

Oregon's Action Plan for Health

December 2010



Table of contents

An urgent call to action	4
Oregon’s solutions	7
OHPB committees	8
Foundational strategies in brief	11
• Strategy #1 – Use purchasing power to change how we deliver and pay for health care	12
• Strategy #2 – Shift focus to prevention	13
• Strategy #3 – Improve health equity	14
• Strategy #4 – Establish a health insurance exchange to make it easier for Oregonians to get affordable health insurance	14
• Strategy #5 – Reduce barriers to health care	15
• Strategy #6 – Set standards for safe and effective care	16
• Strategy #7 – Involve everyone in health system improvements	16
• Strategy #8 – Measure progress	18
Key actions	19
What will be different after <i>Oregon’s Action Plan for Health?</i>	22
Taking advantage of federal reform opportunities for real change	24
Foundational strategies in action	27
• Strategy #1 – Use purchasing power to change how we deliver and pay for health care	29
• Strategy #2 – Shift focus to prevention	34
• Strategy #3 – Improve health equity.....	37
• Strategy #4 – Establish a health insurance exchange to make it easier for Oregonians to get affordable health insurance	40
• Strategy #5 – Reduce barriers to health care	43
• Strategy #6 – Set standards for safe and effective care	46
• Strategy #7 – Involve everyone in health system improvements	52
• Strategy #8 – Measure progress	57
Appendix A – OHPB committee reports and policy documents	60
Appendix B – Full timeline	61
Appendix C – Draft Oregon Health Scorecard, with data sources and notes	64
Appendix D – Public and stakeholder input	66
Appendix E – List of references used in <i>Oregon’s Action Plan for Health</i>	68

An urgent call to action

In 2009, the Oregon Legislature created the Oregon Health Policy Board and charged it with creating a comprehensive health reform plan for our state. *Oregon's Action Plan for Health* meets that charge by laying out strategies that reflect the urgency of the health care crisis and a timeline for actions that will lead Oregon to a more affordable, world-class health care system.

Over the past 12 months the Board has heard from hundreds of Oregonians around the state — individuals, small business owners, policymakers, members of the health care community, and state and local government.

Everyone is facing the same challenges: costs are too high, outcomes are unsatisfactory and care is fragmented. As a state, we have an imperative. The cost of health care for state government accounts for an estimated 16 percent of state General Fund spending in a time when we are facing a \$3.5 billion shortfall. The services people need are not integrated, which leads to poorer health outcomes and higher costs. Treatments for mental health, substance abuse, oral health, and long-term care needs are fragmented and are insufficiently tailored to meet the needs of Oregon's diverse populace. If we do not act today to rein in these costs, they will continue to overwhelm the state budget. The same is true for family and business budgets.

Meanwhile, for all the dollars we spend, the quality of our care is uneven and the allocation of our resources is illogical. Nationally, it is estimated that about 30 percent of care provided is either unnecessary or does not lead to improved health. For racial and ethnic minorities, access to care and health status are worse than for the general population. For example, 35 percent of minority women in Oregon have no regular care provider, as compared to 18 percent for white women and the life expectancy for African Americans and American Indians/Alaska Natives in Oregon is two years less than for Caucasians. Correcting these disparities and waste will go a long way toward improving our health system.

We can do better. We must do better. And we must take action now.

To achieve world-class quality of health in Oregon, all recommendations in the plan point toward three important objectives — also known as the “Triple Aim.”* These simply stated objectives are powerful because they encompass all that we hope our state health system would include:

Triple Aim

- » Improve the lifelong health of all Oregonians;
- » Increase the quality, reliability and availability of care for all Oregonians; and
- » Lower or contain the cost of care so it is affordable for everyone.

Under the Triple Aim, this *Action Plan* includes steps toward creating a health system in which:

- » The health of all Oregonians is improved;
- » Consumers can get the care and services they need, coordinated locally with access to statewide resources when needed, by a team of health professionals who understand their culture and speak their language;
- » Consumers, providers, community leaders and policymakers have the high-quality information they need to make better decisions and keep delivery systems accountable;
- » Quality and consistency of care are improved and costs are contained through new payment systems and standards that emphasize outcomes and value rather than volume;
- » Communities and health systems work together to find innovative solutions to reduce overall spending, increase access to care and improve health; and,
- » Electronic health information is available when and where it is needed to improve health and health care through a secure, confidential health information exchange.

