

# Oregon Health Policy Board

## AGENDA

September 11, 2012

Market Square Building

1515 SW 5<sup>th</sup> Avenue, 9<sup>th</sup> floor

8:30 am to Noon

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

#	Time	Item	Presenter	Action Item
1	8:30	Welcome, call to order and roll <b>Action item:</b> Consent agenda: 8/14/10 minutes	Chair	X
2	8:35	Director's Report <ul style="list-style-type: none"><li>• CCO Implementation</li><li>• Medical Liability</li><li>• Medicaid Essential Health Benefit</li></ul>	Bruce Goldberg	
3	8:50	Metrics and Scoring Committee update <ul style="list-style-type: none"><li>• Timeline</li></ul>	Bruce Goldberg	
4	9:05	Public Testimony		
5	9:20	National Models for Community Health Integration: Introduction	Diana Bianco	
6	9:30	Blue Zones by Healthways (part of Iowa's Healthiest State Initiative) <ul style="list-style-type: none"><li>• Presentation</li><li>• Board Q &amp; A</li></ul>	Healthways and guests (by phone)	
	10:30	Break		
7	10:45	Board Discussion	Diana Bianco	
8	11:45	Adjourn	Chair	

**Next meeting:**

**October 9<sup>th</sup>, 2012**

**1 pm to 4:30pm**

**Coos Bay**

**Location TBD**



**Oregon Health Policy Board**  
**DRAFT Minutes**  
**August 14, 2012**  
**12pm to 3 pm**  
**Market Square Building**  
**1515 SW 5<sup>th</sup> Ave, 9<sup>th</sup> Floor**  
**Portland, OR 97201**

**Item**

**Welcome and Call To Order**

Vice Chair Lillian Shirley called the Oregon Health Policy Board (OHPB) meeting to order. All Board members were present except Chair Eric Parsons and Brian DeVore.

Tina Edlund was present from the Oregon Health Authority (OHA).

**Consent Agenda:**

The minutes from the July 10, 2012 meeting were unanimously approved.

**Director's Report – Tina Edlund**

Tina Edlund gave an update on Coordinated Care Organizations. She said the Medicaid contracts for Wave One CCOs became effective on August 1. Wave One organizations include:

- Umpqua Health Alliance
- FamilyCare Tri-County
- InterCommunity Health Network
- AllCare Health Plan
- PacificSource Health Plans – Central Oregon
- Western Oregon Advanced Health
- Trillium Community Health Plans
- Willamette Valley Community Health

Edlund also gave an update on the Metrics and Scoring committee, stating that more than 51 people applied for positions and the first meeting would be at the end of August.

**Joint Meeting with Oregon Health Insurance Exchange Board**

**Essential Health Benefit – Jeanene Smith and Lou Savage**

Jeanene Smith and Lou Savage presented the recommendations from the Essential Health Benefit workgroup. Smith said the recommended plan is the PacificSource Preferred CoDeduct small group plan, with supplements including pediatric vision, pediatric dental and habilitative services. Lou Savage said cost was the driving factor behind the recommendation.

*Recommendations from the Essential Health Benefit workgroup can be found [here](#), starting on page 17.*

**Public Testimony on EHB Recommendations – Vice Chair Lillian Shirley and ORHIX Chair Liz Baxter**

The board heard testimony on the Essential Health Benefit Workgroup Recommendations from 10 people:

- John Gobble, registered dietician, said registered dietitians should be allowed to provide care beyond the limited amount of permitted visits each year.
- Ted Amnn, Central City Concern, spoke about the benefits of acupuncture for a patient's quality of life. He said acupuncture should be included as part of the essential health benefits.
- John Mullin, Oregon Law Center, spoke about the essential health benefits package.
- John Hummel, Oregon Primary Care Association, said patients have complex health needs and there needs to be Exchange quality measures.
- Gary Cobb, Central City Concern, said as former Medicare patients enter the Exchange they will be disappointed as acupuncture is not included. Cobb said people should have a choice to continue using a treatment that has been working for them.
- Allison Sutherland, Oregon Alliance of Freestanding Birth Centers, voiced her concern about the exclusion of benefits for out-of-hospital births.

- Karen Stephenson, We Can Do Better, spoke about using previously established, commercial plans for the baseline benefit package. She said Oregon and commercial organizations have different objectives: benefits designed to improve health vs. benefits designed to sell policies.
- Carolyn Kohout, a homecare worker, said dental, hearing and vision are all very important to a person's overall health. She said dental health, for example, affects all parts of the body as teeth are an essential part of survival.
- Stephanie Tama-Sweet, American Heart Association, spoke about tobacco cessation benefits. She said it's important for OHP clients to be able to continue with medication and treatments if they move into Exchange.
- Cynthia Johnson, advocate for acupuncture and naturopathic physicians, said pain is high cost in this country and prescription drug use could be greatly decreased if more people had access to naturopathy and acupuncture.

**Board Action on EHB Recommendations – Vice Chair Lillian Shirley and ORHIX Chair Liz Baxter**

Joe Robertson moved to accept the Essential Health Benefits Recommendations. Mike Bonetto seconded the motion. Vote: 6-1-2; Nays: Hagins Excused: Parsons, DeVore

**Federal Health Care Reform Update and Next Steps – Jeremy Vandehey and Lou Savage**

Jeremy Vandehey spoke about the Affordable Care Act ruling by the Supreme Court. He said the Medicaid expansion and the current Medicaid program are considered two different programs. He said next steps include defining what flexibilities we need. Lou Savage spoke about the Wakely report, which estimates the financial impact of increased health care access and the essential benefit plan on the cost of insurance. Savage said it will help Oregon develop strategies to mitigate adverse impacts on some individuals and businesses.

**Adjourn**

**Next meeting:**

**September 11, 2012**

**8:30am to 12pm**

**Market Square Building**

**1515 SW 5<sup>th</sup> Ave, 9<sup>th</sup> Floor**

**Portland, OR 97201**

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**Monthly Report to  
Oregon Health Policy Board  
September 11, 2012**

*Bruce Goldberg, M.D.*

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**PROGRAM AND KEY ISSUE UPDATES**

**Healthy Kids Program**

- Through June 2012, **113,043** more children have been enrolled into Healthy Kids for a total child enrollment of **383,116**.
- **7,077** of these children are now enrolled in Healthy KidsConnect.
- This is 141% of our goal of 80,000 more children and a 42% increase in enrollment since June 2009 (baseline).
- *See the attached table for a more detailed look at Healthy Kids enrollment.*

**OHP Standard**

- The 2011/2013 biennial goal is to have an average monthly enrollment of 60,000 individuals enrolled in OHP Standard. This goal has been carried over from the 2009/2011 biennium.
- As of August 6, 2012, enrollment in OHP Standard is now **68,510**.
- The last drawing was on July 5, 2012 for 1,000 names. The next drawing will be on October 3 for 1,000 names.

**Update on work groups and committees**

Please see attached updates:

- Patient Safety and Defensive Medicine (PSDM) Workgroup
- Metrics and Scoring Committee
- Medicaid Advisory Committee
- Health Information Technology Oversight Council

