

# Oregon Health Policy Board

## Workgroups and Committees

These documents provide an overview of the committees and workgroups under the OHPB, a summary of 2015 activities, progress, emergent issues and key decision points. For many of the workgroups, the most recent meeting minutes have also been included for reference.

### OHPB-CREATED WORKGROUPS:

- Joint Early Learning Council/OHPB subcommittee
- Coordinated Care Model Alignment Workgroup (CCMA)

### STANDING COMMITTEES:

- Health Care Workforce Committee (HCWF)
- Public Health Advisory Board (PHAB)
- Health Information Technology Oversight Council (HITOC)

### LEGISLATIVELY-MANDATED SHORT-TERM WORK UNDER OHPB:

- SB 440: Statewide strategic plan for data use and collection
- SB 231: Investments in primary care
- HB 5507: Home-visiting programs (*note: there are multiple programs and allocations under HB 5507, as it outlined budget notes from the 2015 session*)

# Oregon Health Policy Board

**Joint Early Learning Council/OHPB Subcommittee**  
**Standing Committee**  
 OHPB Liaison: Zeke Smith  
 OHA Staff: Steph Jarem

**Coordinated Care Model Alignment Workgroup (includes former SHEW)**  
**Time-limited Workgroup**  
 OHPB Liaison: TBD  
 OHA Staff: Veronica Guerra

**Health Care Workforce Committee**  
**Standing Committee**  
 OHPB Liaison: Carla McKelvey  
 OHA Staff: Marc Overbeck; Steph Jarem

**Behavioral Health Integration**  
**HCWF subcommittee; time-limited**  
 OHA Staff: Steph Jarem & Mike Morris

**Provider Incentive Payments Study (HB 3396)**  
**HCWF subcommittee; time-limited**  
 OHA Staff: Marc Overbeck & Oliver Droppers

**Health Information Oversight Council (HITOC)**  
**Standing Council**  
 OHPB Liaison: TBD  
 OHA Staff: Susan Otter, Justin Keller, OHIT staff

**Public Health Advisory Board (PHAB)**  
**Standing Board**  
 OHPB Liaison: Joe Robertson  
 OHA Staff: Lillian Shirley & Public Health Division staff

**Health Plan Quality Metrics Committee (2017)**  
**Standing Committee**  
 OHPB Liaison: TBD  
 OHA Staff: TBD

**PURPLE:** OHPB-created committees or workgroups  
**GREEN:** Standing committees/councils that are required in statute to report to the OHPB  
**BLUE:** Subcommittees of OHPB workgroups, usually time-limited

# JOINT ELC/OHPB SUBCOMMITTEE

## 2015 SUMMARY:

The joint ELC/OHPB subcommittee met four times in 2015. The focus for 2015 was on the development of the Child & Family Well-Being Measures, which was driven by a workgroup comprised of diverse stakeholders and experts brought together for this purpose. The final report and recommendations were produced in September 2015 and were shared with the OHPB (1/6/16) and the ELC (1/28/16).

Other areas of discussion and review by the joint subcommittee in 2015 included infant mental health, the Kindergarten Readiness Assessment, and developmental screening.

## NEXT STEPS AND PLAN FOR 2016:

A joint meeting between the full policy bodies (ELC and OHPB) has been scheduled for February 25, 2016. The goals of the meeting include:

- Discuss next steps for Child & Family Well-Being Measures work
- Discuss opportunities for greater alignment and collaboration between the education system and the health system
- Determine the future of the Joint ELC/OHPB Subcommittee

The OHPB/ELC joint meeting on February 25, 2016 will offer much-needed insight on the future of the joint subcommittee and will provide direction on efforts towards alignment and coordination of the early learning system transformation and health system transformation. OHA is in the midst of mapping connections between the agencies and other efforts and can share that with the OHPB at a later date.

## FOR OHPB CONSIDERATION:

A set of six recommendations are pending from the Child & Family Well-being Measures Workgroup:

1. Adopt the *definitions* and *domains* of child and family well-being.
2. Adopt the recommended child and family well-being *measures library*.
3. Implement a child and family well-being measures *dashboard*.
4. Encourage the Metrics & Scoring Committee, Oregon Health Authority, Early Learning Council and the Early Learning Division to consider child and family well-being *accountability measures* in their management and contracting arrangements with CCOs and Hubs.
5. The Joint Subcommittee, Oregon Health Authority, Early Learning Division of the Oregon Department of Education and Department of Human Services should periodically review performance for the *measures in the monitoring set*.
6. The Joint Subcommittee should support a *successor body* to the workgroup to serve as custodian of the child and family well-being measure sets.

**Joint ELC OPHB Meeting  
DRAFT Minutes  
September 14, 2015  
Portland State Office Building  
800 NE Oregon, Rm. 1E  
9:00 a.m. to 12:00 p.m.**

**Item**

**Welcome, meeting minutes, and agenda overview**

**Present:** Dana Hargunani, Pam Curtis, Zeke Smith, Megan Irwin, Lynne Saxton, Leslie Clement, Stephanie Jarem, Teri Thalhofer, Janet Sourgherty-Smith, Jerry Waybrant

**Absent:**, Jim Carlough, Nakesha Knight-Coyle

Dana called the meeting to order and announced that she has stepped down from her position at OHA as the Child Health Director. Dana introduced Stephanie Jarem (OHA) and Nakesha Knight-Coyle (ODE) who are now staffing the joint ELC OHPB meetings.

**Consent Agenda:** The minutes from the June 22, 2015, approved.

**Child and Family Well-being Measures Workgroup: Final Report and Recommendations - Tim Rusk and Helen Bellanca, Workgroup Co-Chairs and Dana Hargunani, Consultant**

Dana gave a brief background. Dana gave kudos to staff who helped make this report possible.

Tim and Helen presented the report and recommendations to the full group. Discussion centered on why there is a need to use existing metrics rather than creating new metrics. The long-term goal is still to move towards a “kindergarten readiness” metric, but the system is not there yet.

**Motion:** Approved Child and Family Well-being Measures Workgroup Report and recommend there be a focus on a joint conversation between the Early Learning Council and the Oregon Health Policy Board with an emphasis on implementation.

**Motion carried**

The full report can be viewed [here](#).

**Kaiser Permanente Pediatric Population Health Report Card – Elizabeth Engberg, Daniel Field, Brian Sikora and Gina Carter-Beard**

Elizabeth Engberg, Dan Field, Delilah Moore and Gina Carter-Beard presented their report card to the committee.

Presentation can viewed [here](#).

**A longitudinal look at child at risk in Oregon – Pam Curtis and OHSU Staff**

Pam presented information on Pay for Prevention. Feel free to visit [www.oregonp4p.org](http://www.oregonp4p.org) to experience this interactive website and we would appreciate your feedback.

Presentation can viewed [here](#).

