

Oregon Health Policy Board

AGENDA

July 13, 2010

Market Square Building
1515 SW 5th Avenue, 9th floor
1pm to 4:30pm

Live web streamed at: [OHPB Live Web Streaming](#)

#	Time	Item	Presenter	Action Item
1	1:00	Welcome, call to order and roll call Consent agenda: <ul style="list-style-type: none"> Minutes from June 9, 2010 meeting 	Chair	X
2	1:05	Director's Report	Bruce Goldberg	
3	1:15	Update on Administrative Simplification recommendations	Tina Edlund	
4	1:20	Draft Health Improvement Plan (HIP) recommendations	Tammy Bray Lila Wickham	
		<i>Public Comment on Draft HIP recommendations</i>	<i>The Board will accept public comment on the HIP draft recommendations immediately following the presentation.</i>	
5	2:30	Update on comprehensive plan framework: Board discussion and feedback	Gretchen Morley	
	2:45	Break		
6	3:00	Board Discussion: Essential Benefit Package	Intro: Bruce Goldberg Presentation: Jeanene Smith and Lisa Dodson	
		<i>Public Comment on draft Essential Benefit Package</i>	<i>The Board will accept public comment on the HIP draft recommendations immediately following the presentation.</i>	
7	4:15	General Public Comment		
8	4:30	Adjourn	Chair	

Next meeting:

August 10, 2010

Market Square Building

8:30 am to 12:00 pm

Oregon Health Policy Board

DRAFT Minutes

June 8, 2010

Market Square Building
1515 SW 5th Avenue, 9th floor
8:30am – 12:00pm

Item

Welcome and call to order

Chair Eric Parsons called the Oregon Health Policy Board (OHPB) meeting to order. All Board members were present. Oregon Health Authority (OHA) staff members present were Bruce Goldberg and Tina Edlund.

Consent agenda – *Minutes from May 11, 2010 meeting*

The May 11, 2010 minutes were reviewed. No changes were noted. Minutes were approved by unanimous voice vote. Final minutes will be posted on the web.

The Chair asked the audience to note that participation in the meeting is encouraged. The chair informed the public that internet questions would be referred to staff to respond to after the meeting instead of to the Board during the meeting to ensure they were answered completely.

Review and Approval of 2010 OHPB Agenda – Tina Edlund

Committees have been set up to do work for the Board. From now through the end of the year, OHPB meetings will focus on the recommendations and reports of those committees. It was suggested that the Board might want to consider having topics presented one month for discussion and then be brought back the next month for consideration and movement.

- June – Presentations on the Administrative Simplification Workgroup recommendation and draft strategic plan from Health Information Technology and Oversight Committee (HITOC)
- July
 - Essential Benefit package
 - Oregon Health Improvement Plan Committee work will be presented, including the results of listening sessions and development of a statewide health improvement plan
 - Presentation from Mel Kohn, Director of the Public Health Division, on how public health works in Oregon
 - Gretchen Morley from the Office of Oregon Health Policy and Research (OHPR) will speak about the staff comprehensive plan and will continue to give updates every month
- August – Draft business plan for the health insurance exchange will be presented
- September – No OHPB meeting; instead, there will be public forums to get feedback on the draft plan for the health insurance exchange
- October – Extended meeting where the public input will be presented to the Board, as well as draft core quality and efficiency measures, and the recommendations from the Public Health Purchasers Committee
- November – Recommendations from the Health Care Workforce Committee, Medical Liability Task Force, and the comprehensive plan
- December – Final plan for the health insurance exchange and comprehensive plan will be submitted for Board approval before sending to the Legislature; Amy Fauver, Legislative Director for OHA will give an overview of the anticipated legislative activity in the upcoming session
- January – Extended meeting to develop a strategic plan for the next two years and review of the revenue forecast

Director's Report – Bruce Goldberg, MD

- In early June, news came that the budget was going to have a shortfall of \$570 million. DHS has been struggling with rising expenditures as caseloads and needs for services have increased. The agency has been trying to work more efficiently and to live within the anticipated available revenue.
- The Governor has two options: wait for the next forecast and hope that it is better, or make reductions to each appropriation by the same percentage. Each agency will receive a 9.2% decrease in revenue. DHS will be submitting proposed cuts later today.

- DHS is currently waiting to see if the federal government will extend current Medicaid stimulus funds to July 2011. If this happens, 1/3 of the decrease in revenue could be covered by these funds.
 - State legislators have the option to call themselves into special session, but although a call has gone out, Dr. Goldberg does not feel that a special session will happen at this time.
 - The options for DHS to cut services include working more efficiently, reducing services or payments for those services, or reducing the number of people who are eligible for those services.
- ↪ The Board asked for an update on the DHS/OHA transition, specifically a written report on shared services.

Health Information Exchange (HIE) Presentation – Steve Gordon and Carol Robinson

- The purpose of the HIE is to create a flow of information to accomplish outcomes. When information flows, processes of care change and improve and create new models of care.
- HIE has five goals
 - Improve patient experience
 - Engage patients and families in their own care by making information more available to patients and families as well as health care providers
 - Coordination of care through information
 - Improve population and community health as a whole
 - Improve public trust in health care
- The HIE will result in healthy Oregonians. Transparency and trust are promoted through a public and private partnership. The state will support the regional investments that have been made and the community conversations that have been occurring. The state understands that the market wants to develop on its own, so the state is providing support to, rather than competing with, regional health organizations.
- Core components of the strategic plan
 - Incremental, phased approach
 - Support local health information organizations
 - Light central services – help with contracting, public health reporting and other things regional health organizations cannot maintain or implement on their own
 - Standards and certifications
- Role of state is to communicate, coordinate and facilitate the exchange, mitigate risks and cover gaps
- The draft strategic plan will be released for review on 06/17/10, stakeholder feedback will be collected in June and July, and then the HITOC will finalize the plan on 08/05/10
- The Board asked that the HIE be focused on not just providing information to doctors and patients but to create data sets that could be used by the community as a whole for researching trends. Steve and Carol assured them this was one of the intentions of the HIE, and that they were also working with the All Payer All Claims (APAC) Database team to integrate the two projects.
- The Board asked how people would be incentivized to use the software. Steve informed them that the intent is to have products that communicate effectively with each other, regardless of which product a person is using. A change in the culture is going to have to occur for the HIE to be successful.
- HITOC is working with the Treasurer's office to secure a private loan that will give providers access to capital that will help them purchase and implement software. It is important to look at health IT as an enabler and an accelerator for health reform.

Break

Administrative Simplification Workgroup Report – Laura Etherton, Lynn-Marie Crider, Dale Johnson

The Chair reminded everyone that HB 2009 directed the Office of Oregon Health Policy and Research (OHP) to convene a stakeholder workgroup to create uniform standards. The law authorizes Consumer and Business Services to adopt the recommendations via administrative rule.

- Administrative simplification is an effort to reduce the complexity of health insurance administrative and financial transactions between payers and providers.
- Goals
 - Standardization, elimination of useless forms, automation
 - Improve patient experience
 - Reduction of costs

- Health care administrative costs are high. The federal government took the lead on standardizing and automating transactions with Health Insurance Portability and Accountability Act (HIPAA), but it did not result in the expected degree of automation.
- Potential opportunities for savings
 - Clinics – those with the highest volumes will experience the greatest savings
 - State – roughly \$100 million per year could be saved by standardizing and automating claims submission, remittance advice, eligibility verification, claims payment and claims status inquiry
- Recommendations
 - Adopt the Minnesota Plan – standardize electronic processes by replacing the plan’s companion guides with a single uniform companion guide for three key transactions and then require all plans, providers and clearinghouses to do those three transactions electronically.
 - Oregon requirements for standardization and automation should be phased in.
 - Oregon should lead and not wait for the federal government to standardize the HIPAA transactions.
 - Technical assistance to providers will be important to help providers adjust and take full advantage of administrative simplification opportunities.
 - There is a need for ongoing public/private partnerships to identify successes, challenges and opportunities for future administrative simplification.
- The Board asked whether other states were working to create an administrative simplification process. Laura answered that Oregon is one of the leaders right now.
- The Board asked if there are overlapping data fields between the HIE and administrative simplification projects. Laura answered that there are some, but Oregon is not examining them in detail because it would require the state to take over all information systems as we move forward, which is not the intent.
- ↪ The Board asked the Administration Simplification Work Group to gather more input from small group practices, as they might be adversely affected by these requirements.
- ↪ The Board asked for more detail on the Minnesota Plan. Staff will prepare a memo.