**Upcoming**

**Next OHPB meeting:**

**October 9, 2012**

**1:00 p.m. – 4:30 p.m.**

**Coos Bay**

	OHP Net Enrollment	HKC Net Enrollment	Total Net Enrollment	Increase Over Baseline	Monthly net enrollment change	% of Goal Achieved
9-Jul	271,493	0	271,493	3,648	3,648	5%
9-Aug	276,712	0	276,712	8,867	5,219	11%
9-Sep	281,374	0	281,374	13,529	4,662	17%
9-Oct	289,015	0	289,015	21,170	7,641	26%
9-Nov	294,459	0	294,459	26,614	5,444	33%
9-Dec	298,600	0	298,600	30,755	4,141	38%
10-Jan	303,026	0	303,026	35,181	4,426	44%
10-Feb	305,785	205	305,990	38,145	2,964	48%
10-Mar	309,047	549	309,596	41,751	3,606	52%
10-Apr	312,191	923	313,114	45,269	3,518	57%
10-May	314,933	1,133	316,066	48,221	2,952	60%
10-Jun	316,891	1,338	318,229	50,384	2,163	63%
10-Jul	319,878	1,662	321,540	53,695	3,311	67%
10-Aug	322,694	1,948	324,642	56,797	3,102	71%
10-Sep	326,545	2,335	328,880	61,035	4,238	76%
10-Oct	331,837	2,700	334,537	66,692	5,657	83%
10-Nov	334,120	3,046	337,166	69,321	2,629	87%
10-Dec	337,498	3,441	340,939	73,094	3,773	91%
11-Jan	342,272	3,712	345,984	78,139	5,045	98%
11-Feb	348,660	4,081	352,741	84,896	6,757	106%
11-Mar	349,424	4,372	353,796	85,867	971	107%
11-Apr	353,526	4,732	358,258	90,329	4,462	113%
11-May	354,070	4,970	359,040	91,111	782	114%
11-June	356,645	5,196	361,841	93,892	2,781	117%
11-July	358,990	5,419	364,409	96,432	2,540	121%
11-Aug	360,644	5,626	366,270	98,300	1,868	123%
11-Sep	363,474	5,935	369,409	101,428	3,128	127%
11-Oct	366,811	6,140	372,951	104,890	3,462	131%
11-Nov	367,953	6,364	374,317	106,241	1,351	133%
11-Dec	369,723	6,503	376,226	108,148	1,907	135%
12-Jan	370,561	6,492	377,053	108,965	817	136%
12-Feb	371,497	6,780	378,277	110,188	1,223	138%
12-Mar	372,614	6,597	379,211	111,151	963	139%
12-Apr	373,376	6,662	380,038	111,967	816	139%
12-May	373,670	6,958	380,628	112,501	534	141%
12-June	<b>374,514</b>	<b>7,071</b>	<b>381,585</b>	<b>113,447</b>	<b>946</b>	<b>142%</b>
12-July	<b>374,144</b>	<b>7,077</b>	<b>381,221</b>	<b>113,043</b>	<b>-404</b>	<b>141%</b>

**Update on: Patient Safety and Defensive Medicine (PSDM) Workgroup**

As directed by Senate Bill (SB) 1580 during the 2012 Legislative session, Governor Kitzhaber established the **Patient Safety and Defensive Medicine Workgroup** to recommend medical liability legislation focused on improving patient safety, effectively compensating injured individuals, and reducing medical liability system costs. Based on a proposal from the Governor, the Workgroup developed draft legislation for an Early Discussion and Resolution Program (**see attached**) involving a notice of serious event, discussion and resolution, and mediation if the parties agree. Notices will be reported to an *administrative entity* responsible for collective reporting and making recommendations on how to reduce medical errors and improve patient safety. The draft legislation is being forwarded to the Legislature to be introduced in the 2013 regular session. More information, including the draft legislation, is available at

<http://cms.oregon.gov/oha/OHPR/Pages/PSDM/index.aspx>.

DRAFT

# Draft Legislation

## Early Discussion and Resolution

Relating to patient safety in resolution of health care serious events.

### **Section 1. Notice of Serious Event**

(1) If a serious adverse event occurs during the course of health care, the treating health care provider, or designee, must submit a notice of serious event to the health care facility in which the event occurred, if any. This notice must also be submitted to the {Administrative Entity} in the form and format established by the Entity by rule. If the serious adverse event occurs outside a health care facility, the notice must be submitted only to the Entity. A copy of the notice submitted pursuant to this subsection must also be provided to the patient.

(2) If a serious adverse event occurs during the course of health care, the patient who is the subject of the event, or the patient's representative, may submit a notice of serious event to the health care facility in which the event occurred, if any, pursuant to a process established by the health care facility. If the event did not occur in a health care facility, the patient may submit the notice to the {Administrative Entity}. If submitted to the Entity, the Entity shall notify the health care provider of the submission within {24 hours} of receipt by the Entity.

(3) The notice of serious event required in this section does not constitute a written complaint or claim demanding a monetary payment for damages nor does it constitute a claim for purposes of ORS 742.400.

### **Section 2. Discussion and Resolution**

(1) If a notice of serious event is filed pursuant to section 1 of this Act, the treating health care provider must engage in a discussion regarding the event with the patient or the patient's representative within {30} days of filing of the notice. During this discussion, the health care provider or other individuals participating in the discussion may disclose as much relevant information as is then known regarding the circumstances surrounding the event.

(2) The patient or patient's representative may choose to include other individuals in the discussion described in subsection (1) of this section, including but not limited to family, friends and legal counsel. The health care provider or health care facility in which the event occurred also may choose to involve other individuals in the discussion, including but not limited to risk management personnel, malpractice carrier representatives, other health care providers and legal counsel. The patient must provide the necessary permission for disclosure of the patient's protected health information as necessary for the discussion described in this section.

(3)(a) No later than {90} days after the discussion described in subsection (1) of this section, the health care provider shall communicate to the patient or the patient's representative the steps the health care provider will take to prevent future occurrences of the serious event. In addition, the health care provider shall:

(A) Determine that no offer of compensation is warranted and communicate that determination to the patient or the patient's representative orally or in writing; or

(B) Determine that an offer of compensation is warranted and extend that offer in writing to the patient or the patient's representative. Any discussions and negotiations between the patient or the patient's representative and the health care provider must remain oral.

(b) The {90} day period described in paragraph (a) of this subsection may be extended if the patient or the patient's representative and the health care provider mutually agree in writing to an extension. In no event may this period be extended more than {180} days from the date the notice of serious event was submitted.

(4) The patient or the patient's representative shall have {30} days from the date an offer is made to accept the offer. The patient or the patient's representative and the health care provider may mutually agree in writing to extend this {30} day period but in no event shall the period extend more than {180} days from when the notice of serious event was submitted until the parties also mutually agree to extend the statute of limitations.

(5) The patient or the patient's representative may accept or reject any offer made pursuant to this section. If an offer made pursuant to this subsection is accepted, the health care provider, or health care facility if the event occurred in a facility, shall notify the {Administrative Entity} that the matter has been resolved.

### **Section 3. Confidentiality**

(1)(a) Disclosures and offers of compensation made pursuant to the early discussion and resolution process established in this Act and information collected or developed for the purpose of and with the intent to communicate with or to make a disclosure to the patient or the patient's representative, or to make an offer of reasonable compensation to a patient or the patient's representative pursuant to this Act, including the terms of any offer, do not constitute an admission of liability and shall be confidential and privileged and not admissible in evidence in any civil action, including but not limited to a judicial, administrative, arbitration or mediation proceeding.

(b) The information described in subsection (1)(a) of this section is not subject to:

(A) Civil or administrative subpoena;

(B) Discovery in connection with a civil action, including but not limited to a judicial, administrative, arbitration or mediation proceeding; or

(C) Disclosure under state public records law pursuant to ORS 442.820 (3).

(2) Subsection (1) of this section does not:

(a) The confidentiality provisions of this section do not require the exclusion of any evidence otherwise discoverable pursuant to the Oregon Rules of Civil Procedure; or the discussion and resolution process including but not limited to records of a patient's medical diagnosis and treatment created in the ordinary course of business.

(b) Require exclusion when the evidence is offered for another purpose, such as proving bias or prejudice of a witness, negating a contention of undue delay, or proving an effort to obstruct a criminal investigation or prosecution.

(3) The {Administrative Entity} may disseminate information provided pursuant to the early offer and resolution process to the public and to other health care providers or health care facilities not involved in the serious event in the aggregate. Any information disseminated may not identify any individual patient, health care provider or health care facility. In no event will any information provided to the Entity be disclosed to a regulatory agency or licensing board. The Entity may use and disclose information received as necessary to assist individual health care providers or health care facilities involved in a serious event determine the cause of and potential mitigation of a serious event.

#### **Section 4. Mediation**

(1) A patient and health care provider shall enter into mediation pursuant to the process described in ORS 36.185 through ORS 36.238 if the early discussion and resolution process described in sections 1 to 3 of this Act does not resolve the serious event unless:

(a) No offer is made and not all parties agree to mediation; or

(b) An offer is made and rejected by the patient or the patient's representative and both parties waive mediation

(2) The {Administrative Entity} shall develop and maintain a panel of qualified individuals to serve as mediators for the early discussion and resolution process. The parties may choose any mediator by mutual agreement, either from the panel or outside the panel.

(3) The cost of mediation shall be borne equally by the parties unless otherwise mutually agreed.

(4) Participants in mediation under this section shall include the patient or the patient's representative and the health care provider or health care facility involved in the serious event. Participants may also include but are not limited to:

(a) The patient's family at the discretion of the patient or the patient's representative;

(b) Legal representation for either or both parties, at the discretion of the parties;

- (c) The health care provider or health care facility's malpractice insurer;
- (d) Risk management personnel; and
- (e) Any lien holder with an interest in the dispute.

(5) Participation in mediation satisfies the requirements of ORS 31.250.