**Reflections and Next Steps – Zeke Smith and Pam Curtis**

The group thanked Dana for all her hard work. The Child & Family Well-being Measures will be presented independently to each policy body (ELC and OHPB), and then the two policy bodies will meet to discuss next steps and any other areas of potential overlap between the early learning system and the health system.

**OHPB video and audio recording**

To listen to the audio link of the Joint ELC OPHB meeting in its entirety click [here](#).

**Adjourn**

**Next meeting:**

TBD

# Coordinated Care Model Alignment Workgroup

## Background and scope

Through its 2013 recommendations for aligning the Affordable Care Act with Oregon's health system reform, the Oregon Health Policy Board (Board) directed the Administrator of the Public Employee Benefits Board (PEBB), the Administrator of the Oregon Educators Benefits Board (OEBB) and the Director of the Oregon Health Authority (OHA) to jointly charter a workgroup charged with spreading Oregon's coordinated care model.

The Oregon Health Policy Board has charged the CCMA Workgroup with spreading the Coordinated Care Model (CCM) to the commercial market. The Workgroup is charged with developing a host of tools that will assist in the implementation of CCM principles across multiple market segments, including a toolkit for purchasers. The workgroup is expected to do the following:

- Develop a timeline and work plan to spread the Coordinated Care Model;
- Conduct and publish an environmental scan assessing broad market needs regarding implementation and spread of coordinated care model principles;
- Develop common contract terms and "tool-kit" (e.g. Framework for Coordinated Care Model purchasing) for interested purchasers;
- Develop and adopt a process for organizational alignment and shared learning among purchasers to foster broad implementation of the coordinated care model and aligned purchasing policies and standards;
- Support systems wide measure and metrics alignment;
- Collaborate with private purchasers to spread the coordinated care model and support alternative payment methodologies; and
- Provide workgroup progress reports at least bi-annually to the Director of OHA and the Board.

## Membership

- Laura Cali, Insurance Commissioner Department of Consumer and Business Services, Insurance Division
- Terry Coplin, CEO, Trillium Community Health Plan
- Dan Forbes, Benefits Manager, OHSU
- Marc Gonzales, CFO, Clackamas County Department of Finance
- Heidi Williams, Director of Operations, OEBB
- Kathy Loretz, Deputy Administrator, PEBB
- Diane Lovell, Council Representative, AFSCME
- Jesse O'Brien, Health Care Advocate, OSPIRG
- Jordan Pape, Chief Executive Officer, The Pape Group, Inc.
- Robin Richardson, Senior Vice President, Moda Health
- Anthony Behrens, DCBS, Health Insurance Marketplace

## Summary of 2015 activities

- **Oregon's Coordinated Care Model communications tool (toolkit product)** – the tool highlights the various elements of the CCM and translates each element to the purchaser, employees, and the health plan.
- **Framework for contracting and procurement (toolkit product)** – this tool is designed to be used by self-insured purchasers looking to incorporate the CCM components into their benefits purchasing. The framework highlights the critical elements of the model and offers specific measures or targets that could be adopted to encourage progress towards transformation of specific areas included in the document.
- **Environmental scan** – the scan aims to develop a more comprehensive picture of Oregon's health insurance market and existing programmatic and operational efforts to adopt the CCM. The Oregon Health Authority, with support from Bailit Health Purchasing, interviewed carriers and purchasers throughout the state. The information will help the CCMA workgroup define other tools that might be helpful to purchasers and carriers thinking about adoption of the CCM components and for consumers seeking to understand the model.

## Next steps and plan for 2016

- **CCM spread and client communications** – Under the State Innovation Model Grant, the communications team has contracted with a vendor (Metropolitan Group) that will develop messaging and communication strategies for specific groups, including local governments, brokers, and PEBB and OEBC clients.
- **Model contract language (toolkit product)** – the model scope of work will provide model contract language framed around the CCM that can be adopted (wholesale or partially) by purchasers entering into a contract with a Third Party Administrator.
- **PEBB/OEBC APM tracking**– using the CCO financial report (report L16) that tracks alternative payment arrangements, we will develop a template report for PEBB and OEBC carriers.
- **Return on Investment (ROI) (toolkit product)** develop an ROI for the core elements of the Coordinated Care Model (e.g. PCPCH).
- **Inclusion of CCM principles into QHP RFI** – OHA and DCBS staff will collaborate to ensure the CCM principles are incorporated into the upcoming RFI.

## For OHPB consideration

- The workgroup's charter sunsets in June 2016. Input is needed on how and whether the CCMA workgroup can be useful going forward to continue to spread the Coordinated Care Model. There are three potential options for the group's continued work: (1) focus on communications and outreach to purchasers and brokers, (2) offer targeted evaluation/tracking of the CCM in Oregon, (3) move towards aligning state purchasing efforts around the CCM (e.g., ensuring CCM is embedded in PEBB and OEBC and bringing local governments into PEBB and OEBC).
- What additional tools could be developed to make the group's existing work useful and of value to purchasers?
- Is there interest in a second phase of the Sustainable Health Care Expenditures Workgroup (under the CCMA) to more directly focus on activating this work from a policy perspective?

**2016 Coordinated Care Model Alignment Workgroup  
Meeting Summary**

January 25, 2016 3:00-4:30pm

Committee Members in Attendance

Lee Ballard (in lieu of Jordan Pape)  
Heidi Williams  
Marc Gonzalez  
Laura Cali  
Kathleen Loretz

Chris Ellertson  
Diane Lovell

Staff

Veronica Guerra, Policy Analyst  
Leslie Clement, Director of Policy and Analytics  
Kate Nass, Deputy Director of Finance  
James Raussen, OEBB Administrator  
Alissa Robins, Communications Manager  
Steph Jarem, Policy Analyst  
Oliver Droppers, Policy Analyst

Also in Attendance

Jennifer Heilbronner, Metropolitan Group  
Beth Waldman, Bailit Health Purchasing  
Leona Sander, Umpqua Health Alliance  
Adam Matar, Matar Pacific

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Veronica welcomed Chris Ellertson into the group. He will replace Terry Coplin, who is retiring in the next few months.

1. Spreading the Coordinated Care Model in the commercial market

Jennifer Heilbronner from the Metropolitan Group gave a presentation highlighting focus group findings on spreading the Coordinated Care Model in the commercial market. Their goal in doing this research was to develop messages to:

- Spread coordinated care into the commercial market by motivating brokers, employers and employees to choose or ask for it
- Spread PEBB/OEBB to local governments (as a delivery vehicle for coordinated care)

Her research group took part in workshops with the Coordinated Care Model Alignment Workgroup and focus groups with brokers and supplementary interviews with key audiences around Portland and Salem. Her presentation focused on the findings with Brokers, Employers and Employees.

Overall it is important to talk about the Coordinated Care Model to brokers and employers in order to get employees understand the model better. It is also important to show how it works with specific

plans rather than a theoretical general view of the coordinated care model. Messaging is very important in helping to spread the coordinated care model.