Public Testimony

Professional Insurance Agents Association (PIAO) of Oregon - Presented a letter to the Board regarding the exchange. They informed the Board that PIAO is ready and willing to work on the insurance exchange and is here to help, particularly with small businesses. They ask the Board to retain agents as a preferred source of information to insurance participants.

Lisa Lettenmaier, Insurance Agent – Informed the Board that insurance agents can provide navigator services at no cost to the state when the insurance exchange goes live. Insurance producers in Oregon have had a significant role in helping clients understand the various insurance and health care options that are available. Insurance agents can be advocates or a marketing arm to help bring information to the public.

Pat Mitchell, Citizen – Pat was one of the first to earn a Ph.D. in computer science, and he has an excellent grasp of how to use the Internet. Despite his knowledge, though, Pat has found navigating internet insurance sites difficult and confusing. He found an insurance agent through Northwest Insurance Solutions and has been pleased with the agents and the cost of hiring an agent. He asked the Board to be sure professional agents are included in the plan for the insurance exchange.

Adjourn 12:01 p.m.

Next meeting:

July 13, 2010

12:00pm – 4:00pm

Market Square Building

1515 SW 5th Avenue (Between Market and Clay), 9th floor

OHPB Agenda Schedule (June 2010 to January 2011)		
Month	Board Role	Webinar
June		
Administrative simplification [Dale Johnson, Laura Etherton]	Review & endorse or amend workgroup recommendations	Webinar: Administrative simplification background and survey results [Lynn Marie Crider]
Health Information Oversight Council [Carol Robinson, Steve Gordon]	Review summary of strategic plan and process for stakeholder engagement	
July		
Essential Benefit Package [Jeanene Smith, Lisa Dodson]	Review and comment on draft essential benefit package.	Building the benefit package. Data presentation on cost sharing and relationship to cost sharing. [Jeanene Smith, Darren Coffman]
Health Improvement Plan Committee [Tammy Bray, Lila Wickham]	Review and comment on draft recommendations. Review results of statewide listening sessions.	Oregon's Public Health System [Mel Kohn, Kathleen O'Leary]
Draft Comprehensive Plan [Gretchen Morley]	Review and amend comprehensive plan elements	
August		
DRAFT Business Plan for a Health Insurance Exchange including a public plan	Review/amend	Elements of a public plan: What makes a health plan a "public plan"? Results of modeling re: microeconomic analysis (e.g., expected patterns of take-up in the exchange, numbers potentially waived from individual mandate, etc)
Final recommendations from administrative simplification workgroup	Endorse/amend recommendations	

OHPB Agenda Schedule (June 2010 to January 2011)		
August		
Final recommendations for adoption of essential benefit package	Endorse/amend recommendations	
DRAFT Comprehensive Plan-update	Review	
Preview Legislative Concepts	Review	
September--PUBLIC FORUMS		
OFF	OFF	OFF
October [FULL DAY MEETING]		
Summary of public input from forums		
Final recommendations from Health Improvement Plan Committee	Review and endorse/amend HIP Committee recommendations	
Final business plan for a health insurance exchange and recommendaions for a public plan	Review and endorse/amend final business plan and public plan recommendations	
Public Employers Health Purchasing Committee recommendations	Review/amend PEHPC recommendations.	Background on public employers as purchasers (e.g., OEPP/PEPP)
DRAFT core quality and efficiency measures and payment reform methodologies from Ins and Outs Committee	Review/amend core measures and payment reform methodologies. Review Committee strategy and principles. Review/amend payment reform plan/methodologies.	
DRAFT Comprehensive Plan-update [Gretchen Morley]	Review	

OHPB Agenda Schedule (June 2010 to January 2011)		
November		
Final recommendations from PEHPC	Review and endorse/amend recommendations	
Final recommendations from Ins and Outs Committee	Review and endorse/amend recommendations	
Final business plan for a health insurance exchange and recommendations for a public plan	Review and endorse/amend recommendations	
Workforce Committee Recommendations	Review/amend recommendations.	
Medical Liability Recommendations	Review/amend recommendations.	
DRAFT Comprehensive Plan-update [Gretchen Morley]	Review	
December		
Final recommendations from Workforce Committee	Review/amend recommendations.	
Final recommendations from Medical Liability Task Force	Review/amend recommendations.	
Submit Final Business Plan for an Exchange including a public plan	Approve plan for submission to legislature.	
Final Comprehensive Plan	Approve plan for submission to legislature.	
Legislative Preview	Informational.	
January 2011 [FULL DAY]		
RETREAT		
Review 11-13 Revenue Forecast 2011-2013 Strategic Plan		

**Monthly Report to
Oregon Health Policy Board
July 13, 2010**

Bruce Goldberg, M.D.

PROGRAM AND KEY ISSUE UPDATES

Healthy Kids Plan

- ❖ Enrollment – Through May, 48,000 more children have been enrolled.
- ❖ This is 60% of our goal of 80,000 more children and an 18% increase in enrollment since June 2009 (baseline).
- ❖ Just over 1,300 of these children are enrolled in Healthy KidsConnect.

Outreach

- ❖ Continue to do aggressive outreach to community organizations to enlist their help in spreading the word about Healthy Kids
 - To date, the Healthy Kids outreach team has trained about 1,000 people from 130 different organizations around the state on Healthy Kids.
- ❖ Working with a number of school districts to have a Healthy Kids direct mail piece sent to 250,000 households with school-aged children through July and August
- ❖ Community partners are signed up to do outreach and enrollment at 281 summer food sites this summer
- ❖ Developing an employer campaign to reach out to more families above 200% FPL
 - Creating marketing materials specifically for employers who don't provide health coverage to dependents
 - Child Support Division now including Healthy Kids information in their statewide employer seminars

System Improvements:

- ❖ Improving the application and eligibility determination process remains the #1 goal of the Office of Healthy Kids.
 - Working with the Center for healthy Literacy over the last month, we've made good progress and now have a draft of an improved application.
 - Seeking feedback from partners / stakeholders and conducting usability testing with current/ potential clients through July
 - Working with Children, Adults and Families (CAF) to streamline and simplify the eligibility determination process used by eligibility staff, with the goal of reducing the amount of time it takes to process an application while maintaining high

standards of accuracy. Using Lean “rapid improvement process” to achieve this goal quickly.

- Plan to roll out the new application in time for a back-to-school enrollment push at the end of August
- ❖ Pushing forward with other system improvements. Later this month, we will begin using SNAP (Food Stamp) data to enroll as many as 15 – 20,000 children using “Express Lane Eligibility” methods (i.e., use income information in SNAP data to automatically enroll children into Healthy Kids).

OHP Standard

- ❖ As of May 15 enrollment in OHP Standard of 29,234.
- ❖ As of June 25, 2010, 131,994 individuals had signed up for the OHP Standard reservation list since it opened in October 2009.
- ❖ DHS has completed six random drawings. The next drawing will be July 21, 2010 – 20,000 names.

Committee reports

As you know, the **Administrative Simplification Workgroup** held its final meeting by conference call on June 1 and presented to you at the last meeting. Staff are now working with the Oregon Medical Association to arrange to meet with 5-10 small practices to discuss the work group recommendations, identify barriers to making the contemplated transition, discuss the kinds of support that would be useful to them, and explore what additional administrative simplification activities would be most helpful to them. We expect to complete the interviews by early August. A summary of the additional feedback and final staff committee and staff recommendations will be presented to the Board at the August 10th meeting.