**Section 5. Dispute resolution.** In the event a dispute arises during the early discussion and resolution process, including mediation pursuant to section 4 of this Act, the dispute will be referred to a mediator for binding resolution of the issue.

**Section 6. Compensation and resolution.**

- (1) Any payment made to a patient or the patient's representative pursuant to the early discussion and offer process described in this Act does not constitute a payment resulting from a written claim or judgment.
- (2) The health care provider may require the patient or the patient's representative to execute all documents and obtain any necessary court approval to resolve a serious event and the form of such documents or court approval shall be discussed and negotiated as necessary.

**Section 7. Malpractice carriers. ORS 743.056 is amended to read:**

**743.056** (1) As used in this section:

- (a) "Adverse event" means a negative consequence of patient care that is unanticipated, is usually preventable and results in or presents a significant risk of patient injury.
- (b) "Claim" means a written demand for restitution for an injury alleged to have been caused by the medical negligence of a health practitioner or licensed health care facility.
- (c) "Health practitioner" means a person described in ORS 31.740 (1).
- (d) "Patient's family" includes:
  - (A) A parent, sibling or child by marriage, blood, adoption or domestic partnership.
  - (B) A foster parent or foster child.

(2) An insurer may not decline or refuse to defend or indemnify a health practitioner or a health care facility with respect to a claim, for any reason that is based on the disclosure to the patient or the patient's family by the health practitioner or facility of an adverse event or information relating to the cause of an adverse event, **or based on participation in the early discussion and resolution process described in this Act.**

(3) A policy or contract of insurance or indemnity may not include a provision or term excluding or limiting coverage based on the disclosure to a patient or the patient's family by a health

practitioner or facility of an adverse event or information relating to the cause of an adverse event, **or based on participation in the early discussion and resolution process described in this Act.**

**(4) An insurer may establish requirements for coverage of offers of compensation made pursuant to the early discussion and resolution process described in this Act. Requirements established pursuant to this subsection may not be intended to or have the effect of preventing meaningful participation in the early discussion and resolution process.**

### **Section 8. Litigation**

(1) Nothing in the early discussion and resolution program described in this Act is intended to prevent or discourage a patient or the patient's representative from filing a claim for damages for alleged medical negligence of a health care provider or health care facility if the early discussion and resolution process described in this Act is not successful.

(2) The statute of limitations applicable to a medical malpractice claim and any applicable tort claim notices shall be tolled for {180} days from the submission of a notice of serious event pursuant to the early disclosure and resolution process unless the parties otherwise agree in writing. Nothing in this Act shall change the existing operation of the statute of limitations, the statute of ultimate repose or any Oregon Tort Claims notice requirements.

(3) If a claim has been filed in court before the notice of serious event is filed or at any point in the process, the presiding court must stay the proceeding until such a time as the parties have the opportunity to engage in the early discussion and resolution process established in this Act. If the process is successful, the plaintiff must notify the presiding court and the court will dismiss the action. If the process is not successful, the plaintiff must notify the presiding court and the court will return the action to the active docket. The Chief Justice of the Oregon Supreme Court shall adopt such rules as are necessary to carry out the provisions of this subsection.

(4) Evidence of an offer, the amount, payment or acceptance of any compensation offered pursuant to the early discussion and resolution process established in this Act shall not be admissible in any litigation. However, in the event a judgment is entered against a health care provider who has paid compensation under Section 2 or Section 4, the amount of the judgment shall be reduced by the amount of any such payments made.

### **Section 9. Discovery**

(1) The parties are encouraged to reach a fair and equitable resolution to a serious event without undue delay or expense. Accordingly, ORCP 36 does not apply to the early discussion and resolution process established in this Act. Discovery in the early discussion and resolution process shall be limited to only that information necessary to determine the nature and scope of the serious event.

## Section 10. Patient Safety

(1) The {Administrative Entity} shall establish in rule procedures to accept notices of serious event as required by the early discussion and resolution process described in this Act. Notices shall be submitted electronically to the greatest extent practicable.

(2) The {Administrative Entity} shall use notices of serious events to:

- (a) Establish quality improvement techniques to reduce systems' errors contributing to serious events;
- (b) Disseminate evidence-based prevention practices to improve patient outcomes; and
- (c) Assist individual health care providers and health care facilities, upon request of the provider or facility, to reduce the incidence of a particular serious event, including but not limited determining the underlying cause of the event and providing advice regarding preventing reoccurrence of the event. Any analysis provided to a health care provider or health care facility pursuant to this paragraph shall also be provided to the patient or patient's representative who was involved in the event.

(3) The {Administrative Entity} may upon its own initiative investigate events reported to the commission pursuant to this section pursuant to criteria adopted by the Entity in rule.

## Section 11. Definitions. As used in this Act:

(1) "Health care facility" has the meaning provided in ORS 442.015:

(2) "Health care provider" includes:

- (a) A psychologist under ORS 675.030 to 675.070, 675.085 and 675.090;
- (b) An occupational therapist under ORS 675.230 to 675.300;
- (c) A physician under ORS 677.100 to 677.228;
- (d) An emergency medical services provider under ORS chapter 682;
- (e) A podiatric physician and surgeon under ORS 677.820 to 677.840;
- (f) A nurse under ORS 678.040 to 678.101;
- (g) A nurse practitioner under ORS 678.375 to 678.390;
- (h) A dentist under ORS 679.060 to 679.180;
- (i) A dental hygienist under ORS 680.040 to 680.100;
- (j) A denturist under ORS 680.515 to 680.535;

(k) An audiologist or speech-language pathologist under ORS 681.250 to 681.350;

(L) An optometrist under ORS 683.040 to 683.155 and 683.170 to 683.220;

(m) A chiropractor under ORS 684.040 to 684.105;

(n) A naturopath under ORS 685.060 to 685.110, 685.125 and 685.135;

(o) A massage therapist under ORS 687.011 to 687.250;

(p) A physical therapist under ORS 688.040 to 688.145;

(q) A medical imaging licensee under ORS 688.445 to 688.525;

(r) A pharmacist under ORS 689.151 and 689.225 to 689.285;

(s) A physician assistant as provided by ORS 677.505 to 677.525; or

(t) A professional counselor or marriage and family therapist under ORS 675.715 to 675.835

3) "Serious Event": An objective and definable negative consequence of patient care that is unanticipated, usually preventable and results in patient death or serious physical injury.

4) "Serious Injury": Harm that is significant to a reasonable and objective person.

### **Update on: Metrics and Scoring Committee**

The Metrics and Scoring Committee, established by SB1580, met for the first time on August 22, 2012. As directed by the statute, the OHA Director appoints the nine members—3 CCO representatives, 3 measurement experts and 3 at-large members—for 2 year terms. *See attached roster*. The Metrics and Scoring Committee role is to adopt measures of cost, quality and access that will be reported by CCO.

The state's recently approved Medicaid waiver directed OHA to develop a Quality Incentive Pool as part of their global budgets beginning on July 1, 2013, so the Committee's first order of business will be to make recommendations to the Director about the design of the incentive program, including which metrics will be attached to the pool and what the thresholds will be to be eligible for incentive payments. The Robert Wood Johnson Foundation is supporting our efforts by providing consulting assistance from Michael Bailit from Bailit Health Purchasing, a firm with broad experience in developing incentive and reimbursement systems. The parameters established by CMS in the state's waiver require that the incentive pool metrics include access, quality and cost metrics as well as measures of EHR adoption.

The Quality Incentive Program design and specifications are due to CMS no later than November 5<sup>th</sup> as part of the set of deliverables that are due 120 days after the waiver was approved.

One of the items that came out of the first meeting was a recommendation to OHA that the agency postpone its requirement that CCOs submit their Transformation Plans until January 1, 2013 so that CCOs can align their Transformation Plans with the areas of emphasis identified in the Quality Incentive Program design. The state is in discussions with CMS about aligning these due dates.

After the Committee completes its recommendations for the Quality Incentive Program in late October, it will turn its attention to a CCO Metrics and Measurement Framework. Committee members expressed an interest in moving beyond the core metrics identified in the waiver toward a set of metrics that more accurately capture health system transformation goals.