## 2. Finalize model contract, review fact sheets, and next steps

The group was provided a draft model contract that the group can look over and provide comments to Veronica or Beth.

Veronica distributed some fact sheets based on the last meeting's request to help employers better understand the model. The 3 fact sheets that she prepared are:

1. Patient-Centered Primary care Homes
  2. Payment Reform Matters
  3. Multi-State Employers should participate in payment reform
- Some of the comments were:
    - Provide examples that are relevant to small and mid-sized employers
    - Language should be clearer and appropriate for the audience. It should resonate with the audience and should avoid wonky language.
    - Revise language to focus on delivering better outcomes and value-based care. Though important, there should be less focus on costs.
    - We may also want to talk about avoiding unnecessary or duplicative services.
    - Given the fairly broad Providence/MODA networks we could consider incorporating language that reassures employers/individuals that they would have access to a broad network of providers.
    - Better explain that the individual's PCP will be coordinating their care
    - Think about our target audience(s) for the fact sheets? What is our ask for the target audience(s)? What first steps can they take?
  - Additional tools/resources/next steps:
    - Is it possible to develop "testimonials" from the local government that have moved into PEBB/OEBB or is it too soon?
    - The group should focus on PEBB/OEBB and local governments and then build evidence to make the case for other purchasers
    - Messages for PEBB/OEBB members initially and then focus on other consumers  
May want to develop a set of questions that an employer can use when procuring health care services. Questions can be used by employer to understand how carriers are doing business and designing their plans.  
It seems like the PEBB/OEBB RFPs would be a good basis for developing the list
      - We may want to combine with a checklist that helps employers identify a Coordinated Care Model type product.
      - Aligning Forces for Quality developed a set of questions for consumers that can be used as a reference point when developing this tool.

- This would be helpful in moving the broker community. We need to help build the demand for CCM-type products in the commercial markets and it seems like there is a serious lack of understanding and actual resistance from brokers.
- Small employers need additional information about the options that are available. We may be able to repurpose existing information about CCM type products from the commercial side. Can also reference marketing materials being used by multi-payer PCPCH collaborative.
- Would be helpful to understand what plans/products are out there that align with CCM and what is of interest to employers who are selecting those plans/products?  
Absolutely

*Veronica will bring more products to the next meeting based on the suggestions/comments from today's discussion.*

### 3. Return on Investment brainstorm

- ROI brainstorm:
  - Additional evidence that can be used –
    - PEBB members that moved from commercial line of business to All Care CCO.
    - Prospective risk scores from premium/rate setting would likely be helpful to us.
    - Can also reach out to other carriers (e.g., Moda, Pacific Source, Providence) to get additional data for ROI. We can use the environmental scan to help us identify additional carriers.
    - Data/evidence from the Moda Chronic Care Condition program can also be helpful but it is limited to those who are high utilizers.
    - Oregon specific evidence can be supplemented by national evidence.
- What/how are we measuring?
  - Suggestion to focus on a pre/post comparison as being used by a carrier.
  - What we are measuring will help us identify the carrier data that is needed.
  - Cannot recommend one carrier over another so need to be thoughtful about the design of the ROI.
- There might be an interest in understanding the ROI for a child population. Do we want to focus on adults only or should the ROI also include children?

### 4. Public Comment

There was no public comment.

Next Meeting

March 17, 2016 2:00-4:00pm

# HEALTH CARE WORKFORCE COMMITTEE

## Background and scope

The Health Care Workforce Committee (HCWF) was established by House Bill 2009, Section 7 (3)(a). The Committee is guided by the Triple Aim of improving population health, improving the individual's experience of care and reducing per capita costs. The HCWF Committee develops recommendations and action plans for the Oregon Health Policy Board for implementing the necessary changes to train, recruit and retain a changing health care work force scaled to meet the needs of new systems of care. One important objective of the Committee is to provide regular analysis and reporting of workforce supply and demand.

The Health Care Workforce Committee aims to identify resources, needs, and supply gaps, and works to ensure a culturally competent workforce reflective of Oregon's increasing diversity. To the extent possible, the Committee coordinates and aligns recommendations of other health care workforce initiatives in its recommendations to the Oregon Health Policy Board.

## Membership

- Chair: David Pollack, MD, OHSU psychiatrist and public policy professor
- Vice-chair: Robyn Dreibelbis, DO, Western University of Health Sciences
- Patrick Brunett, MD, Clinical professor, OHSU Dept. of Emergency Medicine
- Jeff Clark, ND, Naturopathic physician, True Health Medicine PC
- David Nardone, MD, Veteran's Administration
- Jeff Papke, Executive Director at Cascades East Area Health Education Center
- Daniel Saucy, DMD, Private practice dentist
- Annette Fletcher, Workforce planning consultant at PeaceHealth
- Troy Larkin RN, Regional Director of Clinical Education and Development, Providence
- Janus Maybee, FNP, Mill Street Psychiatric
- Lita Cooligan, Associate VP, Oregon Institute of Technology
- Alisha Moreland-Capula, MD, OHSU Psych Dept, Chief Med Director for Volunteers of America
- Shilena Battan, Talent Acquisition Manager, Virginia Garcia Memorial Health Center
- Kate Lee, Provider recruiter, Multnomah County
- Tawna Sanchez, Director of Family Services, Native American Youth & Family Center

## Summary of 2015 activities

The Health Care Workforce Committee met six times in 2015. During the first half of the year, its focus was on specific activity that arose from its 2013-14 Charter, which included:

- Support and guidance for the new GME consortium
- Providing direction for the final Workforce Development Report
- Surveying members to identify possible topic areas within the OHPB priorities for focus

During the second half of the year, the Committee discussed the new Charter provided by the Board, and began organizing for a new set of deliverables requested in August by the OHPB through the new Charter for the HCWF Committee.

## Next steps and plan for 2016

As a result of action by the OHPB, the Workforce Committee now has a full complement of 15 members, representing a diverse range of constituencies and perspectives around the health care workforce and populations in Oregon needing health care.