*Institute for Healthcare Improvement, The Triple Aim, www.ihl.org/IHI/Programs/StrategicInitiatives/TripleAim.htm, (accessed November 22, 2010).

Oregon's solutions

The ideas in this report come from Oregonians themselves. *Oregon's Action Plan for Health* builds directly on the recommendations developed through an extensive public process led by the Oregon Health Fund Board in 2007 and 2008. Over the past year, the Oregon Health Policy Board (OHPB) and Oregon Health Authority (OHA) were advised by more than 300 people from all walks of life who served on almost 20 committees, subcommittees, workgroups, task forces and commissions to examine all aspects of the health and health care system. More than 850 people attended six community meetings across the state to provide feedback to the Board. Likewise, many organizations and groups around the state, such as the Oregon Health Leadership Council, advocacy organizations, small businesses and community groups have provided input.

Through this process, OHPB members heard about the problems we face from different viewpoints and received some conflicting input. While not all perspectives can be represented in this report, it is this diversity of perspectives that will lead to successful reforms. The Board has synthesized and prioritized more than 100 recommendations into this *Action Plan*, which clearly identifies the next steps Oregon should take to reform its system. We recognize that as we accomplish these steps, we will need to develop additional strategies. The Board thanks everyone who participated in the process of developing these plans and salutes their efforts and willingness to tackle thorny issues. Without their input, wisdom and support, the strategies outlined in this *Action Plan* would never have been identified.

The Oregon Health Policy Board is a nine-member citizen board appointed by the Governor. Board members serve four-year terms, and include representatives from consumers, business, public health and health care.

Oregon Health Policy Board

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Oregon Health Policy Board

OHPB committees

The Oregon Health Policy Board has two statutory committees that met throughout 2010. Their work was central to the foundational strategies in Oregon's *Action Plan*.

- » **Public Employers Health Purchasing Committee** — Makes specific recommendations to achieve uniformity in the design of all public benefit plans; develops action plans for ongoing collaboration among public and private purchasers; and identifies uniform provisions for state and local public contracts for health benefits.
- » **Health Care Workforce Committee** — Charged by statute to coordinate efforts to recruit and educate health care professionals and retain a quality workforce to meet the demand created by health insurance coverage expansions, system transformation and an increasingly diverse population.

OHPB also convened the following advisory groups in 2010 to develop recommendations on five crucial aspects of health reform.

- » **Administrative Simplification Workgroup** — Developed recommendations for standardizing administrative transactions between health plans and health care providers, with the goal of making coverage more affordable by reducing health insurance administrative costs.
- » **Health Equity Policy Review Committee** — Proactively evaluated recommendations made throughout the policymaking process to ensure that they promote the elimination of inequities and promote health equity.
- » **Health Improvement Plan Committee** — Developed and presented to OHPB recommendations for development and implementation of a plan to promote statewide and local strategies that promote population health and chronic disease prevention. The recommendations incorporate policy, systems, and environmental approaches.

- » **Health Incentives and Outcomes Committee** — Evaluated and developed initial recommendations to the Board for transparent payment methodologies that provide incentives for cost-effective, patient-centered care and reduce variations in cost and quality of care. The committee also made recommendations to the Board about initial quality metrics that all purchasers of health care, third-party payers and health care providers could use to evaluate payment reform.
- » **Medical Liability Task Force** — Examined current state medical liability laws and policies, their impact on the cost and delivery of health care, and developed a range of medical liability reform proposals for consideration by the Oregon Health Policy Board and the Oregon Legislature.

Foundational strategies in brief

STRATEGY

1

Use purchasing power to change how we deliver and pay for health care

Align public purchasing, reduce administrative costs, change how we pay, establish value-based benefits, and set budgets

STRATEGY

2

Shift focus to prevention

Improve health, lower costs, and allow smarter allocation of resources

STRATEGY

3

Improve health equity

Better health and lower costs for everyone

STRATEGY

4

Establish a health insurance exchange to make it easier for Oregonians to get affordable health insurance

STRATEGY

5

Reduce barriers to health care

Adequate insurance, providers with the right training for the right places, and easy access to care

STRATEGY

6

Set standards for safe and effective care

Primary care homes, electronic health information, evidence-based care, and addressing medical liability

STRATEGY

7

Involve everyone in health system improvements

Consumers, patients, health partners and regional health care organizations

STRATEGY

8

Measure progress

Timely data and meaningful information

Foundational strategies in brief

Oregon's Action Plan for Health calls for actions by policymakers, health care providers, consumers, stakeholders, the Oregon Health Authority and others who are affected by our current broken health system.