## Metrics and Scoring Committee

### Roster

#### Committee members:

Maggie Bennington-Davis  
Cascadia BHC  
Portland, OR

Gloria Coronado  
Kaiser Permanente Center for Health  
Research  
Portland, OR

Robert Dannenhoffer  
Umpqua Health Alliance  
Roseburg, OR

Robert Gillespie  
Oregon Pediatric Improvement  
Project  
Portland, OR

Phil Greenhill  
Western Oregon Advanced Health  
Coos Bay, OR

Bob Joondeph  
Disability Rights Oregon  
Portland, OR

David Labby  
HealthShare of Oregon  
Portland, OR

Jeff Luck  
Oregon State University  
Corvallis, OR

Jeanine Rodriguez  
SEIU  
Portland, OR

#### Staff:

Carole Romm  
Oregon Health Authority

Sarah Bartelmann  
Oregon Health Authority

## **Update on: Medicaid Advisory Committee**

### **What is the Oregon Medicaid Advisory Committee?**

Oregon is required by federal law to have a committee that advises the Oregon Health Authority (OHA) and Division Medical Assistance Program (DMAP) about the health and medical care services for recipients of the Oregon Health Plan (OHP). For the past eight years, and as outlined in federal and state statute, Oregon's Medicaid Advisory Committee (MAC) has successfully participated in policy development, oversight, and review of Oregon's administration of its Medicaid program, as well as formulated recommendations to state agencies and committees. Committee members include health care professionals, OHP clients, representatives from health plans, advocates, providers, and other stakeholders.

### **Affordable Care Act and Medicaid Benchmark Requirement?**

The federal Affordable Care Act (ACA) established a new Medicaid eligibility group of non-pregnant adults between 19-65 with incomes up to 133-138% of the Federal Poverty Level (PFL). As directed by the Affordable Care Act, States have the option to provide Benchmark or Benchmark-equivalent coverage to adults in the new adult eligibility group as described under §1937 of the Social Security Act (DRA). This means the Medicaid benchmark could be:

- Its full Medicaid package (e.g. OHP Plus for adults)
- Largest federal employees plan
- Largest state employee plan (Providence Statewide)
- Largest private HMO plan (a Kaiser plan)

And, can consider:

- The commercial EHB reference plan adopted for individual and small group commercial market.

Whichever choice, the Benchmark plan will need to include the same 10 Essential Health Benefits used in determine the commercial benefits, so some of the options would need to be supplemented to achieve this.

### **How will Oregon's Medicaid Benchmark Benefit be determined?**

Oregon, as it prepares for the 2014 Medicaid expansion, will need to define its Medicaid Benchmark to the Centers for Medicare and Medicaid Services (CMS) for review and approval. The MAC is leading the effort to develop a recommendation for the Oregon Health Policy Board (OHPB) and the Governor's Office to consider. Once Oregon determines the Medicaid benchmark, the OHA will need to submit a State Plan Amendment to the Centers for Medicare and Medicaid Services (CMS) for federal approval. For more information, refer to the MAC website at:

<http://cms.oregon.gov/oha/ohpr/pages/mac/macwelcomepage.aspx>.

### **What has the MAC accomplished?**

On August 22nd, 2012, the MAC received an overview of the recent work and final recommendation completed by Oregon's commercial Essential Health Benefits (EHB) Workgroup. That Workgroup was chartered to recommend an EHB benchmark plan for Oregon that applies to the individual and small group market both inside and outside of the Oregon Health Insurance Exchange (ORHIX). For more information, refer to the EHB website at [www.oregon.gov/OHA/OHPR/EHB/index.shtml](http://www.oregon.gov/OHA/OHPR/EHB/index.shtml). At their August meeting, MAC members also considered a set of decision-making criteria to guide the committee's work in selecting a Benefit package, one that is least disruptive to the Oregon Health Plan. Committee members also reviewed federal requirements around Medicaid benchmark, identified open policy questions, and learned about key considerations for designing Oregon's Medicaid Benchmark plan working with Deborah Bacharach, a national expert from Manat consulting.

### **What are the next steps?**

The next MAC meeting, scheduled for September 26th in Portland—the committee will begin comparing benefits across potential EHB reference plans including OHP (i.e. existing Plus and Standard benefit packages for Oregon's adult Medicaid population). Over the next two months, the MAC will review a series of options in developing a recommendation for Oregon's Medicaid Benchmark plan, identify meaningful differences in coverage amid the benchmark options; understand the effect of required supplemental benefits if a choice doesn't contain it (e.g. limited dental and routine vision), and work to develop a preliminary recommendation. It is anticipated that a draft recommendation will be posted early November for public comment, which will be brought back to the MAC at their November 28th meeting for consideration in their final recommendation. The final recommendation will be presented to the OHPB on December 11, 2012.

### **Is there opportunity for public comment?**

All MAC meetings are open for the public to attend. However, public comment or testimony will be limited to 15 minutes at the end of each meeting. Due to the time limitations, individuals can also submit public comment or testimony by visiting the MAC website or submitting it to staff via email: [Mac.Info@state.or.us](mailto:Mac.Info@state.or.us). Public comment and testimony are also welcome at the Oregon Health Policy Board's (OHPB) monthly meetings or through their public comment processes, and will be shared with the MAC as they develop their recommendation, and to the Health Policy Board for final consideration at their December meeting.

## **Update on: Health Information Technology Oversight Council**

Below is a summary of Health Information Technology Council (HITOC) and related workgroups, panels, and stakeholder meetings from August 11 to September 10, 2012. Full HITOC meeting summaries are available on the HITOC website at <http://cms.oregon.gov/OHA/OHPR/HITOC/Pages/index.aspx>.

### **September 6, 2012, HITOC:**

HITOC members received information about the Center for Medicare and Medicaid Innovation State Innovation Model application and approved a letter of support, had an introductory overview of the new federal rules for Stage 2 meaningful use of electronic health records (EHRs) and were informed of the upcoming HIT Trailblazer States site visit from the Office of the National Coordinator for Health IT (ONC) and the National Academy for State Health Policy (NASHP). After reviewing public comments on Oregon's Strategic Plan for Health Information Technology (OSP) and discussing a strategy to advance population health, members voted to conditionally approve the OSP, subject to the addition of some revisions. HITOC members reviewed and discussed ongoing work on CareAccord, including engagement efforts, pilot projects and research on Direct-enabled care coordination tools. An introduction to the CCO Metrics and Scoring Committee's work was provided, as well as information about the Oregon Health Care Quality Corporation's pilot project to merge claims and EHR data. Finally, members received information about the recently completed census of Oregon clinical laboratories and their use of electronic reporting.

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**Oregon Health Policy Board**  
**Summaries of Community Health Initiatives**  
**September 2012**

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## **Blue Zones communities – Part of Iowa’s Healthiest State Initiative**

**Summary:** The “Blue Zones communities” concept originated with Dan Buettner, a researcher who studied choices and behaviors in communities around the world where people lived the longest and healthiest lives. Communities that are part of the Blue Zones project by Healthways encourage citizens to focus on nine guiding practices that promote and support healthy behaviors, habits, and lifestyles. The Power 9 Principles are to move naturally, know your purpose, down shift (reduce stress), 80% rule (eat until you are 80% full), plant slant (choose more plants in your diet), wine at five, right tribe (find a social circle), community, and loved ones first.

City residents, government agencies, schools, employers, grocery stores, media/communications channels and restaurants take pledges to support the Blue Zones practices and commit to completing the required number of actionable step towards improving health. For example, individuals can pledge to use the Blue Zones Kitchen Checklist to set up their kitchens in ways that help them to eat less food and eat better food by default. Worksites can install workstation equipment that allows workers the flexibility to sit or stand throughout the workday, and restaurants can pledge to offer half-size portions of their top-selling entrees. For additional examples and information, see the Blue Zones Certification Overview.

Site visits are conducted by international experts on longevity and health, who provide tailored guidance to communities on permanent changes that can be made in local policy, the built environment and social networks. Chosen communities will then mentor other cities that join the movement in the future. Non-selected communities and their residents can still take the pledge and participate in self-directed actions analogous to the official Blue Zones communities.

In 2009, a Blue Zones pilot project was initially conducted in Albert Lea, MN. In 2010, three of the Los Angeles area California beach cities were selected as part of the Healthways-Blue Zones Vitality City initiative. In 2012, as part of the Iowa Governor’s goal to make Iowa the healthiest state by 2016 (Iowa ranked 16<sup>th</sup> in the country in 2011 according to the Gallup-Healthways Well-Being Index), Iowa contracted with Blue Zones/Healthways to makeover ten communities.

**Goal:** Make the community a happier, healthier place to live, work and play.

**Project Timeline:** In Iowa, four communities were selected from 54 applications in June 2012. Six other communities will be selected in the next year based on community readiness, with a total of ten demonstration sites over five years.