The Board has charged the Committee to deliver the following in the 2015-17 biennium:

1. Baseline demographic and geographic profile of Oregon's behavioral health workforce using current workforce licensing data. Due: October 2015 (Completed)
2. Report and recommendations (Due: July 2016—will request an extension from OHPB)
  - Bringing successful behavioral health integration pilots statewide
  - Addressing any gaps in education and curriculum needed to train physical health and behavioral health providers to work in a team-based system
  - Policy changes needed to overcome barriers to behavioral and physical health integration faced by providers.
3. Study and report on the efficacy of Oregon's provider incentives and recommendations on improvements to the current incentives. Recommendations should also include other types of incentives such as subsidies to hospitals for graduate medical education, bonus payments to providers, loans to hospitals, retirement plans and tax credits. Due to the Oregon Legislature by September 1, 2016. Required by HB3396.
4. Ongoing Biennial Reporting (Due January 2017)
  - Projected Demand for Primary Care Providers in response to expanded ACA coverage
  - Ethnic and Demographic profile of Primary Care Providers

## For OHPB consideration

- **Extension:** Request that the Committee be given an extension for its remaining deliverables on Behavioral Health until November 2016 (originally slated for July 2016).
- **Membership:** Historically, the Committee has had several members participating from post-secondary education, in recognition of the relationship of training programs and supply of workers. When reviewing appointments for 2017, Committee and OHA leadership should consider including additional members from higher education.
- **Strategic Plan:** It may be useful for the Committee to conduct a review of its 2013 Strategic Plan for workforce recruitment and retention. The Committee's mandate identified in statute says that the "Committee shall coordinate efforts to recruit and educate health care professionals and retain a quality workforce to meet the demand that will be created by the expansion in health care coverage, system transformations and an increasingly diverse population."

**Oregon Healthcare Workforce Committee**  
**January 6, 2016 9:30 am – 12:30 pm**  
**at Wilsonville Training Center**  
**DRAFT - Meeting Summary**

<b>Committee Members in Attendance:</b>	Patrick Brunett Jeff Clark Jeff Papke (by phone) Robyn Dreibelbis (Vice-Chair) Janus Maybee Alisha Moreland Shilena Battan	David Nardone (by phone) David Pollack (Chair) Daniel Saucy Annette Fletcher Kate Lee Tawna Sanchez Troy Larkin
<b>Committee Members not in Attendance:</b>	Lita Colligan (Maria Lynn Kessler attended in place of Lita Colligan)	
<b>OHA staff, OHWI, OCN</b>	Stephanie Jarem, OHA Marc Overbeck, OHA Margie Fernando, OHA Oliver Droppers, OHA	Mike Morris, OHA Chad Johnson, OHWI Jana Bitton, OCN
<b>Others</b>	Carla McKelvey, Oregon Health Policy Board liaison	

<b>1</b>	<b>Welcome</b>
	David Pollack, Chair, welcomed everyone to the committee, especially the new members, who were confirmed by the Oregon Health Policy Board at its meeting on Jan 5, 2016.
<b>2</b>	<b>Approval: Nov 4, 2015 Meeting Summary</b>
	Meeting summary for Nov 4, 2015 meeting was approved with no changes.
<b>3</b>	<b>Election of Vice-Chair</b>
	David Pollack noted that the Bylaws of the Committee call for a Chair and Vice-Chair, and that for some time the position of Vice-Chair has been vacant. He then proposed that Robyn Dreibelbis be appointed as Vice-Chair. Proposal was approved without objection.
<b>4</b>	<b>Updates</b>
	<u>OHPB Updates</u> Carla McKelvey updated the Committee on the Oregon Health Policy Board meeting held on Tues Jan 5, 2016.

The main update was that the Board formally appointed seven new members and reaffirmed the full membership and charter for the Committee. Carla also spoke about the briefing the Board had from OHA Director Lynne Saxton and the reorganization of OHA. The new Leadership Team is now in place. A copy of the high-level organization chart was distributed.

Carla also noted that there is a strategic planning meeting in February for the Health Policy Board to set their goals and priorities for the year.

#### OHA Updates

Steph updated the committee on the 10 priorities that OHA Director Lynne Saxton shared with the Health Policy Board that represent the Leadership Team's priorities for 2016 through 2017. These are:

1. Eligibility, enrollment, and determination systems (ONE, MMIS, etc.)
2. Behavioral health system
3. Pharmacy and high cost drugs
4. Public Health Modernization
5. Marijuana
6. 1115 Waiver renewal
7. Health System Transformation "for real"
8. Health disparities and health equity
9. Financially sustainable budget
10. Employee empowerment

+11 Legislative or Governor-directed activities, as needed

Staff will distribute this list to the committee as part of follow-up to the meeting..

#### Other updates

David and Marc updated the full Committee on the orientation that was held earlier today for the new members. The group discussed the history and mission of the Committee, its Charter, and deliverables—both past and upcoming. New members were given the opportunity to ask questions.

Marc also provided a written update from the Office of Equity and Inclusion on the Traditional Healthcare Worker Program. Of note is that the Commission that oversees the program is looking for members.

Patrick Brunett updated the committee on the GME consortium. There were no new updates since the last meeting, but for the benefit of the new members he explained what the GME consortium was about. Robyn added that it was a big achievement to see how the concept and conversation about GME originated with the Committee and is now at the stage where a Consortium has been established and has been launched.

<b>5</b>	<b>Update on HB 3396 Provider Incentives Study Timeline</b>
	<p>Marc and Oliver provided a brief overview of the history of HB 3396, which calls for a study and recommendations to the legislature on provider incentives in Oregon. Specifically, HB 3396 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 and make recommendations to the Legislature. The Board has asked the Committee to act on its behalf and come back with a report in the summer.</p> <p>Since the last meeting OHA has selected a vendor, The Lewin Group, to analyze the program data needed for an evaluation of the effectiveness of existing programs. In addition, OHA will organize focus groups and stakeholder meetings to include viewpoints from the community, from agencies and from the direct beneficiaries of the incentives themselves.</p>
<b>6</b>	<b>Multnomah County’s Behavioral Health Integration Efforts</b>
	<p>Julie Oyemaja from the Multnomah County Health Department was scheduled to provide information to the Committee but was unable to attend due to a conflict. David Pollack and Marc informed the Committee that they would look for another date at a future meeting for Julie to brief the Committee on her work.</p>
<b>7</b>	<b>OHA Transformation Center’s Behavioral Health Integration Efforts</b>
	<p>Chris DeMars, Director of Systems Innovation and Summer Boslaugh, Transformation Analyst from the OHA Transformation Center presented an overview of the Transformation Center, the Center’s Strategic Plan, their Behavioral Health deliverables and their workforce-related activities. Chris and Summer took questions from members.</p>
<b>8-9</b>	<b>Break up of committee into 2 groups to discuss Provider Incentives and Behavioral Health</b>
	<p>The Committee split into two groups for approximately an hour.. One group discussed Behavioral Health Integration work and the second discussed the HB 3396 Provider Incentives work. The groups were asked to meet and develop plans, milestones and timetables for how the work in the Committee Charter is to be accomplished.</p> <p>a) Behavioral Health Integration work  The group decided to appoint Dr. Steven Levy and Dr. Alisha Moreland as Co-Chairs of this project. The group decided to address the three deliverables as follows:</p> <ol style="list-style-type: none"> <li>1. Bringing successful behavioral health integration pilots statewide: Conduct an environmental scan of successful pilots and programs; Develop a survey for clinics and providers; Utilize results to identify best practices for recommendation.</li> <li>2. Addressing any gaps in education and curriculum needed to train physical health and behavioral health providers to work in a team-based system: Define the key functions/competencies of team-based, integrated care; Survey education programs in</li> </ol>

