficacy and the return on investment of funds allocated to them?
- 4) Have other states utilized incentive programs that have proven effective that might in turn be useful in Oregon?





OREGON STATE SENATE
DISTRICT 17

Oregon, like every other state, faces a healthcare provider shortage now that will only worsen with our aging population. We must ensure that we use evidence-based practices to mitigate this shortage in the most cost-effective ways. Work undertaken via HB 3396 will increase the likelihood of our doing so.

SB 440 - Standardized Metrics

Metrics which hold healthcare providers as groups and individuals accountable for quality healthcare do not represent a new concept in medicine. They have been used by insurance companies in a variety of ways since at least the 1990's during the managed care era. Over the subsequent 20+ years, insurers have increasingly used quality metrics such as mammography rates, Hemoglobin A1C levels, and others as measures through which providers can earn bonuses or have "hold-backs", percentages held back from negotiated reimbursement rates, rebated. The data suggest that such metrics can help increase the rates of important screening interventions and treatment parameters.

However, over the years, each commercial insurer has developed its own set of metrics. The advent of Oregon's Coordinated Care Organizations (CCO's) with their rigorous metrics only exacerbated this diversity of expectations. Individual providers, provider groups, and hospitals & healthcare systems must report on a wide range of metrics to a wide range of organizations, and do so in multiple reporting formats. As a result, they must devote money & time, both scarce resources, to preparing and submitting these reports.

SB 440 seeks to eliminate this diversity of metrics and reporting systems by developing and implementing standardized metrics that all commercial insurers, CCO's, and the Public Employees' Benefit Board (PEBB) and Oregon Educators' Benefits Board (OEBC) would use. As Chief Sponsor of this bill, I believe that we can develop a single set of metrics that would reflect the best evidence on what measurements ultimately result in improvements in the Triple Aim (improved health, improved healthcare delivery, and decreased costs). Using such standardized measures would decrease the costs and hassles associated with results reporting, and allow "apples to apples" comparisons of outcomes between providers or hospitals and health systems.

Thank you in advance for considering my thoughts on these two metrics that will help Oregon increase its healthcare provider workforce in the most effective ways, and help them deliver the best care that is measured in the most consistent manner.

Respectfully submitted,

Senator Elizabeth Steiner Hayward MD