### **Key Leadership:**

- **Champions:** Iowa Governor Terry Branstad, city Blue Zones committees, Dan Buettner
- **Sponsors/Partnerships:** Iowa’s initiative is sponsored by Wellmark Blue Cross Blue Shield, which pledged \$25 million over five years. The Beach Cities project is sponsored by Beach Cities Health District. The project in Albert Lea, MN was sponsored by AARP and United Health Foundation.
- **Key agencies:** State, county, and local health departments, planning departments, transportation departments

**Outcomes:** No outcomes for Iowa or California have been reported yet. However, the 2009 Blue Zones pilot conducted in Albert Lea, Minnesota (population 18,000) has produced measurable results. In three years, the city reported an average weight loss of three pounds per resident, an increase in average life

expectancy of 3.1 years, a 40 percent decrease in health care costs for city employees, and a 20 percent reduction in absenteeism for key employers. Overall, the Blue Zones project engaged 60 percent of the city's restaurants, 51 percent of employers, 100 percent of schools, and 27 percent of its citizens.

### **Key Elements:**

- Focus is on small changes in healthy behavior for individuals, supported by larger changes to the surrounding environment, with strong community backing.
- Extensive public-private partnership and support from individual community members
- Cities must demonstrate community readiness prior to being selected as a Blue Zones project
  - Community readiness is based on comprehensive applications demonstrating city potential, need, steps the city has already taken to improve health, and the number of initial pledges from community members
  - Site visits from Blue Zones experts, from which they make the final selection
- Project begins in a small number of demonstration communities primed for change, and spreads over time to other communities as they demonstrate desire and commitment
- “Completion” of the project occurs when communities become certified as official Blue Zones communities, which requires:
  - 20% of citizens sign up with Blue Zones Project and complete at least one Action
  - 25% of schools become Blue Zones Schools
  - 25% of locally-owned or independent restaurants become Blue Zones Restaurants
  - 25% of grocery stores become Blue Zones Grocery Stores
  - 50% of the top 20 community-identified worksites become Blue Zones Worksites
  - Implement at least one policy from each section of the Community Policy Action List
  - Complete at least two changes to the built environment to help people adopt healthier behaviors
  - Earn at least 40% of the total available points for community policy pledge actions

**Reasons for Success:** Evidence supports the Blue Zones principles for living as choices that contribute to a healthier lifestyle. For individuals, these are relatively simple changes, especially when supported by corresponding changes in the environment (e.g., reducing stress at school/worksites, improving access to grocery stores, healthier choices at restaurants, new public walking paths, etc.). Blue Zones relies on the energy and commitment of the whole community, in every sector and at all levels, creating a ground-up transformation. Site visits and contributions from experts also guide each city in determining which changes would have the greatest impact and support for their specific community.

**Challenges:** Contracting with Blue Zones by Healthways is a large expense, especially when only a few populations and communities benefit in the early years. An initial proposal from Blue Zones by Healthways, focusing on three large employers first, estimated the cost at \$2.2-\$4.0 million in year one and \$3.5-\$4.5 million for implementation in years 2 to 4. Extensive commitment and support from community members, local government, and business owners is necessary prior to the start of the Blue Zones Project, which could be a barrier if communities are not interested. Blue Zones certification following the project only results in the commitment of at least 20-25% of citizens, businesses, and schools; the sustainability of Blue Zones communities could be an issue following completion of the project.

**Links and Additional Resources:**

Iowa's Healthiest State website:

<http://www.iowahealthieststate.com/blue-zones>

Blue Zones Project website:

<http://www.bluezonesproject.com/bluezones>

Blue Zones Project Community Readiness Assessment:

<https://s3.amazonaws.com/BlueZonesProject/docs/misc/Community+Readiness+Assessment.pdf>

Blue Zones Certification Overview:

[http://s3.amazonaws.com/BlueZonesProject/docs/certification/Certification+Overview\\_FINAL\\_3+15+12.pdf](http://s3.amazonaws.com/BlueZonesProject/docs/certification/Certification+Overview_FINAL_3+15+12.pdf)

2010 AARP article on Albert Lea, MN:

[http://www.aarp.org/health/longevity/info-01-2010/minnesota\\_miracle.html](http://www.aarp.org/health/longevity/info-01-2010/minnesota_miracle.html)

## **Durham Community Health Network**

**Summary:** The Durham Community Health Network (DCHN) serves as a managed care program for Durham area Carolina Access II enrollees (Medicaid or Children's Health Insurance Program enrollees). Patients in the program receive chronic disease management, health education, patient support, service coordination, and patient advocacy at any of the eight Duke and community primary care practices, and receive support from case management teams. DCHN serves approximately 24,000 patients.

DCHN is a partner in the Northern Piedmont Community Care (NPCC) network, one of the state's fourteen regional Community Care of North Carolina (CCNC) networks. CCNC oversees the statewide medical home initiative across the state, which included approximately half of the primary care practices in North Carolina (1,500 practices with 4,000 physicians) in 2010.

DCHN also includes:

- The Pharmacy Home Initiative, which helps local networks to further educate providers on cost-effective strategies for patient prescribing, in order to lower overall pharmacy costs for the program. Additionally, DCHN employs a clinical pharmacist to monitor and review patients' medications, in order to verify the medication's cost-effectiveness and its utility for the patient.
- The Chronic Care Initiative, which focuses on the aged, blind and disabled populations of Medicaid recipients, which account for approximately 70% of the state's Medicaid expenditures. This initiative supports enhanced screening and assessments for services, including in-home occupational therapy assessments, nutrition counseling, mental health screening and referral, medication therapy management review and education, and nurse case management.
- The Medicaid In-Home Aide Service project, which began as a DCHN pilot project in 2008, but is now being implemented statewide due to its success. Home-visits conducted by occupational therapists determine whether behavioral changes or inexpensive physical alterations to the home could be made instead of the in-home assistance service requested by the enrollee.

Additionally, DCHN works in conjunction with numerous other community health outreach programs through Duke University and the town of Durham (e.g., School Wellness Centers, local clinics, Local Access to Coordinated Care, African American Health Improvement Partnership, etc.).

**Goal(s):** Improve the quality of care for the Durham Community Health Network, a community-based managed care program established for Durham Carolina Access II (Medicaid) enrollees, by reducing barriers to healthcare access, educating patients on their health and healthcare in order to improve compliance with treatment, and sharing best practices.

**Project Timeline:** Initial pilot was in 1996. Electronic data tracking and sharing was introduced in 1999. Additional pilots (e.g., asthma pilot), programs, and initiatives have been added over time; currently all 100 state counties are supported by CCNC.

### **Key Leadership:**

- Champion: Administered by Duke University Medical Center Department of Community and Family Medicine; Duke University School of Nursing.
- Sponsors/Partnerships: Community Care of North Carolina, Northern Piedmont Community Care; NPCC and DCHN are governed by a network of providers and agencies serving the Medicaid

population, including local hospitals, primary care clinics, and the Durham Departments of Social Services and Health.

- Key agencies: NC Department of Health and Human Services and the Division of Medical Assistance

#### **Outcomes:**

- Over two-thirds of the state's Medicaid population is covered by Community Care of North Carolina.
- Asthma Pilot Program results (focused on disease maintenance for CCNC enrollees with asthma):
  - From 1999-2003, the percentage of patients who were on maintenance medications increased from 60 percent to 93 percent; and 39 percent more patients with asthma received flu shots.
  - From 2002-2006, hospital admission rates decreased by forty percent for asthma patients.
- Medicaid In-Home Aide Service results:
  - From 2008-2009, 61 percent of requests for personal care assistants were avoided through in-home evaluations; 70 percent of the avoided requests were further satisfied through improvements to functioning behavior and/or the home, at less than \$150 per patient.
  - With expansion of this program state-wide, the state anticipates saving nearly \$100 million annually without negatively impacting patients' chronic disease management or care.

#### **Key Elements:**

- Public-private partnership with extensive collaboration among providers in the region; Duke University contributes extensive research and data collection, and provides education to further improve practices and support innovative new program ideas.
- Funding: Practices receive \$2.50 per patient per month (pp/pm) from the state in addition to the established fee-for-service reimbursement for taking part in the networks' quality-improvement programs; the network receives \$3 pp/pm. Practices and networks can make an additional \$2.50 pp/pm for each Medicaid patient served who is in the aged, blind, and disabled category.
- Case management teams, consisting of clinical personnel, nutritionists, social workers, and community health workers, coordinate care for individual Carolina Access patients.
- Shared central data system, which can alert care managers to patients' emergency room visits, compliance/non-compliance with prescription refills, and preventive screenings/results. Additionally, patients can access relevant health information for their individual conditions through kiosks placed in the community.