These actions are scheduled to begin immediately and continue in stages over the next several years until Oregon has the system and infrastructure necessary to meet the Triple Aim goals of better health, contained cost, improved access, and quality of care.

This *Action Plan* does not specifically address the need for integration of long-term care with physical, behavioral, and oral health care. But the time has come for that work to begin here in Oregon. Federal reform offers new opportunities to coordinate state programs with the federal Medicare program. The Board intends to work with OHA leadership and stakeholders to pursue federal permission where necessary to allow Oregon to develop an integrated and coordinated system that cares for people through the full continuum of their lives and by doing so, improves health and reduces unnecessary system costs.

To get to this kind of fundamental change, the Board has identified eight key strategies as the foundation. Each builds on and complements the others, and each has specific actions that are identified in the table on page 19. More detail about actions can be found beginning on page 27.

STRATEGY

1

Use purchasing power to change how we deliver and pay for health care.

Align public purchasing, reduce administrative costs, change how we pay, establish value-based benefits, and set budgets

Health care is expensive and becoming more so by the day. Health care accounts for an estimated 16 percent of Oregon's state General Fund budget, which is currently threatened by a \$3.5 billion shortfall. Everyone is feeling the squeeze: businesses struggle to provide their employees with health insurance and increasingly require employees to pay a greater share of the bill; public insurance rolls expand as deficits strain Oregon's budgets; individuals put off necessary care until health problems become emergencies. Left unchecked, this trend will undermine our best efforts to improve Oregonians' health. We must act now to bend the cost curve.

While cost reduction will come from a variety of overall improvements to the

health system, such as improved prevention strategies, increased equity and other actions, there are specific cost-related steps to be taken.

The *Action Plan* cost reduction tactics include aligning health care purchasing for the more than 850,000 people who receive health care through the Oregon Health Authority; reducing administrative overhead in the health care industry; crafting value-based essential benefit plans that remove barriers to preventive care in association with innovative payment strategies that reward efficiency and outcomes; and setting “global” budgets for health care.

For more information on how these and other strategies will bend the cost curve downward, go to page 29. For evidence and rationale behind purchasing recommendations, please see the committee reports referenced in the appendices.

Shift focus to prevention.

Improve health, lower costs and allow smarter allocation of resources

Almost 40 percent of deaths in the U.S. are caused by modifiable factors such as tobacco use, poor diet and physical inactivity, and alcohol use. At the same time, 75 cents of every health care dollar is spent on the treatment of chronic conditions. To realize the Triple Aim, the Board is calling for a focus on prevention both within the health care system and beyond it, in the places we live, learn, work and play. The *Action Plan* calls for a health system that integrates public health, health care, and community-level health improvements to achieve a high standard of overall health for all Oregonians regardless of income, race, ethnicity or geographic location. Reforms must occur in every one of those settings if we hope to improve lifelong health for all Oregonians.

A new focus on prevention will also mean that our health system will strive to prevent chronic diseases by reducing obesity, tobacco use, and drug and alcohol abuse. In addition, we must increase coordination and reduce duplication among public health, addictions and mental health, health care systems and communities by supporting innovation and integration. For more detail about the focus on prevention, go to page 34. For evidence and rationale behind prevention recommendations, please see the committee reports referenced in the appendices.

STRATEGY

2

STRATEGY

3

Improve health equity.*Better health and lower costs for everyone*

Health equity means reaching the highest possible level of health for all people. Health inequities are a result of health, economic and social policies that have disadvantaged communities of color, immigrants and refugees, and other diverse groups over generations. These disadvantages result in tragic health consequences for diverse groups and increased health care costs for everyone. We must achieve health equity to reach the Triple Aim.

Oregon's health system must ensure that everyone is valued equally and health improvement strategies are tailored to meet the unique needs of all population groups. For more detail on the Health Equity strategy, go to page 37. For evidence and rationale behind health equity recommendations, please see the committee reports referenced in the appendices.

STRATEGY

4

Establish a health insurance exchange to make it easier for Oregonians to get affordable health insurance.