	<p>Oregon on training opportunities for those competencies; identify gaps through survey results and other research.</p> <p>3. Policy changes needed to overcome barriers to behavioral and physical health integration faced by providers: Review previous presentations and research policy changes, including alternative payment methodologies, process of work issues, and mental health carve-outs.</p> <p>Mike Morris and Steph Jarem will support the group to work out a timeline for when this work needs to be completed. It was agreed that the initial deadline of July 2016 is not feasible for this large a task set.</p> <p>b) HB 3396 Provider Incentives work  The group largely spent its time understanding the current thoughts from OHA staff on organizing the work and ensuring that all stakeholders can be heard in the process. The members in this group determined that three Committee members would participate in the Steering Group for this effort, and they would take responsibility for keeping others informed. Jeff Papke will lead efforts on this topic for the Committee. Members expressed their desire to see “town hall”-type forums in different parts of the state in addition to reaching out to a larger group of external stakeholders to get input, which would include people and organizations who directly benefit from provider incentives. OHA staff will identify potential dates for these meetings.</p> <p>Once the vendor, the Lewin Group has completed their data analysis, it will be sent to the Steering Committee and on to the full Committee. The group will work within the timeline proposed by OHA staff in order to complete the work before September 2016.</p> <p>Staff in OHA will coordinate all the meetings and work with the vendor.</p>
<b>10</b>	<b>Public Comment</b>
<b>11</b>	<p>There was no public comment.</p> <p>Meeting was adjourned at 12:35. The next meeting will be on March 2, 2016.</p>

# Public Health Advisory Board (PHAB)

## Background and scope

The PHAB is a new subcommittee of the OHPB, created by House Bill 3100 (2015). The PHAB was appointed by Governor Brown in December 2015. A previous form of the PHAB did exist prior to HB 3100 but it was used mainly as an expert advisory panel and was not responsible for oversight.

The purpose of the PHAB is to be the accountable body for governmental public health in Oregon. The role of the PHAB includes:

- Oversight for the implementation of Oregon's State Health Improvement Plan.
- Oversight for the implementation of public health modernization.
- Development and implementation of accountability measures for state and local health departments.
- Development of equitable fund distributions to support governmental public health.

## Membership

Members of the PHAB are governor-appointed.

- Carrie Brogoitti, Public Health Administrator, Center for Human Development., Inc.
- Muriel DeLaVergne-Brown, Public Health Administrator, Crook County Health Dept.
- Silas Halloran-Steiner, Director, Yamhill County Health and Human Services
- \*Katrina Hedberg, State Epidemiologist and Health Officer (OHA)
- Prashanti Kaveti, Special Projects Coordinator, Willamette Family Medical
- Safina Koreishi, Medical Director, Columbia Pacific Coordinated Care Organization
- Jeffrey Luck, Associate Professor, OSU
- Alejandro Qeral, Director of Systems Planning and Performance, United Way of C-W
- Eva Rippeteau Chavira, Political Coordinator, AFSCME
- \*Joe Robertson, President, OHSU
- Akiko Saito, Operations Chief, OHA Public Health Division
- Eli Schwarz, Professor and Chair, OHSU
- \*Lillian Shirley, Director, OHA Public Health Division
- Teri Thalhofer, Public Health Administrator, North Central Public Health District
- Latricia Tillman, Public Health Director, Multnomah County Health Department
- Jennifer Vines, Health Officer, Multnomah County Health Department

*\*denotes ex-officio member*

## Plan for 2016

The PHAB is scheduled to hold its first meeting on January 29. This meeting will include election of a chair and co-chair, review of a draft charter, and presentations about Oregon's governmental public health system and public health modernization.

Future meeting topics will include:

- Review of Oregon's State Health Improvement Plan (SHIP), with updates on activity for each of the seven priorities included in the SHIP;
- Discussion about options for the use of incentives to encourage the effective and equitable provision of public health services by local public health authorities;
- Review of the public health modernization assessment findings and final report;
- Discussion about the statewide public health modernization plan;
- Discussion about accountability measures for Oregon's public health system.

### For OHPB consideration

The PHAB would like to request that OHPB:

- Provide a recommendation for how often the PHAB should provide updates and reports;
- Review and approve the PHAB charter;
- Provide input on the implementation of public health modernization;
- Provide input on progress toward the goals identified in the SHIP.

# Health Information Technology Oversight Council (HITOC)

## Background and scope

The passage of House Bill 2294 in June 2015 improves the Oregon Health Authority's ability to advance HIT in Oregon. HB 2294 also realigned the HITOC's charter and membership to report to the Oregon Health Policy Board. Responsibilities include:

- Identify and make specific recommendations to the Board related to health information technology ("HIT") to achieve the goals of health system transformation.
- Regularly review and report to the Board on:
  - OHA's HIT efforts, including the Oregon HIT Program, toward achieving the goals of health system transformation;
  - Efforts of local, regional, and statewide organizations to participate in HIT systems;
  - This state's progress in adopting and using HIT by providers, health systems, patients and other users.
- Advise the Board or the Congressional Delegation on changes to federal laws affecting HIT that will promote this state's efforts in utilizing HIT.

## Membership

- Richard (Rich) Bodager, CPA, MBA, CEO/Board Chair, Southern Oregon Cardiology/Jefferson HIE
- Maili Boynay, IS Director Ambulatory Community Systems, Legacy Health
- Robert (Bob) Brown, Retired Advocate, Allies for Healthier Oregon
- Erick Doolen, COO, PacificSource
- Chuck Fischer, IT Director, Advantage Dental
- Valerie Fong, RN, CNIO, Providence Health & Services
- Charles (Bud) Garrison, Director, Clinical Informatics, OHSU
- Brandon Gatke, CIO, Cascadia Behavioral Healthcare
- Amy Henninger, MD, Site Medical Director, Multnomah County Health Department
- Mark Hetz, CIO, Asante Health System
- Sarah Laiosa, MD, Physician, Harney District Hospital/HDH Family Care
- Sonney Sapra, CIO, Tuality Healthcare
- Greg Van Pelt, President, Oregon Health Leadership Council

## Summary of 2015 activities

HITOC was fully reset in 2015 to reflect the priorities of the Board and held its first meetings in October and December 2015. Actions that occurred during the first two meetings:

- Discussed and approved their own charter, previously approved by the Board;
- Discussed and approved a set of by-laws, clarifying roles of chair/vice-chair, members, subcommittees, meeting logistics, etc.;
- Discussed and endorsed the charter of the HIT/Health Information Exchange Community & Organizational Panel (HCOP), which is a subcommittee charged with facilitating communication

between health information exchange entities and other organizations, and providing input to HITOC and OHA regarding ongoing strategy, policy, guidance, and implementation efforts.