**Reasons for success:** Community Care of North Carolina has been successful due to the wide implementation of the program (all fourteen regions of the state), the continued backing from the state legislature, and the supportive partnerships formed throughout the networks. Evidence shows that medical homes can reduce complications and improve targeted care for patients with chronic disease. One of the strengths of the program is the regional governing; DCHN can make its own programmatic decisions, conduct research, and implement new initiatives based on its specific population and their needs. If successful, pilots developed in the region (e.g., the DCHN Medicaid In-Home Aide Service program) can then be implemented state-wide.

**Challenges:** Collaborating region- and state-wide requires effective sharing of funding and resources, including compatible data management technology and any necessary training to ensure access for all providers. Decision-making is done on a regional and state level as well, which requires commitment and efficient communication between multiple partners on a variety of levels. Community outreach and

continued support and engagement of Medicaid enrollees is also vital for the success of the program and is dependent on regional care management teams. Rural, urban, and suburban teams face very different challenges in community outreach and care that must be accounted for by their regional governing board.

**Links and Additional Resources:**

DCHN/Duke University website: <http://communityhealth.mc.duke.edu/clinical/?/DCHN>

2010 Health Affairs article on DCHN: <http://content.healthaffairs.org/content/29/5/956.full>

CCNC program overview and results: <http://commonwealth.communitycarenc.org/about/overview.aspx>

## **Vermont Community Health Teams (Part of VT's Blueprint for Health)**

**Summary:** The Vermont Blueprint for Health, initially signed into Vermont law in 2006, serves as a guide on how the state will provide all citizens with access to affordable, high-quality health care. The Blueprint centers on the expansion of medical homes throughout the state, supported by community health teams that serve all residents; this initiative is known as the Advanced Primary Care Practice Model and Blueprint Integrated Health Service Program. Patient health data is collected in a state-wide web-based central registry.

Any support received from the community health team is provided at no cost to the patient, with no referral necessary and no eligibility restrictions. For every 20,000 residents, a \$350,000 annual grant is provided to communities/regions to build and select the community health team that would best serve the needs of their individual population. Funding for the shared resource is provided by the three major commercial insurers in Vermont, as well as Medicaid. Each team is led by a registered nurse, and is typically supported by a combination of nurses, social workers, behavioral health counselors, dietitians, community health workers, or public health specialists, to make up a five full-time equivalent staff. Community health teams typically work at physician practices throughout their designated region.

Community health teams communicate with physicians, hospitals, support services, and patients to provide more thorough and coordinated care to the general population. The community health team performs a variety of services, including: tracking and notifying patients about appointments, screenings, and tests; connecting patients to different types of providers for treatment; helping patients fill out insurance applications; educating patients on medication and treatment plans; assisting patients in finding transportation or child care services during appointments; or teaching families how to improve their diets.

**Goal(s):** Transform care delivery, reduce costs, improve health outcomes, and enable everyone in the state to receive seamless, well-coordinated care.

**Project Timeline:** In July 2008, the Community Health Teams were piloted in the St. Johnsbury Hospital Service area. Two other pilots were then conducted (2008 and 2010); the model is currently being expanded statewide and will be implemented in all areas of Vermont by October 2013.

### **Key Leadership:**

- **Champions:** Craig Jones (director of the Blueprint); Vermont Governor Peter Shumlin (and prior Governor Jim Douglas)
- **Sponsors/Partnerships:** The three major commercial health insurers (BCBSVT, MVP Health Plan, CIGNA) and Medicaid; regional participation/coordination of physicians and hospitals; University of Vermont
- **Key agencies:** Vermont Agency of Human Services/Dept of Vermont Health Access/Health Care Reform

**Outcomes:** A 2011 analysis of the St. Johnsbury pilot program showed significant annual decreases in hospital inpatient admissions (21 percent decrease), emergency department visits (31 percent decrease), overall patient use rates (8.9 percent decrease) and lower overall per patient per month costs (11.6 percent decrease). It is projected that the initiative will reduce the predicted increase in incremental health spending by 28.7 percent once implemented statewide.

Additionally, a qualitative assessment of the Blueprint and its community health teams showed that physicians and patients responded positively to the community health teams. Providers were able to respond more completely and quickly to a greater variety of patient needs with the support of the community health teams, and patients with chronic conditions were able to schedule appointments more regularly.

### **Key Elements:**

- Public-private partnership and funding allows all residents to benefit from the Blueprint design;
- Funding: In addition to normal fee-for-service reimbursements, participating primary care practices receive a variable per patient per month payment. The payment is based on the practice's score on the National Committee for Quality Assurance patient-centered medical home standards; scoring is completed at baseline and every six to twelve months by a team from the University of Vermont.
  - Payments range from \$1.20-\$2.39; a five point change in NCQA score corresponds with a \$0.08 change in payment (increase or decrease, accordingly).
- Local control of the multi-disciplinary, practice-based community health teams allows for flexibility and responsiveness to an individual community's needs (staffing, design, scheduling, worksite, etc.).
- All patients can utilize the services of the community health teams with no referral, no eligibility requirements, and no cost-sharing.

**Reasons for Success:** By design, community health teams are able to fulfill the greatest needs of the individual region and population, as identified by the board selecting the team. Providers are better able to serve patients and connect them with necessary services when supported by the greater capacity and depth of the team, due to its multi-disciplinary staff. Monitoring and supporting patients across the system (with the help of the central web-based registry) improves care coordination, which can reduce costs and improve health outcomes.

**Challenges:** While the cost-savings are currently promising, financial stability in the future (continued funding for the community health teams, as well as the enhanced reimbursements) could be an issue if the program does not actually reduce costs in the longer term; private insurers may not have an incentive to continue with their support. The local control and selection of the community health team must be carefully maintained in order to best support the needs of the regional population over time; success of the program can vary based on the makeup, knowledge, and commitment of the community health team.

### **Links and Additional Resources:**

2011 Health Affairs innovation profile:

<http://content.healthaffairs.org/content/30/3/383.full>

AHRQ Innovations Profile:

<http://www.innovations.ahrq.gov/content.aspx?id=2666>

VT's Blueprint for Health:

[http://hcr.vermont.gov/sites/hcr/files/final\\_annual\\_report\\_01\\_26\\_11.pdf](http://hcr.vermont.gov/sites/hcr/files/final_annual_report_01_26_11.pdf)

VT's Blueprint for Health Implementation Manual:

<http://hcr.vermont.gov/sites/hcr/files/printforhealthimplementationmanual2010-11-17.pdf>

## **Austen BioInnovation Institute in Akron (ABIA)**

**Summary:** The Austen BioInnovation Institute in Akron, OHIO (ABIA) opened in 2008, and is a collaborative effort between Akron Children’s Hospital, Akron General Health System, Northeast Ohio Medical University (NEOMED), Summa Health System, and the University of Akron to improve patient-centered care, access, education, prevention, treatment and disease-management through commercialization of innovative life-saving and life-enhancing biomaterials and medicine especially in orthopedics, wound care, and other related specialties.

One of the supplementary goals of ABIA is to spur new startup companies, attract private funding and encourage venture capitalist investments to come to the area for new projects; by doing this, ABIA aims to support economic development and bring over 2,000 jobs to the Akron area within the next decade.

Five centers in ABIA focus on translating research into biomedical commercialization, improving access, education, clinical services and disease management: the Center for Biomaterials and Medicine, the Medical Device Development Center, the Center for Clinical Trials and Product Development, the Center for Simulation and Integrated Healthcare Education, and the Center for Community Health Improvement.

### Accountable Care Community Initiative

Within the Center for Community Health Improvement, ABIA has begun to move forward on its 2011 “Healthier By Design” Accountable Care Community (ACC) initiative, which focuses on care coordination and integration of patient services to improve health. The ACC initiative takes the foundational ideas of Accountable Care Organizations (ACOs) and expands them throughout the community, in all sectors, in order to avoid redundancy of programs and services, save money, increase care coordination, and improve health outcomes for those with chronic conditions, especially those with asthma, obesity, diabetes, and hypertension.

The ACC initiative focuses on the health of the entire population in the region, under all health plans, and are not dependent on providers adopting the Medicare infrastructure. Over 60 public, private, philanthropic, and faith-based organizations are included in the ACC initiative, which is funded by the Centers for Disease Control and Prevention.

The ACC model has eight components (listed from the ABIA website):

- Development of integrated medical and public health models of care;
- Utilization of interprofessional care management teams;
- Collaboration among health systems and public health, to enhance communication and planning;
- Development of a robust health information technology infrastructure;
- Implementation of an integrated and fully mineable surveillance and data warehouse functionality;
- Development of a dissemination infrastructure to rapidly share best practices;
- Design and execution of a robust ACC implementation platform, specific tactics, and impact measurement tool; and
- Policy analysis and advocacy to facilitate ACC success and sustainability.