One of the cornerstones of the Board's reform proposals is a health insurance exchange. Beginning with individuals and small businesses, the exchange will provide a one-stop central marketplace for all Oregonians to access insurance products, including a value-based essential benefits package, at an affordable cost. Health plans in the exchange will meet higher standards than those in the market at large on measures such as outcomes, quality and cost.

Oregon's Health Insurance Exchange will be designed to work for individuals, small businesses, and participating insurance carriers by:

- » Providing useful, comparative information on health plan offerings, benefits and costs;
- » Helping individuals, small employers and their employees to access insurance that meets their needs;
- » Helping people access premium tax credits and,
- » Simplifying options and processes across the industry.

In addition, the exchange will be the conduit through which individuals with income up to 400 percent of the federal poverty level (\$88,200 for a family of four in 2010) will access the federal premium tax credits that will make health

insurance much more affordable for many people. The Exchange also will provide access to cost-sharing assistance for individuals with income up to 250 percent of the federal poverty level.

Additionally, certain small businesses purchasing through the Exchange may be eligible for tax credits of up to 50 percent of their contribution to employee insurance premiums. All small businesses using the Exchange will be able to offer their employees a choice of high-quality plans. Small businesses also will have the same type of buying power that large businesses currently enjoy. Because the Exchange relieves small businesses of the burden of health benefits management, using the Exchange should also reduce their administrative costs.

The Exchange's legal entity should be a mission-driven public corporation with a governing board and high level of public accountability. For more detail on the Exchange, see page 40. For evidence and rationale behind Exchange recommendations, please see the committee reports referenced in the appendices.

Reduce barriers to health care.

Adequate insurance, providers with the right training for the right places, and easy access to care

By 2014, it is estimated that 93 percent of all Oregonians will have access to health care coverage via insurance market reforms, expansions of Medicaid, creation of state health insurance exchanges, and federal tax credits that will make coverage offered through exchanges more affordable. This expanded access to health insurance is an important advance, but it is not enough. The next step is to make sure that all Oregonians, including the newly covered and the 7 percent who will remain uninsured, have access to health care. Ensuring access to care means building a robust workforce trained to deliver care in new ways and making sure we have enough health care providers in all areas of the state. It means finding locally relevant solutions to access problems caused by geographic, cultural, or other social and economic barriers.

For more detail on expanding access to health care through the health insurance exchange, go to page 43. For more detail on how to build Oregon's health care workforce go to page 46. For evidence and rationale behind access recommendations, please see the committee reports referenced in the appendices.

STRATEGY

5

STRATEGY

6

Set standards for safe and effective care.

Primary care homes, electronic health information, evidence-based care, and addressing medical liability

Our health system lacks consistency in care delivery, paperwork processing and information exchange. The differences contribute to lack of coordination between providers, poor quality care, unnecessary administrative complexity, and ultimately higher costs. Oregon's public and private sectors can work together to create guidelines, standards and common ways of doing business that increase efficiency, provide better customer service and transparency, and reduce system costs.

One key improvement endorsed by the Board is moving to “patient-centered primary care.” Under this model, people have more than a doctor — they build a relationship with a team of health care professionals who comprise their medical home. This team will focus on wellness and prevention, coordination of care, active management and support of individuals with special health care needs, and a patient- and family-centered approach to all aspects of care.

Standardization and use of evidence-based best practices are strategies that improve care delivery, technology, and health insurance. For more detail on patient-centered primary care homes, go to page 46. For more detail on health information technology, go to page 33. For more information on evidence-based care and benefit design, go to page 46. For evidence and rationale behind these recommendations, please see the committee reports referenced in the appendices.

STRATEGY

7

Involve everyone in health system improvements.

Consumers, patients, health partners and regional health care organizations

Health care consumers, patients and citizens are at the core of Oregon's health system reform efforts. Under successful reform, consumers and patients will be the ultimate beneficiaries: our social and environmental context will support their individual efforts to stay healthy; it will be easier and more affordable for many to get health care; and the care they get will be of higher quality. But patients and consumers are key players on the front end of reform as well. For more information, go to page 52.

The Board also proposes an infrastructure of partners to support our transformed health care system — one in which existing players may have new roles and functions, while new entities are created to further the Triple Aim

through collaboration and patients are at the center of interventions. For more information, go to page 52.