## Next steps and plan for 2016

HITOC will begin meeting regularly, every other month, starting in February 2016. The work of HITOC in 2016 can be summarized into five broad categories:

1. **Priority policy topics:** Input from the Health Policy Board and other stakeholders led to the identification of two priority policy topics that HITOC will address in 2016:
  - a. Real-world interoperability – significant HIT investments have been made at the local, regional, and state levels. Barriers still exist in connecting HIT systems to each other and ensuring systems can securely exchange health information. HITOC will identify and make recommendations regarding actions that the state can take to improve interoperability over the course of the next two years.
  - b. Behavioral health information sharing – federal policies (e.g., 42 CFR part 2), lack of clarity regarding federal and state laws, and technical limitations/challenges are all barriers to sharing behavioral health information more broadly in Oregon. HITOC will focus initially on: understanding the behavioral health IT environment in Oregon and barriers to information sharing (including a behavioral health provider survey); monitor and support existing behavioral health information sharing efforts; and eventually make recommendations regarding additional actions that could be taken.
2. **Strategic planning:** the current strategic plan for Health IT in Oregon is set to end in 2017. HITOC will develop a process in 2016 for updating the strategic plan and will plan to deliver an updated strategic plan in 2017.
3. **Oversight of existing state-led health IT efforts:** HITOC will consider pressing issues of the Oregon HIT Program as it continues to develop and will be regularly updated by OHA staff on the progress of statewide HIT activities.
4. **Scanning the health IT environment and reporting to the Board:** HITOC will work with OHA on initial reporting for the HIT environment in Oregon and OHA's HIT efforts. HITOC will also plan to submit its first report to the Board in June 2016 which OHA will provide to the legislature in July 2016.
5. **Monitoring federal policy:** significant federal policy changes in 2016 include the final rules for Stage 3 of Meaningful Use as part of the HITECH Act. HITOC will also consider the potential HIT impact of the Medicare Access & CHIP Reauthorization Act of 2015 (MACRA), which will be proposed in 2016.

## For OHPB consideration

- Review and feedback on first HITOC report due to the Board in June.
- Potential findings or recommendations related to interoperability and/or behavioral health information sharing proposed to the Board in the future.

## Health Information Technology Oversight Council

Thursday, October 14, 2015; Portland, Oregon

1:00 – 4:30 pm

**Council and Ex-officio Members Present:** Erick Doolen (Chair), Bob Brown (Vice-Chair), Rich Bodager, Maili Boynay, Chuck Fischer, Valerie Fong, Bud Garrison, Brandon Gatke, Amy Henninger, Mark Hetz, Betty Kramp, Jim Rickards, Greg Van Pelt

**Council and Ex-officio Members by Phone:** Sarah Laiosa

**Council and Ex-officio Members Absent:** Sonney Sapra

**Staff Present:** Susan Otter, Rachel Ostroy, Britteny Matero, Marta Makarushka, Lisa Parker, Melissa Isavoran, Kim Mounts, Justin Keller, Tyler Lamberts

<p><b>Welcome</b> – Susan Otter and Erick Doolen (Chair)</p> <p>Refer to slide 2-7</p> <ul style="list-style-type: none"><li>• Susan started the meeting and welcomed the group; the Chair then reviewed the agenda for the meeting. There were no additional comments or announcements.</li><li>• Susan reviewed the three goals of HIT-Optimized Health Care, and explained the vision of these goals in Oregon, the role of HITOC and its' reporting to the Oregon Health Policy Board, as well as Health Information Technology (HIT) opportunities and challenges in Oregon.</li></ul>
<p><b>Introductions</b> – HITOC Members</p> <p>Refer to slide 8</p> <ul style="list-style-type: none"><li>• Susan noted the variety of experience reflected in the HITOC membership. She emphasized the Oregon Health Policy Board's key HIT policy interests of interoperability and behavioral health and how HITOC experience will relate to these topics.</li><li>• Each member of HITOC was then asked to answer the question 'Why is it important to you to move health IT forward in Oregon? (OHIT staff will provide summarized responses in the December HITOC meeting materials.)</li></ul>
<p><b>Health IT Overview</b> – Susan Otter</p> <p>Refer to slides 9-22</p> <p><u>Presentation:</u></p> <ul style="list-style-type: none"><li>• Susan gave an overview of HIT/Health Information Exchange (HIE) in Oregon, including how technology supports Oregon's Medicaid coordinated care organizations (CCOs) and the coordinated care model. Maps were presented highlighting various HIT/HIE efforts in Oregon. Susan discussed the role of the Oregon Health Authority (OHA) in statewide HIT, the specific role of the Office of HIT (OHIT) within OHA, and the Oregon HIT Program.</li><li>• Susan asked the group if orientation webinars were a useful way to bring HITOC members up to speed outside of HITOC meetings. Several HITOC members agreed this would be helpful and staff agreed to schedule a webinar to delve deeper into the content of the Oregon HIT Program.</li></ul> <p><u>Discussion:</u></p> <p><i>Electronic Health Record (EHR) and HIE use in Oregon (pie charts and maps)</i></p> <ul style="list-style-type: none"><li>• There were comments about the high representation of Epic in Oregon and the opportunity for organizations to come together to leverage greater influence with specific vendors for interoperability needs.<ul style="list-style-type: none"><li>○ Susan commented that provider challenges navigating EHR and other vendors is something that OHIT hears about often and that OHIT would like to look for opportunities to help providers with this challenge and support them.</li></ul></li><li>• Question: do the EHR Vendor pie charts include dental providers?<ul style="list-style-type: none"><li>○ Answer: Susan offered that OHIT staff can provide more detail about the EHRs that dental providers receiving incentive payments are adopting</li></ul></li></ul>

- Question: could future versions of the EHR Incentive Payment data present further detail, such as rates of providers receiving Meaningful Use Stage 2 payments?
  - Answer: Susan answered that yes, Meaningful Use Stage 1 (MU1) and Meaningful Use Stage 2 (MU2) data can definitely be added in the future, as well as report on rates of providers meeting certain Clinical Quality Measures (CQMs).
- Discussion on presentation of data:
  - Interest in EHR adoption rates normalized by populations in each county
  - Interest in weighting hospital data by hospital size of facility/number of beds
- Question: what is the goal of looking at these maps? For example, are we trying to find gaps by region, system, or other factors so that we can make recommendations about how to address those gaps?
  - Answer: Susan explained that these visuals are being shown to provide background information and to support conversations about interoperability and health information exchange. They can also be used for identifying and targeting efforts to fill gaps where needed.
- Question: what three HIEs are represented in the ‘Participation in HIE – by County’ visual?
  - Answer: Susan answered that the three HIEs are Jefferson Health Information Exchange (JHIE) in Southern Oregon and the Columbia Gorge regions, Central Oregon Health Connect (currently in transition), and Care Team Link (in development in the Corvallis area).