The **Cost Sharing Workgroup** did not meet in June and does not anticipate meeting until fall 2010.

The **Healthcare Workforce Committee** met on June 24 in Wilsonville. Committee members reviewed and made changes to a one-page draft summary of their short-term priorities and strategic recommendations. Committee staff will incorporate the changes and will also prepare an accompanying document with more details on each recommendation, including strategies by which public and private entities can act on the recommendations. The Committee also heard from several experts on the topic of building a diverse and culturally competent workforce; their presentations will be available shortly on the Committee’s website. The next meeting of the Workforce Committee will be Wednesday, July 21 from 1- 4 pm, at the Wilsonville Training Center (Room 111/112, 29353 Town Center Loop East in Wilsonville).

The full **Incentives and Outcomes Committee** did not meet in June. However, both of its subcommittees did meet; see below for details. The next meeting of the full Incentives and Outcomes Committee is scheduled for Thursday, July 15 from 8:30 am – noon, at the Wilsonville Training Center (Rooms 111/112, 29353 Town Center Loop East in Wilsonville).

- ❖ The **Payment Reform Subcommittee of the Health Incentives & Outcomes Committee** met on June 10 in Portland. The subcommittee reviewed its principles document and decided to break into work groups to have more focused discussion of particular types of services to bring back to inform full-subcommittee discussion of next steps. The chair and staff are working on establishing the work groups so that they can begin their work. The subcommittee's next meeting is scheduled for Thursday, July 8 from 1 – 3 pm, in Portland at 1201 NE Lloyd Blvd, Suite 140 (Board Room). Discussion will focus on making sure there is a common understanding of the tasks assigned to the workgroups and how the workgroup process will inform the subcommittee's effort to formulate recommendations for next steps.

- ❖ The **Quality & Efficiency Subcommittee of the Incentives & Outcomes Committee** met on June 10 in Portland. Subcommittee members updated each other on the direction and progress of the three small work groups created to assist staff in the development of proposed common metrics in three areas: (1) quality/effectiveness & safety; (2) patient/community-centered care; and (3) cost and efficiency. Work will continue in each area, with the intent that these groups will assist staff develop a draft list of core and supplemental measures for discussion with the rest of the subcommittee at the July meeting. That meeting will be held Thursday, July 8 from 10 am - noon in Portland at 1201 NE Lloyd Blvd, Suite 140 (Board Room).

The **Medical Liability Task Force** met July 7 in Portland. The Task Force decided to prioritize three concepts for study: Early disclosure and offer programs in which healthcare facilities investigate adverse events quickly and offer compensation to patients who may have been injured as a result of a medical error or medical negligence; health court programs that establish alternative systems for adjudicating and compensating claims for damages resulting from medical error or medical negligence; and safe harbor rules that protect physicians from liability if they follow state-endorsed clinical practice guidelines. The Task Force began this work with a discussion of disclosure and offer programs. At its next meeting, the Task Force will continue this discussion and begin to consider the health court concept. That meeting will be held on Wednesday, August 4 from 1-4 pm at the Wilsonville Training Center, 29353 Town Center Loop East in Wilsonville.

The **Oregon Health Improvement Plan Committee** held three Community Listening Sessions in central Oregon (Bend, Madras and Prineville) and a committee meeting in Bend on June 10 and 11th. On June 24 and 25th, the eighth and final Community Listening Session and the seventh committee meeting were held at the Grand Ronde Tribal Community Center. These meetings mark the end of the information gathering phase of the committee's work. The focus of the June meetings was to review and revise draft guiding principles, goals, policies and recommendations and population health metrics for the health improvement plan in preparation for the July 13th presentation to the Board. The committee will not meet in July and resumes a monthly schedule in August. In August, the committee will determine the process for gathering public input on the draft plan recommendations. The next committee meeting is August 6th at the Juvenile Justice Center, Carmichael Training Room, 2727 Martin Luther King Jr. Blvd. in Eugene, from 10 am - 2:30 pm.

The **Public Employers Health Purchasing Committee** did not meet in June. The next scheduled meeting of the committee is September 27, 1 - 4 pm at the Wilsonville Training Center in Wilsonville (29353 Town Center Loop East). The committee will receive preliminary recommendations from several committees and decide which of those they will incorporate into their report to the Board. They will also discuss the committee work done over the summer around standardized reimbursement methodologies and evidence-based best practice guidelines, and will review the revised consumer educational tool for consensus.

The **Health Information Technology Oversight Council (HITOC)** will hold a series of community meetings across the state from mid-June through mid-July across the state and webinars to gather input on the draft HIE Strategic Plan. More information about the Statewide Strategic HIE Plan review and input opportunities can be found at http://www.oregon.gov/OHPPR/HITOC/Stakeholder_Events.shtml. HITOC will be holding a webinar public meeting on July 27, time TBD, to discuss the Operational Plan. The next regular HITOC meeting will be on Thursday, August 5, 2010 from 1 – 5 pm at the Portland State Office Building in Portland (Room 1A, 800 NE Oregon Street). At this meeting, HITOC will be voting to approve the Strategic and Operational Plans for Health Information Exchange for submission to the Office of the National Coordinator (ONC), and will be discussing the workgroup structure for the next phase of work.

Exchange/Public Plan

In May and June, OHPR staff convened three meetings of a technical advisory work group to provide input on areas of state flexibility and the implications of various choices in building an exchange. OHPR, OHA and Insurance Division staff participated in the discussions with the technical advisory group members and is using the invaluable input from the group to complete its work on a draft exchange business plan. In addition, the state is eagerly awaiting federal guidance on benefits and other standards related to exchanges. Staff will present draft exchange and public plan business plans to the Board at its August meeting. Once the draft plans are made public, statewide public feedback will be solicited in September.

Comprehensive Plan

The proposed approach to the OHPB Blueprint for Health Reform will be presented to the Board at its July meeting, providing the Board the opportunity to discuss the approach and provide direction to staff. As the work of the committees outlined in this report develop their recommendations, staff will work iteratively with the Board to develop draft sections of the Blueprint.

Oregon's Essential Benefits Package & Value-Based Services Overview and Next Steps

**Office for Oregon Health Policy and Research
July 2010**

Typical Insurance Benefit Package Design

Portion a person pays (cost-sharing) is applied:

- By specific service or
- By the location where the service is provided
- May tier prescription drugs by generic versus brand name

<i>Service</i>	<i>HMO-type plan</i>	<i>PPO-type plan</i>
Hospital	\$50/day up to \$250/stay	15% coinsurance
Office Visit	\$5-\$20 copay	15% coinsurance
Ambulance	\$75 copay	15% coinsurance
Emergency Room	\$75 copay	15% coinsurance

How is Value-Based Benefit Design Different?

Definition

- The use of incentives (or disincentives) in a benefit plan to encourage enrollees to adopt healthier behaviors or use health services of higher value.