In many ways, health is most effectively supported and health care most effectively delivered at the local level. Communities and regions are more likely to have a common vision for health and can develop locally relevant solutions based on shared knowledge and context. Meaningful dialogue and negotiation are easier to find or create within communities and regions than at the state or national level. Combined with federal health insurance reforms, local and regional delivery system reforms have the potential to shift Oregon onto a new path toward achieving the Triple Aim.

OHPB places a high priority on the development and implementation of regional frameworks for health care delivery, such as regional accountable health organizations that are responsible for meeting the unique health needs of their populations. Such new regional organizations would have the ability and accountability for improving the health of their communities, reducing avoidable health gaps among different cultural groups, and managing health care resources. For more information on regional frameworks for health care delivery, go to page 54.

Measure progress

Timely data and meaningful information

The best-run and most successful businesses always know where they stand: what raw materials cost, how much inventory they have, how many orders they have for their goods or services, and a clear plan or vision of where they want their business to be in a year, five years or 10 years. It is difficult, if not impossible, to manage what you don't measure. If Oregon is to transform its health care system, it needs robust data and information systems.

A variety of metrics will help us assess whether we are achieving the *Action Plan's* vision and implementing its plans successfully. The Oregon Health Policy Board and the Oregon Health Authority are working on three levels to develop strong tools for measuring health outcomes, quality, costs, and clinical health information. These tools include an Oregon Scorecard to provide a statewide picture of Oregon's performance relative to the Triple Aim. For more information on measuring progress, go to page 57.

STRATEGY

8

Key actions

In the following table, the Board has listed the actions we believe are priorities for moving health reform in Oregon forward. While there are many other actions we must take to achieve world class health and health care, listed in a more detailed timeline in Appendix B, the Board strongly believes that our energy must focus on these immediate critical steps to develop the momentum and motivation for lasting change. For each action, key dates and actors are shown and checkmarks indicate the foundational strategies with which that action is aligned.

Actions 	Action Dates	Who will Act	Strategic Alignment								
			Use purchasing power	Focus on prevention	Improve health equity	Establish Exchange	Reduce barriers to health care	Standards for safe and effective care	Involve everyone	Measure progress	
Set a target for health care spending in Oregon	2011: Set target	OHPB	✓						✓	✓	
Aligned purchasing <ul style="list-style-type: none"> Standardize certain provider payments to Medicare methodology (not rates) to set stage for future payment reform Focus quality and cost improvement efforts to achieve critical momentum Introduce innovative payment methods that reward efficiency and outcomes 	2011: Pass legislation for standards	Legislature									
	2011: Begin implementation in OHA	OHA	✓			✓			✓		
	2013: Statewide implementation	Partners									
	2011: Identify areas with greatest potential for improvement	OHA	✓		✓	✓			✓	✓	✓
	2012: Implement in OHA's focus areas	OHA	✓			✓			✓	✓	✓
	2013: Extend beyond OHA	Partners									
Reduce administrative costs in health care	2011: Require standardized communication between payers and providers about eligibility, claims, etc.	DCBS									
	2011: Create authority to extend standards to clearinghouses and third-party administrators	Legislature	✓						✓	✓	
	2011-2013: Phase in standards for OHA, insurance companies, TPAs and clearinghouses	DCBS, OHA									
Decrease obesity and tobacco use	2011: Set nutrition standards for food and beverages in public institutions	OHA									
	2011: Make all state agencies and facilities tobacco-free										
	2011: Support evidence-based initiatives that reduce tobacco use		✓	✓	✓				✓	✓	
	2012: Implement standards; work with partners to extend to private sector	Partners									

Actions 	Action Dates	Who will Act	Use purchasing power Focus on prevention Improve health equity Establish Exchange Reduce barriers to health care Standards for safe and effective care Involve everyone Measure progress						
Establish a mission-driven public corporation to serve as the legal entity for the Oregon Health Insurance Exchange	2011: Establish corporation board and Exchange	Governor, Legislature							
	2011: Receive federal implementation funds	OHA							
	2012-14: Implementation 2014: Enrollment and coverage begin Jan. 1		✓		✓		✓	✓	✓
Promote local and regional accountability for health and health care	2011: Explore and develop regional frameworks in cooperation with community stakeholders	OHA and partners	✓		✓		✓		✓
Build the health care workforce									
<ul style="list-style-type: none"> Use loan repayment to attract and retain primary care providers in rural and underserved areas Standardize prerequisites for clinical training via a student "passport" Extend requirement to participate in Oregon's health care workforce database to all health professional licensing boards 	2011: Develop sustainable financing	Legislature, Office of Rural Health.			✓		✓		
	2012: Implement and expand loan repayment								
	2011: Develop consensus requirements	OHA and partners					✓	✓	
2012: Introduce passport									
2011: Legislation	Legislature				✓			✓	✓
Move to patient-centered primary care (PCPCH), first for OHA lives (Medicaid recipients, state employees, educators) and then statewide	2011: OHA implements PCPCHs in regions where it has significant purchasing power	OHA and partners		✓	✓		✓	✓	✓
	2015: 75% of all Oregonians have access to PCPCH								
Introduce a value-based benefit design that removes barriers to preventive care	2012: Offer value-based benefit package in OHA coverage (VBBP)	OHA and partners							
	2014: Offer VBBP in Oregon Exchange		✓	✓				✓	✓