*Oregon HIT Program and Efforts underway*

- Question: how should the group balance meeting the varied needs across the state, since it is impossible to meet the needs of everyone?
  - Answer: Susan gave some background on the development of the current Business Plan Framework: OHA staff engaged in listening sessions in 2013 with CCOs and other stakeholders across the state, then synthesized the information and recommended efforts including state-level technology investments that addressed needs stakeholders had in common, seemed feasible, and made sense to tackle at the state level.
- Discussion on HITOC’s work:
  - HITOC should consider fostering what is already going on and recognize that (statewide HIT) efforts don’t necessarily need to originate at OHA
  - HITOC will need to think about the potential challenges with advancing HIT/HIE and leveraging resources.
  - The group will need to align their ideas to the HIT-optimized goals, which will help drive where the priorities are. It will be important to “organize the chaos” and align to the overall goals.
  - A “one size fits all” solution will not work – a solution that works in one region may not be the answer statewide.
  - HITOC should not reinvent the wheel – we could develop a menu of options for providers that are endorsed by the state. HITOC could develop common definitions (e.g., for attribution), and educate, understand what others are doing
  - Education component is needed – especially for smaller/rural practices on what is available to a practice
  - Behavioral health practices typically don’t have extra revenue to spend on sophisticated tools. Now there are more options and less of a high cost of entry. Separating addiction treatment workflows and parsing data are particular challenges. Resources would be helpful to highlight promising vendors or approaches
  - Common interpretation of federal requirements related to sharing behavioral health information (42 CFR Part 2) is critical

- Providers and hospitals are increasingly getting significant data requests from payers who are not aligned which increases burden
- Making data actionable is critical – there is so much data but it is not consumable. We need to consider what decisions/interventions we will make informed by the data
- Discussion on HITOC’s monitoring and oversight role:
  - HITOC will need to develop metrics surrounding all of the components with the Oregon Health IT Program to evaluate and assess the value of what is being done. Assessing current challenges and obstacles can help inform if resources need to shift.
  - HITOC will want to think about how to prioritize oversight, for example, some efforts are operating smoothly and may not need much energy from HITOC, although HITOC can promote what’s working well. HITOC can help break down barriers to get things done.
- Discussion on HITOC’s strategic planning, priorities and focus areas:
  - Need to identify what we are trying to achieve. A higher level map of goals/aims-strategies-tactics/projects-metrics would really help HITOC focus its work.
  - It would helpful to look at how HITOC can move things along and leverage competencies around the state. Instead of re-doing the strategic plan, HITOC could identify the top three priorities and then work to achieve these.
  - HITOC could lay out its vision for where we want Oregon to be in 2020 and identify what groundwork needs to be laid in the near term
- Discussion on HITOC’s relationship to other efforts and advisory groups:
  - Understanding more about the oversight and responsibility of HITOC, particularly in relation to the other governing and advisory groups would be helpful.
  - Request for staff to bring the charters, roster of advisory group members and meeting times, and further information about roles/relationships to HITOC to the next HITOC meeting.

**HITOC History and Charter – Bob Brown, Justin Keller, Susan Otter**

Refer to HB 2294, HITOC Charter, and HITOC By-Law documents; slides 23-43

Presentation:

- Bob spoke about the history of HITOC and shared year-by-year highlights regarding the work done by the group since 2009, as well as past and present HITOC committees.
- Justin explained the three major components of House Bill 2294, HITOC membership principles and responsibilities of the council, and reviewed the HITOC Charter.
- Mark Hetz moved to approve the Charter, with the caveat that the work plan would need further development. Several HITOC members seconded. All HITOC members present and on the phone were in favor of approving the charter; no one opposed.

Discussion:

- Previous HITOC groups should be proud of the fact that (1) they noticed when things were coming too soon and (2) they were aware of the environment and pulled back when other work was being done outside of HITOC so that duplicative efforts were avoided.
- The 2015 legislation moves HITOC under the Oregon Health Policy Board - having clarity around who HITOC reports to is very helpful.
- Suggestion that HITOC receive regular reports about activities and deliverables of the advisory groups, such as the Provider Directory Advisory Group and Common Credentialing Advisory Group.
- Question: will HITOC be aligning with the federal Office of the National Coordinator for HIT (ONC) Interoperability Roadmap document?
  - Answer: Susan explained that OHIT staff have analyzed the ONC Interoperability Roadmap, provided comment to ONC on the draft Roadmap, and presented to HITOC on this earlier this year, and can bring this analysis back to the new HITOC if

<p>interested. Also, OHIT staff think there could be a benefit with HITOC putting together an interoperability work-group to focus on this topic.</p> <ul style="list-style-type: none"> <li>• The HITOC charter does not include metrics for HITOC. It will be important to know if the group is achieving its goals moving forward.</li> <li>• The charter gives the group good direction and it does not micromanage the work HITOC is tasked to do. Regarding metrics, HITOC could discuss this on a case-by-case basis and revisit those ideas in the future.</li> <li>• Question: will HITOC have the ability to address the charter down the road and make adjustments to it as need? <ul style="list-style-type: none"> <li>○ Answer: Justin explained that yes, changes would take a two-thirds majority of HITOC and then the change would go to the Oregon Health Policy Board for their approval.</li> </ul> </li> </ul>
<p><b>HITOC Logistics, Processes, and Preferences</b> – Susan Otter</p>
<p>Refer to slides 44-46</p> <p><u>Presentation:</u></p> <ul style="list-style-type: none"> <li>• Susan asked for feedback and suggestions from the group related to what worked well and what could be improved for today’s meeting.</li> </ul> <p><u>Discussion:</u></p> <ul style="list-style-type: none"> <li>• Question: can future orientation webinars be recorded so that HITOC members could access them at any time? <ul style="list-style-type: none"> <li>○ Answer: Justin answered that yes, the plan is to record the webinars in the future.</li> </ul> </li> <li>• Comments: <ul style="list-style-type: none"> <li>○ The meeting was well organized, and there was great participation and information shared.</li> <li>○ Location options: Meeting in Wilsonville is also a good option to consider besides Portland and Salem. When meetings are in Portland it would be preferred to have the location near the Max Line for those who are coming from the airport.</li> <li>○ Logistics: good phone etiquette is to announce who is talking before adding a comment or asking a question during a discussion.</li> <li>○ It would be great to plan meetings far in advance to allow for scheduling, etc. <ul style="list-style-type: none"> <li>▪ OHIT staff will bring this up at the December HITOC meeting to set up a recurring meeting time.</li> </ul> </li> </ul> </li> </ul>
<p><b>Public Comment</b> – Erick Doolen</p>
<ul style="list-style-type: none"> <li>• Hearing no comment, the Chair closed the public comment period at 4:25 p.m.</li> </ul>
<p><b>Closing Remarks</b> – Erick Doolen</p>
<ul style="list-style-type: none"> <li>• The meeting was adjourned at 4:31 p.m.</li> </ul>

**The next meeting will be held on December 14<sup>th</sup>, 2015 in Salem.**

# Senate Bill 440 & Health Plan Quality Metrics Committee

## Background

Senate Bill 440 passed in the 2015 legislative session and directed the Oregon Health Policy Board, in consultation with state agencies, to develop a strategic plan for health care data collection, as well as established the new Health Plan Quality Metrics Committee under OHPB.