Examples

- Pitney Bowes – Tiered drug copays and coinsurance for some selected chronic medical conditions
- PEBB: Eliminated copays for certain prescription drugs for a few common chronic diseases (e.g asthma, diabetes, etc)
- Health Leadership Council (HLC)
 - Three tiered value-based benefit plan

Pitney Bowes' Results Over The First 3 Years

Diabetes

- Increased use of diabetic meds from 9% to 22% of all employees
- Evidence that diabetics used their meds more regularly than before
- Increased use of test strips from 28% to 55% by employees with diabetes
- Decreased emergency room visits by 26% for employees with diabetes

Asthma

- Decrease hospital admissions by 38% for employees with asthma

Overall costs in the workplace

- Reduced short-term disability days for employees with diabetes by approximately 50%
- Decrease direct healthcare costs by 6% for employees with diabetes
- Total annual pharmacy costs per person showed a mild increase, but total pharmacy costs for employees with diabetes decreased by 7%

Value-Based Benefit Design: Supports Oregon's Triple Aim for Health

- Improves lifelong health of all Oregonians
 - Incentivizes better chronic disease management
- Increases quality, reliability and availability of healthcare services
 - Reduces barriers to care needed to manage disease
 - Aims to get the right care at the right time and right place
 - Partner with payment reform to use effective care
- Lowers or contains cost of care so it is affordable
 - Lowers more expensive, emergency or delayed care costs

Oregon Has Long History With Value-Based Benefit Design

- Prioritized List of Health Services – uses evidence for Oregon Health Plan benefits since 1994
 - Developed and maintained by the Health Services Commission (HSC)
 - Services are prioritized according to impact on individual and population health, based on best available evidence
 - Legislature determines funding level (3/4 of lines are covered)
 - Services ranked lowest on the List are those that:
 - Do not have evidence showing they are effective
- Or*
- No evidence they have a significant impact on health

Health Fund Board's Benefits Committee: Essential Benefit Package

- Chartered by Fund Board to “develop recommendations for defining a set of essential health services that would be available to all Oregonians under a comprehensive reform plan.”
- Used the value-based benefit approach in developing the package’s framework and applying the cost sharing
- Underlying methodology based on Oregon’s Prioritized List

The Essential Benefits Package (EBP)

- No cost share for:
 - Value-based services
 - Basic diagnostic services
 - Comfort care
- Tiered coinsurance/copays for other services
 - Four tiers based on evidence methodology of Prioritized List
 - Lower cost sharing for primary care outpatient services
- Use of an evidence-based drug formulary also suggested

20 Sets of Value-Based Services in the Essential Benefit Package

- Value-based services are medications, tests, or treatments that are highly effective, low cost, and have a lot of evidence supporting their use
- Most of these services should be provided via outpatient care – ideally in a patient-centered primary care home
- These services should be offered at NO cost to patients (no copays or coinsurance) in order to encourage use of these services given their high level of benefit

Goal: Have these services used as much as possible

Remove Barriers to Care: Examples of the EBP's Value-Based Services

Diabetes

- Meds (insulin or oral); blood test to check control; eye exam to check for changes

Congestive Heart Failure (CHF)

- Meds: Generic versions of blood pressure meds (beta-blocker, ACE inhibitor, diuretic)
- Labs: Annual blood count (CBC), metabolic panel (CMP), cholesterol/lipid profile, urine test, and a thyroid test (TSH) once
- Tests: EKG, Diagnostic echocardiogram
- Other: Nurse case management

Coronary Artery Disease (CAD)

- Meds: Generic versions of aspirin, cholesterol lowering (statin), and blood pressure medications (beta-blocker)
- Labs: Annual cholesterol/lipid profile
- Tests: EKG
- Other: Cardiac rehabilitation for post-heart attack

EBP's Tiered Benefits for Other Services: Cost Sharing Applied Based On Best Evidence

Tier I :

Lower cost share

Highly effective care for severe chronic disease and life-threatening illness & injury

Examples:

- Emergent dental care
- Head injuries
- Appendicitis
- Heart attack
- Third degree burns
- Kidney failure
- Rheumatoid arthritis
- Low birth weight

Tier II:

Next level of cost share

Effective care of other chronic disease and life-threatening illness & injury

Examples:

- Breast cancer
- Bladder infections
- COPD/emphysema
- Multiple sclerosis
- Post-Traumatic Stress Disorder
- Attention Deficit Disorder
- Epilepsy
- Glaucoma

EBP's Tiered Benefits: Cost Sharing Applied Based On Best Evidence

Tier III:

3rd level of cost share

Effective care for non-life-threatening illness & injury

Examples:

- Broken arm
- Ear/sinus infections
- Dentures
- Kidney stones
- Herniated disk
- Reflux
- Migraines
- Fibroids
- Cataracts
- Obsessive-Compulsive Disorder

Tier IV:

Highest level of cost share

Less effective care and care for self-limited illness and minor illness & injury

Examples:

- Cold
- Chronic low back pain
- Sprained ankle
- Cracked rib
- Seasonal allergies
- Acne
- Viral sore throat
- Tension headache
- Dental implants
- Liver transplant for cancer

Essential Benefits Package's Other Components

Excluded conditions

- Non-emergent services that would have no coverage, similar to many commercial plans presently
- Examples: Cosmetic surgery, infertility services, experimental treatments

Discretionary Services

- Non-emergent services that might have a separate benefit limit
- Examples: restorative dental services, glasses & other vision care supplies

How The Essential Benefit Package Compares

	Health Leadership Council's Design	Essential Benefit Package
Categories With No Cost Share	Tier 1 <ul style="list-style-type: none"> • Tests and treatments for <u>six</u> chronic diseases (asthma, CAD, CHF, COPD, depression, diabetes) • Annual exam & Preventive screenings • Immunizations 	Value-Based Services <ul style="list-style-type: none"> • Same plus coverage for 14 additional conditions/chronic diseases (e.g., ETOH Tx, bipolar Dz, HTN, ↑ lipids, maternity/newborn) • Basic diagnostics & Comfort care
Next Level (s) of Cost- sharing	Tier 2 <ul style="list-style-type: none"> • Standard medical product design <ul style="list-style-type: none"> – Portion of hospital services – Portion of outpatient services –Portion of Emergency Room cost 	Tiers I-III <ul style="list-style-type: none"> • Encourages care in primary care • Tiered cost sharing by condition/associated service based on evidence
Highest Cost Sharing or Not Covered	Tier 3 Have higher cost sharing <ul style="list-style-type: none"> • Preference sensitive treatments • Complex outpatient imaging Excluded Services	Tier IV less effective/self-limiting Other <ul style="list-style-type: none"> • Excluded conditions (no coverage) • Discretionary Services (separate benefit limit)

Hypothetical Example—Maria's Story

Maria is single, earns \$40,000 per year as a teacher

- She receives coverage through her employer
- Her deductible is \$1,250; out-of-pocket max is \$3,000
- Plan design is a modified version of the EBP
- Coinsurance is tiered: 5%/15%/30%/50%
- RX coverage is \$5 for generic, \$15 for preferred, 30% for nonpreferred

Maria's Story, continued

- Maria is in good overall health
 - Her GYN exam is covered with no cost sharing
 - She sees her family physician to talk about frequent nasal infections; no copay for an initial diagnostic visit
 - Sees a specialist who recommends repairing her deviated septum. Total Cost: \$8,000 for this Tier IV service.
 - Tier IV has 50% coinsurance. Maria thinks about whether she really needs the surgery.
 - If she proceeds, \$1,250 goes to deductible; Maria pays 50% of remaining charges until out-of-pocket is met; total out-of-pocket: \$3,000.

Note: In typical commercial plan design, Maria would pay a portion of her gyn visit *and* her diagnostic visit while her out of pocket for surgery would be only around \$2,250 (15% coinsurance) so might not pause as much before considering surgery

What Has Been Happening with the EBP Since HB 2009 Passed?