Actions 	Action Dates	Who will Act	Key actions								
			Use purchasing power	Focus on prevention	Improve health equity	Establish Exchange	Reduce barriers to health care	Standards for safe and effective care	Involve everyone	Measure progress	
Expand the use of health information technology (HIT) and exchange (HIE)	2011: Consolidate HIE planning and implementation in a single Office of Health Information Technology (OHIT)	OHA									
	2011: Establish a public-private state-designated entity to connect local, regional, and statewide HIE	Legislature	✓	✓	✓			✓	✓	✓	✓
	2012: Transition HIE services and operation to the state-designated entity	OHIT									
Develop guidelines for clinical best practices	2011: Create 10 sets of Oregon-based best practice guidelines and standards of care for use in public and private settings	OHA and partners			✓	✓	✓		✓	✓	✓
Strengthen medical liability system											
<ul style="list-style-type: none"> Remove barriers to full disclosure of adverse events by providers and facilities Clarify that statements of regret or apology may not be used to prove negligence 	2011: Enact law preventing liability insurers from canceling coverage or refusing to defend providers who disclose errors	Legislature							✓	✓	
	2011: Amend Oregon's "apology" law	Legislature							✓	✓	
Performance measurement	2011: Finalize Scorecard with Oregon standard quality measures	OHPB									
	Ongoing: OHPB reviews, revises, and holds reforms accountable to Scorecard										
	2011: Set common standards for diversity data in OHA systems	OHA and partners	✓		✓				✓	✓	✓
	2012-14: OHPB Roll out standards in OHA systems and work to extend to private sector										

What will be different after the *Action Plan for Health*?

Now: Fragmented system with different standards, reporting requirements, and reimbursement methods, in which many people lack access to even basic care.

The future: A coordinated and regionally integrated health system in which incentives are aligned toward quality care for every Oregonian. Health systems and providers publicly report on common standard measures that improve health. Insurance companies and providers use technology to streamline administrative systems, reduce costs and improve timeliness and efficiency.

Now: Treatment of symptoms when they happen.

The future: A holistic approach that focuses on the patient, not the symptoms, and emphasizes preventive care and healthy lifestyles.

Now: Doctors treat patients.

The future: A community-based team of health care professionals, not just doctors, will help keep people healthy and treat them when they are sick. All the care a patient gets will be coordinated and the patient will be a part of all decisions concerning his or her health.

Now: Doctors and hospitals get paid for the amount of services they provide.

The future: Providers get paid for keeping people healthy or returning them to health if they get sick. Payment is dependent on providers meeting health care quality guidelines and providing the best care for their patients.

Now: Paper-based records in doctors' offices and hospitals.

The future: Private, secure electronic medical records help providers see their patients' complete health picture and instantly know what tests, medications or procedures have been done. Electronic health records also allow patients easier access to their own files so that they can take more control of their own health.

Now: Insurance premiums have increased 125 percent over 10 years, and health care costs continue to outpace what we can afford.

The future: Our health care system will be highly efficient. Providers and insurance companies alike will be accountable for reducing or controlling costs. Consumers will have the information they need to choose providers and affordable insurance plans based on their health, values and life circumstances.

Now: Public health organizations take care of communities; doctors take care of individuals.

The future: Together, clinical and public health providers will be accountable for the health of the whole community. Community-based prevention programs that help keep people healthy will connect seamlessly to preventive clinical services, to self-management services for people living with chronic disease, and to acute or emergency care.

Now: Public health provides a significant amount of medical care to underserved populations.