SB 440 Deliverables	Dates
Strategic plan for data collection and reporting due to legislature	Sept. 1, 2016
HPQM Committee members are appointed (by the Governor) no later than	Feb. 1, 2017
Health outcome/quality measures identified shall be implemented on and after	Jan. 1, 2018
OHA report to legislature on Committee activities and OHA's compliance with SB 440	2017 & 2019

## Summary of 2015 activities

OHA staff presented to the board in December 2015 on SB 440, including the proposed process for developing the legislatively-mandated strategic plan. OHA requested OHPB feedback on several high-level questions, such as the most important health indicators or outcomes to improve over the next five years, as well as the board's ongoing role and level of involvement.

The board indicated they would prefer to be directly involved in creating the strategic plan, rather than establish a subcommittee to develop a report, and noted that further conversation in early 2016 was needed to determine the appropriate level and type of engagement, and respond to the staff questions.

Potential priorities areas noted include: behavioral health and oral health integration, and aligning with focus areas that support the Triple Aim that have been identified in other work (e.g., alcohol / substance use and mental health; pregnant women, children, and adolescents; screening and preventive care; medical errors and pharmacy; customer service).

## Next steps and plan for 2016

OHA is developing a straw proposal for the strategic plan for data collection and will bring to the board after the February retreat. OHA is also working to engage an independent consultant to help obtain stakeholder input on areas of focus and the types of data needed in state health care programs to support health system transformation efforts and promote value. Applications for the new Health Plan Quality Metrics Committee will open in Q2, 2016.

## For OHPB consideration

These questions were brought forward at the December 2015 OHPB meeting:

- Across the next five years, what are the most important health indicators or outcomes to improve?
- What would tell you that health system transformation has been successful?
- What areas of health and healthcare should be the focus for Oregon?
- How would OHPB prefer to be involved in this work?

# Senate Bill 231 – Primary Care Payment

## Summary of issue

Health System Transformation efforts driven by the Oregon Health Authority (OHA), particularly implementation of the Patient-Centered Primary Care Home (PCPCH) program, initiated a marked increase in the level of primary care transformation occurring in clinics around Oregon. While early [evaluation results](#)<sup>1</sup> indicate that this level of transformation is leading to delivery system improvement, the current infrastructure cannot sustain these efforts.

Nationally, approximately 5-6 percent of total health care expenditures go to primary care; however, successful health system transformation relies heavily on a well-functioning primary care system. Most states including Oregon have not had the information necessary to monitor and assess the percentage of total medical expenditures that are directed toward primary care.

Senate Bill 231, passed in 2015, aims to strengthen Oregon's primary care infrastructure.

## Background

In fall of 2013, a majority of payers in the state signed a voluntary agreement to use the OHA's PCPCH recognition as a common marker of primary care transformation and make variable payments to practices based on their level of recognition.<sup>2</sup> Eighteen months after the voluntary agreement, providers were reporting that the multi-payer primary care agreement was not resulting in meaningful payment changes for many. Uneven payer commitment means that some groups stand to reap the benefits of transformation without investing in the change.

In 2014, the Oregon Health Policy Board (OHPB) made a [recommendation](#) to the Governor to expand and improve the primary, preventive, and chronic care infrastructure, specifically by increasing resources directed toward that infrastructure.

## Summary of 2015 activities

Based on the OHPB's 2014 recommendations, OHA put forth Senate Bill (SB) 231 in 2015 to increase the speed and scope of primary care transformation and payment reform while also ensuring its sustainability. As introduced, the bill would have required major payers and CCOs to develop and adopt a limited set of alternative payment methodologies for primary care. Over the course of the legislative session, the bill was amended to focus on systematically assessing the payment landscape in lieu of mandating adoption of specific payment methodologies. These changes were based on feedback from and collaborative work between insurance representatives, CCOs, provider associations, legislators, and state government staff. As passed, [SB 231](#):

1. Requires all major insurers and coordinated care organizations to report the percentage of their total medical expenditures that are directed toward primary care.

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<sup>1</sup> See 2014-2015 PCPCH Program Annual Report (October 2015). Available from:

<http://www.oregon.gov/oha/pcpch/Documents/2014-2015%20PCPCH%20Program%20Annual%20Report.pdf>

<sup>2</sup> See Multipayer Strategy to Support Primary Care Homes (Nov. 2013)

[http://www.oregon.gov/oha/pcpch/Documents/multi-payer\\_support\\_strategy2.pdf](http://www.oregon.gov/oha/pcpch/Documents/multi-payer_support_strategy2.pdf)

2. Directs OHA and the Department of Consumer and Business Services (DCBS) to report back to the Legislature by February 2016 on the percent of total medical expenditures that are directed toward primary care and the methods used for reimbursing primary care services.
3. Directs OHA to convene a primary care payment reform collaborative, protected from anti-trust laws, where insurers and providers can share best practices in primary care alternative payment methodologies and develop strategies for coordinated technical assistance

## Next steps and plan for 2016

On February 1<sup>st</sup>, 2016, OHA submitted to the Legislature the report titled “*Primary Care Spending in Oregon.*” The report provides, statewide, the first snapshot of the percentage of medical spending allocated to primary care across multiple payers using information from 2014. The report, a first of its kind, summarizes the level of primary care spending among individual plans as both a percentage of total medical spending and on a per-member, per-month basis (PMPM). The report and its methodology offers an innovative measurement strategy for Oregon policy makers to use as a tool to gradually close the gap in primary care spending across payers, not just Medicaid.

OHA is actively working to convene a set of participants identified for the primary care payment reform collaborative. The first collaborative meeting will be held in late March 2016, with four to six monthly committee meetings thereafter.

## For OHPB consideration

For the past 2-3 years, the Oregon Health Policy Board has expressed a strong interest in continuing to promote investments and transformation in primary care including PCPCH. The report serves an important milestone in being able to allow the state to assess the level of investment in Oregon’s primary care delivery system. Building on OHPB’s standing interest with promoting primary care, OHA has identified several considerations and next steps:

- Moving forward, OHA would like guidance from OHPB as to ***whether this report should be produced, annually***, in collaboration with the Department of Consumer and Business Services (DCBS) in an effort to promote the Triple Aim.
- Are there other ***measures of primary care spending or investments*** that OHPB would be interested learning about in order to assess the level of investments and transformation in primary care in Oregon, statewide?