Health Services Commission

- Reviewed the latest evidence and detailed out the full list of 20 sets of Value-Based Services included in the Essential Benefit Package

Also

- Initial review of federal reform regarding benefits and cost sharing
- Initial actuarial analysis of how the EBP could fit under federal reform parameters and its impacts by income level
- Cost Sharing Workgroup reviewed the EBP's cost sharing
 - Reviewed how could cost sharing look for each tier, based on work of Fund Board's past work, and under federal reform

And...Federal Reform Passed: Sets Aspects of Benefit Design

Individual Mandate:

- Secretary of HHS will establish Essential Health Benefit Package (EHBP) to qualify plans as minimum essential coverage

Insurance Exchange:

- EHBP is the basis for cost sharing assistance and premium tax credits in the Exchange
- Sets fixed levels of coverage in the Exchange and fully-insured market based on actuarial value

Value-Based Benefit Design:

- Secretary of HHS has oversight
 - “... may issue regulations for allowing value-based insurance design”

Components of the Federal EHBP

Ambulatory Patient Services	Emergency Services	Hospitalization	Maternity & Newborn Care	Mental Health/ Substance Abuse
Prescription Drugs	Rehab and Habilitative Services/ Devices	Lab Services	Preventive, Wellness & Chronic Disease Mgmt	Pediatric, Including Oral/Vision

Federal preventive care—No cost sharing allowed

Federal excluded services—Plans can cover but premium credits/cost sharing reductions to individuals cannot apply towards them

Still Lots To Learn About How Federal Reform Will Shape Benefits, Especially in the Exchange—

- Secretary directed to have the Dept. of Labor survey common products on the market to help define the specific details of the federal minimum package
- Uncertain how much/what kind of flexibility there will be around value-based benefit design
- Products offered in the exchange will have to fit inside set cost sharing limits to fit various federal requirements depending on income
- Awaiting the details on the exchange to see how much states can direct benefit designs offered

Hypothetical Example—Robert's Story

Robert is single, earns \$20,000 per year

- He purchases insurance through an insurance exchange
- He will get tax credits to assist with his premium
- There will be federal limits to the amount of cost sharing based on his income
- Plan design is a modified version of the EBP
- Coinsurance is tiered: 10%/30%/50%/70%
- His deductible is \$300; out-of-pocket max is \$1,600 – amounts limited due to his income level
- Plan uses an evidence-based formulary for medications
 - \$10 for generic,
 - \$30 for preferred,
 - 50% for nonpreferred

Robert's Story, continued

- He has Type 2 Diabetes
- His insulin, eye exams, and diabetic labs/supplies are covered with no cost sharing since all part of a value-based service for diabetes
- During his annual preventive visit, doctor finds a diabetic foot ulcer, and refers him to a surgeon and prescribes a generic antibiotic
 - No cost sharing for preventive service visit
 - For the antibiotic, Robert pays a \$10 copay based on an evidence-based formulary
- The surgeon treats the ulcer; cost: \$2,000
 - This Tier I service has 10% coinsurance
 - \$300 applies to deductible, and Robert pays 10% of the remaining \$1,700 for a total out-of-pocket cost of \$470

Note: Today, in a typical commercial plan out-of pocket costs would be \$810 plus exams, diabetic meds and supplies copays

The Essential Benefit Package: Summary

- Furthers Oregon's Triple Aim by incenting the most effective services
- Could be considered by health care purchasers now
- Preliminary review shows that the EBP's cost sharing could be adjusted to fit federal reform limits and still provide incentives to use the most effective care.
- Further details on the federal minimum benefit to be eligible for subsidies in the Exchange are yet to be determined, but appears the EBP could certainly be a product in the Exchange

References

Oregon Health Services Commission

<http://www.oregon.gov/OHPPR/HSC/index.shtml>

Cost Sharing Work Group

<http://www.oregon.gov/OHPPR/HealthReform/CostSharing/CSW.shtml>

Health Fund Board Benefits Committee Final Report

<http://www.oregon.gov/OHPPR/HFB/Benefits/FinalRecommendation.pdf>

Health Leadership Council (formerly Health Leadership Task Force)

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

Center for Value-Based Insurance Design

<http://www.sph.umich.edu/vbidcenter/>

Questions?

Value-Based Services

Proposed “Barrier-Free” services for use within a value-based benefit package

Diagnosis	Medications	Labs	Imaging/Ancillary	Other
Alcohol & Drug Treatment	Buprenorphine for opioid dependence Acamprosate for alcohol dependence	None	None	Brief behavioral intervention to reduce hazardous drinking (SBIRT) Methadone maintenance treatment
Asthma	Medications according to NICE 2008 stepwise treatment protocol	None	Diagnostic spirometry	None
Bipolar Disorder	Lithium, valproate	Lithium – lithium level (q3 months); creatinine and TSH (q6 months) Valproate -LFTs and CBC (q6 months)	None	Medication management
Cancer Screening	None	Pap smears Fecal occult blood testing	Mammography Colonoscopy/Flexible sigmoidoscopy	Per USPSTF recommendations, “A” and “B” recommendations only
Chronic Obstructive Pulmonary Disease(COPD)	Short-acting inhaled bronchodilator	None	None	None
Congestive Heart Failure (CHF)	Beta-blockers, ACE inhibitors, diuretics	CBC, CMP, lipid profile, urinalysis (annually) TSH once	EKG, Diagnostic echocardiogram	Nurse case management
Coronary Artery Disease (CAD)	Aspirin, statins, beta blockers	Lipid profile (annually)	EKG	Cardiac rehabilitation for post-myocardial infarction (MI) patients

Value-Based Services

Diagnosis	Medications	Labs	Imaging/Ancillary	Other
Dental Care, Preventive	Fluoride supplements (age 6 months to age 16), if indicated Professionally applied fluoride varnish (twice yearly in children aged 12 months to 16 years old who are at high risk), if indicated	None	Pit and fissure sealants in permanent molars of children and adolescents	None
Depression, Major in Adults (Severe Only)	SSRIs	None	None	Cognitive Behavioral Therapy (CBT) or Interpersonal Therapy (subject to limit, e.g. 10 per year) in conjunction with an antidepressant Medication management
Depression, Major in Children and Adolescents (Moderate to Severe)	None	None	None	Psychotherapy (CBT, interpersonal, or shorter term family therapy)
Diabetes – Type I	Insulin (NPH and regular only), insulin supplies, ace inhibitors	HgA1c (annually)	None	Diabetic retinal exam for adults (annually)
Diabetes – Type II	Metformin, sulfonyureas, ACE inhibitors, insulin (NPH and regular only), insulin supplies	HgA1c, lipid profile (annually)	None	Diabetic retinal exam for adults (annually)

Value-Based Services

Diagnosis	Medications	Labs	Imaging/Ancillary	Other
Hypertension	Diuretics, ACE inhibitors, Calcium channel blockers, Beta blockers	Fasting glucose, fasting lipids (annually)	None	None
Immunizations	Routine childhood and adult vaccinations	None	None	Follow ACIP recommendations for non-travel vaccinations
Maternity Care	Folic acid, Rh immunoglobulin (when indicated)	Screening for hepatitis B, Rh status, syphilis, chlamydia, HIV, iron deficiency anemia, asymptomatic bacteriuria, rubella immunity, screening for genetic disorders	None	None
Newborn Care	Ophthalmologic gonococcal prophylaxis, Vitamin K prophylaxis	Sickle cell, congenital hypothyroidism, PKU (cost borne by the state)	None	None
Reproductive Services	Condoms, combined oral contraceptives, intrauterine devices, vaginal rings, Implanon, progesterone injections, female sterilization, male sterilization	See STI screening and maternity care	None	None
Sexually Transmitted Infections	Syphilis – Penicillin IM or doxycycline Chlamydia – azithromycin or doxycycline Gonorrhea – ceftriaxone IM or cefixime po	In certain populations: chlamydia, gonorrhea, HIV, syphilis	None	According to USPSTF guidelines for appropriate populations to screen (A and B recommendations only)

Value-Based Services

Diagnosis	Medications	Labs	Imaging/Ancillary	Other
Tobacco Dependence	Nicotine replacement therapy, nortryptiline, and bupropion	None	None	None
Tuberculosis (TB)	Per CDC guidelines – standard drug treatment for latent and active TB	Screening and diagnostic algorithm according to CDC guidelines	Chest x-ray per CDC guidelines	None

Guidelines based on empirical evidence (systematic reviews and health technology assessments), from trusted sources such as: ACIP, AHRQ, Cochrane Collaboration, CDC, OHSU Center for Evidence-Based Policy, NICE, NIH, Ontario, SIGN, USPSTF, WHO