The future: As more people get health insurance coverage, public health systems will devote more time and resources to maintaining healthy populations by ensuring the safety of our food and water, responding to disease outbreaks, developing policies to support healthy lifestyles, and other essential public health functions.

Stats: The urgent need for immediate action is illustrated by some simple but staggering figures:

- » If we had successfully implemented strategies to reduce the rate of medical inflation by 2 percent over the last five years, health care expenditures in Oregon would have been over \$6.3 billion or 6 percent lower.¹
- » If we had curbed the growth of obesity during the past five years, we would have saved \$1 billion in health care expenditures.
- » Using bundled or episode-based payments for care related to 10 common acute and chronic conditions would have reduced expenditures by approximately \$2.25 billion or 2 percent of total health care expenditures in Oregon over the past five years.²
- » Nationally, the direct and indirect cost of health disparities was estimated to be \$1.24 trillion over a three-year period.

¹ Oregon's total health care expenditures increased at an average rate of 7.7% per year between 1991 and 2004, according to the Centers for Medicare and Medicaid Services' National Health Expenditure Data. Although more recent health expenditure data are not available, if health care expenditures were held at 5.7% instead of continuing on at 7.7%, Oregon would have saved over \$6.34 billion from 2005-2009 even after accounting for new medical spending attributable to population growth rather than the price of health care.

² Acute conditions include hip replacement, knee replacement, bariatric surgery and acute myocardial infarction. Chronic conditions include asthma, chronic obstructive pulmonary disorder, congestive heart failure, coronary artery disease, diabetes and hypertension.

Taking advantage of federal reform opportunities for real change

The passage of the federal Affordable Care Act (ACA) of 2010 complements Oregon's long history of addressing problems in the health care system. The insurance reforms contained in the ACA combined with funding opportunities and policy changes also in the legislation provide incentive and leverage for our state to reform delivery systems and make health care affordable for everyone in the following ways:

Coverage and access

Federal reform provides resources to make insurance more widely available and affordable including:

- » Considerable funding for expansion of health insurance coverage options. This additional funding includes expansion of Medicaid to low-income adults up to 138 percent of poverty and federally funded tax credits for individuals up to 400 percent of poverty to purchase insurance through a state health insurance exchange.
- » Provisions to make insurance companies more accountable and remove barriers that in the past kept sick people from getting the coverage they needed, allowed coverage to be dropped for mistakes on insurance applications, or allowed companies to charge much more for coverage if they could find justifications. These measures will take effect now through 2014.

Recognizing the changing nature of families, federal law now allows adult children to stay on their parents' health insurance plan until they are 26. This is a population that has historically high rates of uninsurance. Federal laws also now protect children: insurers can no longer deny coverage for children because of pre-existing conditions.

Prevention and population health

Federal health reform makes significant investments in prevention and public health by providing funding opportunities to support key health promotion strategies outlined in this document and the Statewide Health Improvement Plan Committee report. These funding sources enhance and integrate prevention and health promotion in state and community health policy planning.

Delivery system reform

Federal reform provides increased funding for care delivery settings that focus on preventive and primary care. This additional support should help Oregon move toward its goal of making affordable, high-quality primary care available to everyone through patient-centered primary care homes. ACA also allows for experimentation with new models of payment and care delivery outside of primary care. Implementation of innovative care models will be supported by the development, recruitment, and retention of a robust health care workforce, trained to deliver care in new ways in the communities where it is most needed.

Stats: The health consequences of a fragmented health system

Every day, all across Oregon – in family living rooms, school classrooms and hospital emergency rooms – we see the human impact of escalating health care costs.

- » Children miss school, or come to school sick, because we have not effectively prevented their illnesses and injuries, and also because their families cannot afford to take them to the doctor. These children get left behind academically, resulting in lower educational achievement and consequences that can last a lifetime such as decreased earnings, poorer health, and greater need and use of social support services.
- » People with chronic diseases do not manage their illnesses as well as they might, see their doctors as often as they should or take the medications they need to control their conditions. Over 19,000 people die each year in Oregon from chronic disease.
- » People with serious mental illnesses die, on average, 25 years earlier than the general population. This is due to largely preventable illnesses and injuries such as cardiovascular disease, diabetes, respiratory illness, suicide and infectious diseases. Tobacco use, poor nutrition, physical inactivity and substance abuse are the underlying cause of many of these conditions.
- » One-third of the recent increase in medical costs in Oregon is attributed to obesity. Costs in Oregon just for treating diabetes are \$1.4 billion per year.
- » Direct medical expenditures related to tobacco use are more than \$1 billion per year.
- » Alcohol abuse costs Oregon's economy \$3.2 billion per year, and the number of Oregon eighth-graders who have had a drink in the past 30 days is twice the national average.