**Goal(s):** ABIA aims to become 1) a global leader in developing and commercializing biomaterial solutions for those with orthopedic and wound healing problems; 2) a national leader in improving health outcomes of the medically underserved, and 3) a leader in the use of simulation technology for healthcare education.

Goals of the ACC include effecting change across the determinants of health and improving the efficiency of community efforts through creative solutions, capitalizing on resources, and streamlining and linking existing community programs. Additional goals include job creation and a spin-out business entity.

**Project Timeline:** ABIA was founded in 2008. Initial funding continues through 2013; other sources of funding have been secured as well. The ACC Initiative was announced in June 2011.

**Key Leadership:**

- Champion(s): Frank L. Douglas (ABIA Director), Janine E. Janosky (head of Center for Community Health Improvement)
- Sponsors/Partnerships: Five member institutions, John S. and James L. Knight Foundation (provided initial funding of \$20 million over five years); Ohio's Third Frontier Fund; Lubrizol Corporation (a medical polymer company); The ACC is funded through the Centers for Disease Control and Prevention.
- Key agencies: State of Ohio, Summit County, City of Akron, CDC

**Outcomes:** Selected outcomes for ABIA include a \$20 million increase in grants-received by the University of Akron and NEOMED between 2008 and 2009; a listing as the nation's most productive university technology transfer program per dollar of research in 2010, receiving recognition as a designated Ohio Center of Excellence for Biomedicine and Healthcare, and contributing to 212 new jobs.

Outcomes for the ACC from 2011 to 2012 include:

- More than 2000 adults were connected with the ACC's ROI program; average cost per month of care for patients with diabetes reduced by more than 10% per month; after one year, consistent reduction in costs are in excess of 25%
- Diabetes management program, which included access to a multi-disciplinary care team: cost/person/contact hour decreased \$12.50 from a comparable earlier program; more than half of patients lost weight, decreased BMI, and reduced waist size; no amputations occurred; emergency department visits due to diabetes declined; exercise increased. NOTE: potentially small sample size (i.e., total ED visits from all patients enrolled in the program with diabetes decreased from 9 to 7 over six months)

**Key Elements (ABIA):**

- Public-private-philanthropic funding and governance ensures sustainability and broad support;
- Partnership between the five original institutions brings together their greatest strengths and allows for them to accomplish more collectively than each would be able to accomplish independently;
- Economic Development: ABIA's goals for economic development include the creation of Akron's "Biomedical Corridor," which aims to attract significant research money and companies;
- Five distinct centers support a wide range of research, education and training, new projects and initiatives, including the Accountable Care Community initiative;
- Commercialization of biomedical solutions and devices allows for additional self-sustainability, recognition, funding support, and continuous attraction of top researchers and scientists.

Key elements (ACC initiative)

- Extensive, intersectoral partnerships that unite community organizations, institutions, private companies, the public sector and foundations under a common goal; governed by the Wellness

Council of Summit County (created in 2010 as a way to bring together multiple sectors around a shared vision of optimum wellness for Summit County, Ohio, residents).

- Community participation ensures that residents will benefit from the ACC's many initiatives
- Health outcomes measured across the population of entire region challenges the ACC to hold its member organizations accountable for the entire region's health, not just a unique set of engaged individuals.
- Benchmarks and data tracking allows the ACC to better understand the problems affecting the community, prioritize initiatives, and meet the standards of Healthy People 2020, an ACC goal.

**Reasons for success:** ABIA's incredible success could be linked to its innovative new design, its broad programs and initiatives, and its initially narrow niche within the biomedicine world. Extensive funding, planning for sustainability and collaboration among top universities and health systems in Akron has propelled ABIA to its current level of growth and success. Additionally, the commercialization piece of ABIA provides a different type of mechanism to spur creativity and innovation among its doctors and researchers. Finally, including a focus on job builds additional support within the community.

The ACC Initiative has seen initial success partly due to its extensive network of partnerships, all working towards the same goal. This is unique to the ACC and offers a new opportunity for a different ACO model. With so many diverse organizations involved, it increases community support, coordinates services and programs that were previously redundant or isolated, and helps organizations reach a much broader population in a more effective way. The extensive tracking of metrics of success (e.g., burden of disease, community participation, patient safety, etc.) also supports continuous improvement and clearer understanding of next steps or focus areas.

**Challenges:** ABIA has faced challenges already, including the loss of funding through grants that were not continued and a decrease in state funding. In its early years, funding will continue to be incredibly important to attain the goals they have set. Fortunately, with such a broad range of interest areas, funding can come from a variety of sources.

The ACC Initiative relies on community members' individual participation and support, which can be challenging to achieve. Since the expectation is to improve health for the entire community, the ACC will need to be creative in its approach to target and reach a variety of populations. Finally, the extensive partnership network that provides the foundation of services for the ACC needs to remain engaged, committed, and supportive of the ACC overall for its continued success.

#### **Links and Additional Resources:**

ABIA website <http://www.abiakron.org/>

ABIA ACC website <http://www.abiakron.org/laccountable-care-community>

White paper on ACCs <http://www.abiakron.org/acc-white-paper>

Health Affairs editorial on ACCs: <http://healthaffairs.org/blog/2011/08/23/an-accountable-care-community-in-akron-ohio-collaborating-to-create-a-healthier-future/?cat=grantwatch>

## **Promise Neighborhoods (Obama Administration initiative)**

**Summary:** The Promise Neighborhoods program is based on the Harlem Children’s Zone (HCZ) in New York City, which has successfully lifted individuals and families out of poverty by providing comprehensive and rigorous education and support (health, social services, etc.) for all neighborhood residents, from “cradle to community.” This is primarily a school-based initiative that expands into the community.

Communities (led by a nonprofit organization, an institute of higher education, or an Indian Tribe) can apply for one-year planning grants for up to \$500,000 from the U.S. Department of Education; subsequently, communities can apply for 3-5 year implementation grants for \$4-\$6 million. The federal government requires communities to raise a 50% match for planning grants, and a 100% match for implementation grants.

Promise Neighborhood applicants each complete a Needs Assessment in order to determine the greatest challenges within the community, and then must develop a plan to adequately and effectively overcome those challenges. Applicants must demonstrate severe need in the neighborhood, as well as the ability to provide the necessary capacity to address the need. There is no pre-determined requirement for area-served or population; some grants work within a range of city blocks, others are implemented across multiple counties. Ideally, the program should be able to expand in the future to reach thousands of children.

**Goal(s):** Provide children in low-income areas with comprehensive and high-quality health, social, community and educational support and services throughout their development.

### **Project Timeline:**

- 2010: \$10 million, 21 one-year planning grants
- 2011: \$30 million, 5 implementation grants, 15 planning grants
- 2012: \$60 million, 5 continuing implementation grants, 5-7 new implementation grants, 15 new planning grants (over 300 communities applied)

Bills have been introduced in the Senate and the House to formally incorporate the Promise Neighborhoods Initiative into the Elementary and Secondary Education Act, which would allow for more sustainable five-year, renewable grants. Currently the bills are both stalled. Plans are underway to continue this initiative in the future, but may be dependent upon leadership.

### **Key Leadership:**

- **Champions:** President Obama, Geoffrey Canada (Director of HCZ), Senator Tom Harkin, Representative Donald Payne (deceased), Representative Mike Honda
- **Sponsors/Partnerships:** PolicyLink (provides technical assistance to grantees and interested parties), Harlem Children’s Zone, Center for the Study of Social Policy, Annie E. Casey Foundation, National Institute on Drug Abuse (funds the Research Consortium), individual grantee schools/school districts
- **Key agencies:** U.S. Department of Education

**Outcomes:** The Harlem Children’s Zone, on which the Promise Neighborhoods are modeled, has demonstrated substantial and significant achievements in education since its origins in the early 1990s

(outcomes: <http://www.hcz.org/our-results>). For example, 100% of third graders at two of the HCZ academies tested at or above grade level on the state math exam, outperforming their peers in New York State, New York City, District 5, and black and white students throughout the state

Reports have not been released for implementation grantees, but extensive data-tracking is required as part of the grant (including the Results Scorecard for Place-Based Solutions, and ETO Software, which tracks efforts-to-outcomes longitudinal data). Promise Neighborhoods grantees have to pre-select indicators that they will track throughout the project and must have a plan to analyze, use and apply the results from the gathered data. Informally, the administration has indicated initial success in the neighborhoods judging by the rapid increase in funding over the three years.