General principles

For medications

- 1) Generics unless no equivalent available
- 2) Medications for ≤ \$4 per month are preferred to more expensive medications

Glossary

ACE: angiotension converting enzyme

ACIP: Advisory Committee on Immunization Practices

AHRQ: Agency for Healthcare Research and Quality

CBC: complete blood count

CDC: Centers for Disease Control and Prevention

CMP: complete metabolic panel

EKG: electrocardiogram

HgA1c: hemoglobin A1c

HIV: human immunodeficiency virus

IM: intramuscularly

LFTs: liver function tests

NICE: National Institute for Health and Clinical Excellence (England)

NIH: National Institutes of Health

OHSU: Oregon Health & Science University

PKU: phenoketouria

SIGN: Scottish Intercollegiate Guidelines Network

SBIRT: screening, brief intervention, and referral to treatment

SSRIs: serotonin specific reuptake inhibitors

STI: sexually transmitted infection

TSH: thyroid stimulating hormone

USPSTF: US Preventive Services Taskforce

WHO: World Health Organization

Oregon Health Policy Board Oregon’s Blueprint for Health

Executive Summary (*serves as concise stand-alone summary of vision and strategies, including overall timeline*)

I. Introduction

- Driving Real Change: the OHPB vision for a healthy Oregon
- The state of health in Oregon: highlights of the first state scorecard on the state of health and health care in Oregon

II. Action Steps to Achieve a Healthy Oregon

The format for each policy area under A, B and C below will include the following elements (with a goal of 4 pages per topic):

- *Goal-oriented heading and desired outcome(s)*
- *Specific short-term strategies and tactics*
- *“Bringing the Triple Aim to life” highlight box*
- *Brief background/context discussion, including cost and other impacts*
- *Longer term strategies and next steps*
- *Implementation timeline*
- *“For more information” links to full committee reports*

A. Ensuring healthy people in healthy communities

- Overview of population health vision, strategies, and timeline
- Strategic action steps
 - *Improve Social and Economic Factors*
 - *Significantly Invest in Prevention and Public Health*
 - *Communities Actively Support Prevention and Health Improvement*
 - *Reduce Obesity*
 - *Reduce Tobacco Use and Exposure*
 - *Support people in managing their chronic diseases*

B. Transform health care delivery to improve health outcomes, reduce health disparities, and control costs

- Overview of health delivery system vision, strategies, and timeline
- Strategic action steps
 - *Primary Care Home*
 - *Payment Reform*

DRAFT OUTLINE – SUBJECT TO CHANGE

- *Quality Standards*
- *Workforce*
- *Administrative Simplification*
- *HIT/HIE/ Electronic Health Records*
- *Medical Liability*

C. Ensure that all Oregonians have equitable access to affordable health care

- Overview of insurance and access vision, strategies, and timeline
- Initiative topics to include:
 - *Health Insurance Exchange*
 - *Public Plan Option*
 - *Value-based Benefit Design*
 - *Implementation of Federally Mandated Insurance Expansions*
 - *Insurance Market Reforms*

III. Integrating the Reform Components to Achieve the Triple Aim

- Ensuring that health reform initiatives promote health equity across all populations in Oregon
- Voluntary uniform contracting standards for health insurance purchasing by public employers
- Integration and coordination of community-level activities
- Aligning policy development across health and social programs in partnership with DHS

Notes:

- A health equity review will be conducted of all strategies by the Office of Multicultural Health and Services and recommendations from that review will be provided to each of the committees for integration.
- The OHA's role in driving initiatives will be clearly highlighted throughout the document.

Appendix: Supporting Documents *(provide brief description and weblinks for each)*

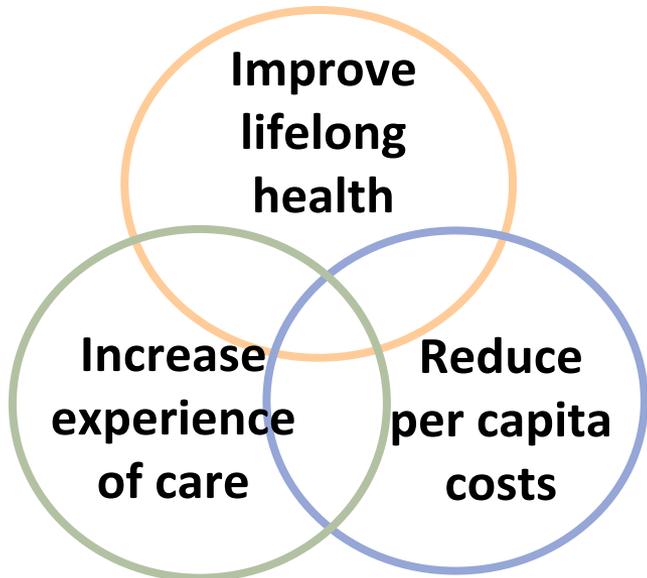
1. Statewide Health Improvement Plan
2. Payment Reform and Patient-Centered Primary Care
3. Healthcare Workforce Plan
4. Quality and Efficiency Metrics
5. Administrative Simplification Report
6. Health Information Exchange Strategic Plan
7. Medical Liability Recommendations
8. Health Insurance Exchange Business Plan
9. Purchasing Standards

Oregon Health Improvement Plan Committee

Draft Goals and Recommendations

**Health Policy Board
July 13, 2010**

Good to Great



Triple Aim

Quality of Life for All Oregonians

-
- Health Policies
 - Health Information Technologies
 - Involved Citizens & Communities

Primary Goal of Health Improvement Plan Committee Defined by Oregon Health Policy Board

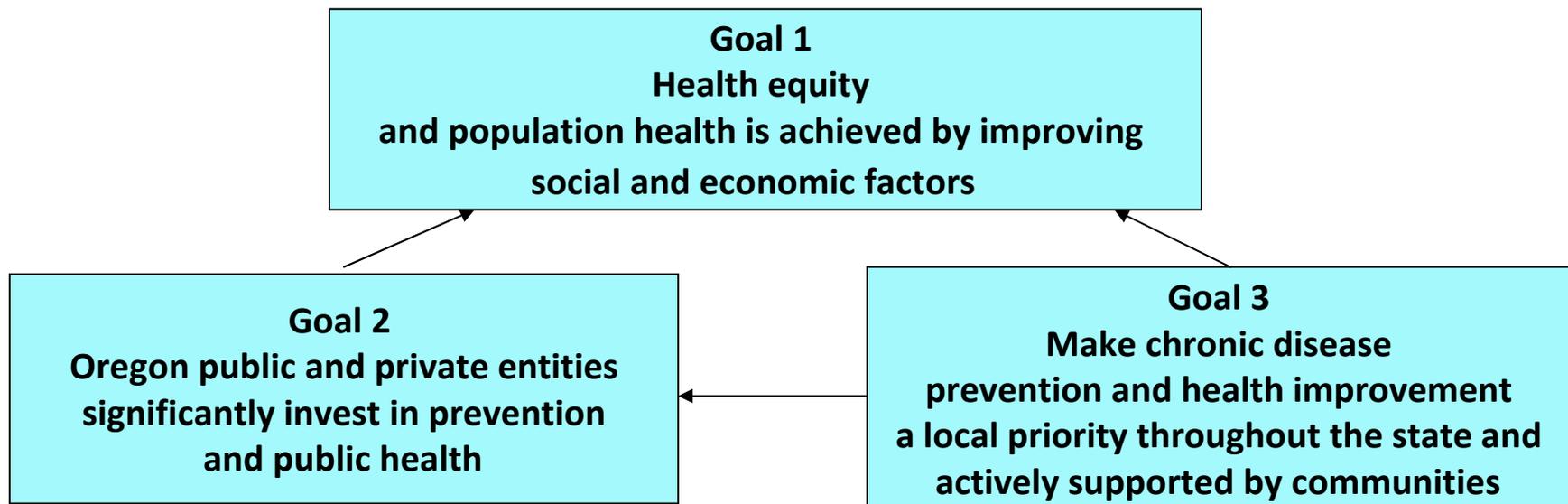
Improve the health of Oregonians by promoting and supporting lifestyle choices that prevent and manage chronic diseases