**Key Elements:** Due to the vast array of challenges that communities are facing, the grant programs are typically broad, complex, and approach the problems from a variety of directions. However, all grantees are required to work in conjunction with a school in the immediate region, and need to focus on the “cradle-to-community” idea of improving services and support at all levels of development. Examples of projects include:

- The Buffalo Promise Neighborhood, which was sponsored by the Westminster Foundation and funded by a local bank (M&T Bank) received an implementation grant for FY2011. The M&T Bank initially partnered with the city’s lowest performing school in 1993; since then, it has become one of the top performing schools in the city. Building on that model of innovation and long-term commitment, the Promise Neighborhoods grant is being used to bring together a large coalition of interested partners who serve the community to develop a common vision and plan. The first planned step is to build an early childhood center and a community playground.
- The Berea College Promise Neighborhood serves three rural counties in Kentucky, and received an implementation grant for FY2011. They are focusing on increasing the access to great schools for all children in the community in order to improve the transition from school to college to career. The vision includes plans to “break down” silos across agencies serving the communities, and increasing access to social services that can support families in the community and at home.

**Reasons for success:** The Harlem Children’s Zone has seen a great deal of success due to the comprehensive and all-encompassing nature of their program, in all stages of life – from pre-natal parenting classes to college prep courses; from nutrition education and cooking classes to asthma maintenance initiatives. Additionally, this has been a long-term, sustained, relentless effort that has built a great deal of community engagement and support.

**Challenges:** Finding a champion that can properly direct, maintain, and stay with the program (similar to Geoffrey Canada’s commitment) can be challenging. Communities must be able to correctly scope and scale their problem, and efficiently address the issues in a comprehensive way. Additionally, applicants must demonstrate that they have the capacity to fulfill the requirements of their grant. Community support and engagement is necessary in order to transform a community as intended.

**Opportunities:**

In 2010, Self Enhancement, Inc. from Portland, OR was a high scoring Promise Neighborhood applicant. The application focused on the North and Northeast neighborhoods serving Jefferson High School, and

included a plan to gather a collaboration of partners who would provide comprehensive services to the school and neighborhood.

See additional information here: <http://www.promiseneighborhoodsinstitute.org/What-is-a-Promise-Neighborhood/Promise-Neighborhoods-Institute-Network-Sites/Self-Enhancement-Promise-Neighborhood-Portland-OR>

**Links and Additional Resources:**

Promise Neighborhoods PolicyLink website:

<http://www.promiseneighborhoodsinstitute.org/>

Promise Neighborhoods Research Consortium:

<http://promiseneighborhoods.org/>

List and links to Promise Neighborhood grantees:

<http://www.promiseneighborhoodsinstitute.org/What-is-a-Promise-Neighborhood/Promise-Neighborhoods-Institute-Network-Sites>

Harlem Children's Zone:

<http://www.hcz.org/>

Report on the Expected Results of Promise Neighborhoods

<http://www.aecf.org/KnowledgeCenter/Publications.aspx?pubguid=%7B39203B94-EB3E-47E9-B4B2-3A3EE2F57468%7D>

## **The Healthy Cities Movement (a World Health Organization initiative)**

**Summary:** The World Health Organization (WHO) Healthy Cities movement was initially conceived in the mid 1980s, and was based on the strategic guidance of the 1986 Ottawa Charter and the principles of Health For All, which is a WHO goal to improve the health and well-being for all people world-wide.

The Healthy Cities Movement is a worldwide initiative to encourage local, urban governments to prioritize the health-related issues on their social, economic, and political agendas. With a greater understanding about how health can be impacted through changes in non-health sectors as well, governments have the ability to greatly improve, promote, and protect their citizens' health and well-being. Healthy Cities uses a multi-faceted approach that supports partnerships, political commitments, institutional change, capacity building, extensive planning, and creative projects. Local governments can concentrate on specific principles, such as empowerment, equity, intersectoral collaboration, and community participation.

Healthy Cities began with 34 cities in the WHO European region, and has expanded to include programs in over 3,000 communities, in over 50 countries, on all continents. The Healthy Cities movement has remained especially strong in the European region. In the United States, during the 1980s and 1990s, over 200 cities and communities self-declared participation in the program. Some of the shared issues have been domestic and youth violence, adolescent services, job and life skills training, and conservation of resources and environmental health.

The movement was initially supported and promoted in the U.S. by the Coalition for Healthier Cities and Communities (CHCC) and the National Civic League. Over time, the CHCC struggled to find sources of funding, and it became part of the Hospital Research and Education Trust of the American Hospital Association. It was then consolidated into the AHA Association for Community Health Improvement, and is now no longer a separate initiative. While some of the participating cities and communities have continued to build on their initial plans (e.g., California's Healthy Cities, MA Healthy Communities), many others have adopted new community health initiatives or have abandoned the program altogether.

**Goal(s):** The goal of Healthy Cities is to encourage local governments in prioritizing health-related issues on their social, economic, and political agendas.

**Project Timeline:** Healthy Cities began in 1988, and its growth has varied on different continents. In Europe, where the movement is still strong, membership encompasses 90 independent cities and 30 national Healthy Cities networks, which includes 1400 cities and towns. In the U.S., it gained great popularity in the mid to late 1990s, but has suffered from declining interest and participation over time.

### **Key Leadership:**

- **Champion:** World Health Organization; John Kessler (former head of CHCC), Tyler Norris (founding director of CHCC)
- **Sponsors/Partnerships:** In the U.S., any sponsors, partnerships or funding sources for the movement are currently based entirely at the local/city level; the American Hospital Association oversees some of the consolidated programs as well.
- **Key agencies:** local/regional health departments, planning departments, departments of transportation

**Outcomes:** Since there is no over-arching framework or guidance to dictate how the healthy cities movement should be implemented (there is an overarching vision statement, but implementation varies by

country and network), communities have developed a variety of models and programs. Some examples from the U.S. include the following:

- The California Healthy Cities Project, Smoke-Free California Initiative supported over 300 communities in writing and passing tobacco control legislation, which resulted in the 1994 California state-wide ban on smoking in the workplace, including bars and restaurants.
- Healthy Valley 2000 was an initiative of six small towns in Connecticut, who joined together to create a common regional vision and plan to improve health, including programs that reached across all six towns.
- Memorial Hospital in South Bend, Indiana, voluntarily tithed 10% of its net revenue back to health initiatives that would benefit the entire community, such as screenings, immunizations, and expanded health care coverage.

### **Key Elements:**

In the U.S., some common themes existed across the various programs:

- Diverse community-wide participation, especially during planning stages, to build ideas and generate solutions from the ground up and to ensure projects are aligned with the local region's needs.
- Local funding, indicating a commitment from businesses and partners within the community.
- Self-evaluation as a tool in the process, to encourage continual, incremental improvement.

In the United Kingdom, there is widespread support for the movement and an extensive UK Healthy Cities Network. The network was funded by the Department of Health for England, and has recently been accredited by WHO as a member of the Network of European Healthy Cities Networks. They focus on:

- Sharing best practices across the region to build capacity and enhance the education of members
- Increasing participation in the movement by supporting interested towns and cities in their planning and testing of programs to address emerging public health issues
- Becoming a united voice to improve health, well-being, equity, and sustainable development through policy change at the local, regional, country and national levels.
- Continuous improvement: Every five years, a new universal set of priorities and criteria are established for the entire European region, and cities can apply to become a designated member of the network, in order to collaborate on community initiatives for those specific health issues.

**Reasons for success:** In the U.S., success was mainly dependent on local interest, community enthusiasm, and the desire to be part of a collective, world-wide movement to improve health. In the WHO European Region, their sustained success has been linked to constant improvement and self-evaluation; every five years the entire focus of the network shifts to accommodate new health challenges and innovative programs and ideas.

**Challenges:** The U.S. Healthy Cities movement has suffered from declining participation, funding, and support in the last ten years. Becoming part of the movement would require substantial local support, a source of funding, and resourcefulness. When compared with other potential community health opportunities, the Healthy Cities movement does not offer a clear vision or direction for the future.

**Links and Additional Resources:**

Journal Article on background and U.S. movement (2000)

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1308699/>

UK Regional Healthy Cities Movement:

<http://www.healthycities.org.uk/the-healthy-cities-movement.php?s=196>

Article, “A Time for Transformation” (2003)

<http://onlinelibrary.wiley.com/doi/10.1002/ncr.10/abstract>

Association for Community Health Improvement

<http://www.communityhlth.org/>