HIP Committee Process to date

- 26 Committee members
- 7 committee meetings March 30 – June 25, 2010
- 8 Community Listening Sessions
- Website Community Input Survey (for those not able to attend a listening session)

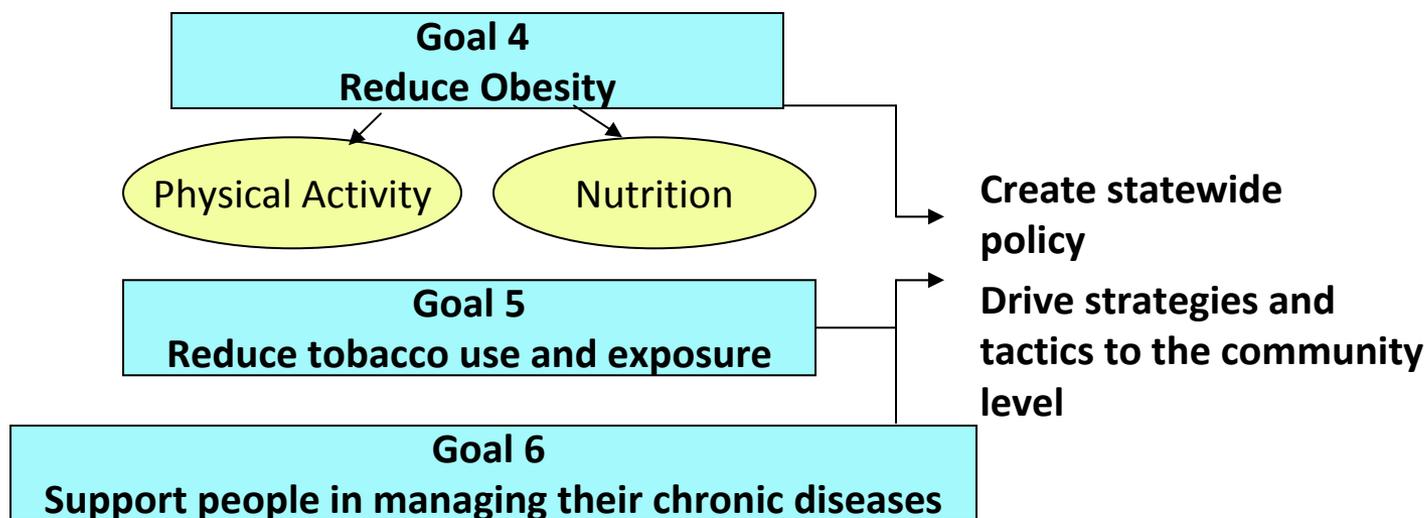


Summary of HIP Recommendations (1)



Implementation of coordinated and comprehensive prevention and health improvement strategies to support people and families where they live, work, learn, play and receive health care

Summary of HIP Recommendations (2)



Goal 1:

**Health equity and population health is achieved
by improving social and economic factors**

Recommendation 1-1:

OHA requests a Governor's Executive Order to create a Coordinating Council on Health Equity. The Council will include state agencies (public health, transportation, housing, education, economic development, employment, agriculture, public safety, DMAP), private business, health care providers, tribes, county public health and community advocacy organizations. The purpose of the Council is to promote and monitor health equity in all statewide policies through funding, and administrative and legislative actions.

Recommendation 1-2:

OHA requests legislation requiring Health Impact Assessments for all publicly funded building and transportation projects including plans to remediate identified health impacts.

Goal 2:

Oregon public and private entities significantly invest in prevention and public health

Recommendation 2-1:

To achieve population health improvement goals, increase funding for public health and raise Oregon from being the 41st state in the nation for investment in public health to at least the national average.

Recommendation 2-2:

To achieve population health improvement goals and build public health capacity, all counties and the state public health division seek accreditation through the Public Health Accreditation Board by 2015.

Recommendation 2-3:

Link revenues to related chronic disease prevention and wellness strategies.

Recommendation 2-4:

OHA requests a Governor's Executive Order requiring state agencies to implement and monitor wellness policies designed to increase fruit and vegetable consumption, physical activity, and chronic disease self-management, support breast feeding, and reduce tobacco use and sugar sweetened beverage consumption.

Goal 3:

Make chronic disease prevention and health improvement a local priority throughout the state and actively supported by communities

Recommendation 3-1:

On a regional or local level Health Departments convene (or delegate) key stakeholders to create and implement Health Improvement Plans that address identified needs based upon comprehensive community assessments. Key stakeholders include but are not limited to: tribes, hospitals, health care providers, businesses, social service agencies, educators, institutions of higher learning, community based organizations, land use, housing and transportation.

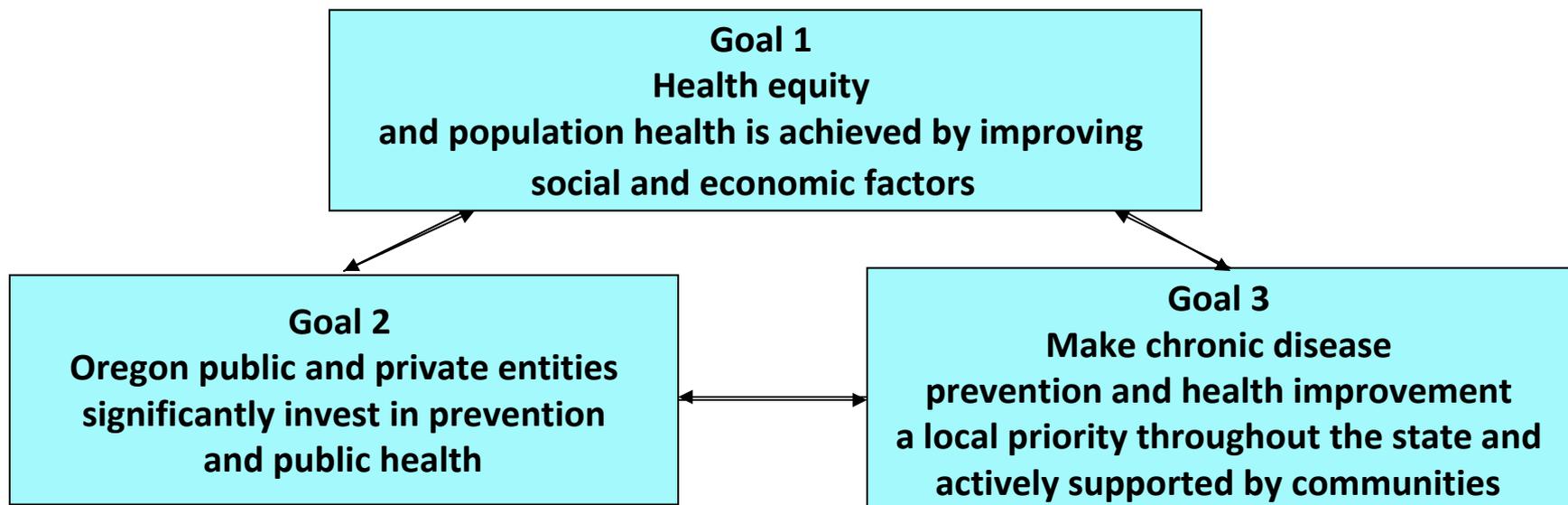
Recommendation 3-2:

In concert with county and tribal governments, and where feasible, create regional “health collaboratives” that track and are responsible for local policy, health improvement planning, priority setting, system development, financial investment and health outcomes.

Recommendation 3-3:

Prioritize resource provision to communities with a Health Improvement Plan that identifies effective strategies to improve health equity.

Summary of HIP Recommendations (1)



Implementation of coordinated and comprehensive prevention and health improvement strategies to support people and families where they live, work, learn, play and receive health care

Next Steps for Goals 4, 5 and 6

Further work by the HIP committee will focus on:

Organizing the recommendations, strategies and tactics that HIP Committee members support and develop the action plan once the Board approves the primary goals and recommendations.

Next Steps for referred recommendations

Refine recommendations to the following committees:

- HITOC
- Public Employers Health Purchasing
- Health Care Workforce
- Health Incentives and Outcomes

Next Steps for Population Health and its Metrics

- HIP committee members have come to consensus on the word definition of ‘population health’
- Confer with OHA staff to coordinate metrics with other committees.
- Gain agreement on core measures for population health.

Oregon Health Improvement Plan (HIP) Committee
Summary of Listening Sessions, Guiding Principles, Population Health - Definition and Measures
July 13, 2010

Community Listening Sessions

Community Listening Sessions were planned during the information gathering phase of the committee’s work. Sessions were held in eight locations over a 2 month period. The two-hour sessions were held the evening before HIP committee meetings, with outreach and invitations by committee members and local/regional stakeholder organizations. The purpose of the sessions was to provide an opportunity for committee members to hear regional and local perspectives as well as emerging themes related to the health of Oregon’s communities.

The format for the Listening Sessions included a brief presentation about the committee and regional health data, one hour for small group discussions, and networking time. The three questions posed to the small groups for discussion were:

1. What are the issues in your community that have the greatest impact on your health and that of others in the community?
2. What is happening in your community that promotes health and supports a thriving community?
3. What 3-5 changes in policy would make your community healthier and thrive?

Listening Session Location and Date	Number of community participants	Number of counties represented
Pendleton, April 29 th	24	4
Medford, May 13	16	4
Portland, May 26	35	2
Hillsboro, May 26	10	2
Bend, June 10	24	1
Madras, June 10	9	1
Prineville, June 10	6	1
Grand Ronde, June 24	16	4
Total	140	19

The Community Input Survey, a web-based survey of the three Listening Session questions was posted on the HIP Committee website during the month of June. The purpose was to provide an opportunity for those who were not able to attend a listening session to share comments and recommendations for consideration by the committee.

Total number of respondents	Number of counties represented by respondents	Total number of counties with participation by survey only
88	19	8 (Baker, Columbia, Hood River, Klamath, Lake, Lincoln, Linn, Marion)

Key themes that emerged from the listening sessions and community input survey include:

- The impact of jobs, the economy, quality education, transportation, and poverty on health
- Communicating a vision for a healthy Oregon
- Changing the focus to wellness rather than illness
- Supporting primary prevention in all sectors
- Implementing nutrition policies: making healthy foods more accessible
- Implementing physical activity policies: promoting safe, easy access
- Building on the collaborative spirit in communities and regions
- Needing data and capacity for local assessment, planning, and policy development
- Tailoring best practices to meet community needs
- Needing sustainable funding for effective programs such as tobacco prevention
- Achieving cultural competence in all data, programs and policies
- Promoting the engagement and collaboration of all sectors
- Investing in children and youth for future generations
- Linking economic development and health
- Acknowledging that costs are higher in rural areas due to distances and fewer resources
- Increasing access to/availability of physical, behavioral and oral health services

HIP Committee Guiding Principles

1. Make prevention the highest priority for improving population health in all sectors from pre-conception to elderly ages
2. Address the conditions that impact social, economic and environmental determinants of health because health behaviors are affected by a large number of factors beyond motivation and knowledge
3. Provide sustainable resources and stimulate communities at the local and regional level to develop local and regional solutions to community health problems based upon statewide health improvement plan goals
4. Achieve health equity among population groups
5. Respect cultural integrity, traditions and perceptions
6. Address the leading causes of chronic diseases - tobacco use and exposure, and obesity
7. Assure availability of community level data for assessment, policy development and monitoring population health improvement
8. Focus on evidence-based, best and promising practices and interventions incorporating policy, systems and environmental approaches
9. Create short and long term policies, outcomes and investments

Definition of Population Health

Population health refers to the health of a population as measured by health status indicators and as influenced by social, economic, and physical environments, personal health practices, individual capacity and coping skills, human biology, early childhood development, and health services. (Health Canada)

As an approach, population health focuses on interrelated conditions and factors that influence the health of populations over the life course, identifies systematic variations in their patterns of occurrence, and applies the resulting knowledge to develop and implement policies and actions to improve health and well-being of those populations. (Health Canada)

**Oregon Health Improvement Plan Committee
Proposed Population Health Measures**

Measure	Data Source(s)	Available For		
		Child	Adult	County
HEALTH OUTCOMES				
Mortality	Premature death			X
Morbidity	Cancer incidence/stage at diagnosis	Oregon Cancer Registry	X	X
	Chronic diseases burden	BRFSS		X
	Good or excellent health	BRFSS		X
	Poor mental health days	BRFSS; OHT ² ; OSWS ³	X	X
	Poor physical health days	BRFSS; OHT; OSWS	X	X
HEALTH FACTORS				
HEALTH BEHAVIORS				
Tobacco	Tobacco use	BRFSS; OHT	X	X
Diet and Exercise	Obesity (BMI)	BRFSS; OHT	X	X
	Physical activity meeting CDC recommendations	BRFSS; OHT	X	X
	Consumed at least 5 servings of fruits and vegetables per day	BRFSS; OHT	X	X
	Soda/sugar sweetened beverages	BRFSS; OHT	X	X
Alcohol use	Binge drinking	BRFSS; OSWS	X	X
	Other substance abuse	OSWS; National Survey on Drug Use and Health	X	X
Teen Pregnancy	Teen pregnancy rate	Birth certificate, ITOP ⁴	X	X
CLINICAL CARE				
Access to Care	Uninsured	Small Area Health Insurance Estimates, U.S. Census		X
	Primary care provider rate	Oregon Medical Board		X
	Other TBD			X
Quality of Care	Hospital readmission	Oregon Hospital Discharge Index	X	X
	Preventable ED visits	All Payers All Claims	X	X
	Other TBD			X
SOCIOECONOMIC FACTORS				
Education	High school graduation	U.S. Census/American Community Survey		X
	College degrees	U.S. Census/American Community Survey		X
Employment	Unemployment	Oregon Employment Department		X
Income	Poverty	U.S. Census/American Community Survey	X	X
	Income inequality	U.S. Census/American Community Survey		X
Family and Social Support	Food insecurity	BRFSS		X
Housing	Affordable housing	U.S. Census/American Community Survey		X
Community Safety	Violent crime	Oregon State Police - Law Enforcement Data System		X
PHYSICAL ENVIRONMENT				
Air Quality	Air pollution-particulate matter days	Oregon Environmental Public Health Tracking		X
	Air pollution-ozone days	Oregon Environmental Public Health Tracking		X
Built Environment	Ratio of fast food stores to grocery stores	Oregon Employment Department		X
	Green spaces	Oregon Geospatial Enterprise Office		X
PUBLIC (LAW) AND ORGANIZATIONAL POLICIES				
Communities	TBD			
Health Systems	TBD			
Schools	TBD			
Worksites	TBD			
State	TBD			

Measure	Data Source(s)	Available For		
		Child	Adult	County
OVERALL MEASURE				
	Good or excellent health		X	X

Measure	Data Source(s)	Available For		
		Child	Adult	County
CORE MEASURES				
	Premature death			X
	Income Inequality			X
	Tobacco use	X	X	X
	Obesity (BMI)	X	X	X
	Teen pregnancy rate	X		X

- 1: Behavioral Risk Factor Surveillance System
- 2: Oregon Healthy Teens
- 3: Oregon Student Wellness Surveys
- 4: Induced Termination of Pregnancy Database