Foundational strategies in action

STRATEGY
1

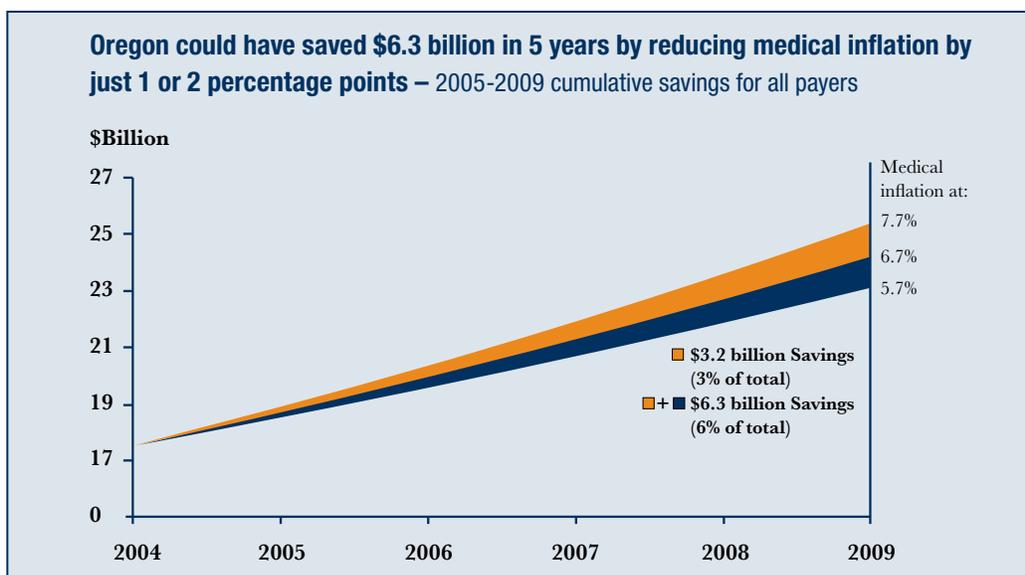
Use purchasing power to change how we deliver and pay for care.

Align public purchasing, reduce administrative costs, change how we pay, establish value-based benefits, and set budgets

Health care is expensive and becoming more so by the day. Health care accounts for an estimated 16 percent of the state’s General Fund budget, which is currently threatened by a \$3.5 billion shortfall. Everyone is feeling the squeeze: businesses struggle to provide their employees with health insurance and increasingly require employees to pay a greater share of the bill; public insurance rolls expand as deficits strain Oregon’s budgets; individuals put off necessary care until health problems become emergencies. Left unchecked, this trend will undermine our best efforts to improve Oregonians’ health. We must act now to bend the cost curve.

We can do better.

The Oregon Health Policy Board (OHPB) believes that we need to limit health care spending over time to a fixed rate of growth. The Board plans to focus on and refine this goal in 2011. The Board believes that through the reforms outlined in this report, we can also foster innovation within fixed resources.



Decisive actions to implement the strategies and tactics in this report can help stem rising health care costs. It is important to recognize that delaying these efforts is costly. Had Oregon successfully implemented strategies to reduce the rate of medical inflation by two percentage points over the past five years, it would have saved \$6.3 billion or 6 percent of total health care expenditures.

The following examples demonstrate savings opportunities that could have been realized by earlier action:

- » Had we successfully contained the growth of obesity during the past five years, Oregon would have saved approximately \$1 billion in health care expenditures.
- » Instituting bundled or episode-based payments for care related to 10 common acute and chronic conditions in 2005 could have reduced expenditures by approximately \$2.25 billion over the past five years.
- » Holding the growth in insurance companies' general administrative expenditures to CPI could have saved \$36 million to \$119 million over the past five years.

Developing the necessary infrastructure and pursuing cost containment will pose many challenges. Leaders and stakeholders must develop creative and courageous solutions in order to overcome technical, organizational and political roadblocks.

Note: It is important to keep in mind that these potential cost savings are subject to considerable uncertainty. The estimates are rough approximations, subject to revision as the health care reform landscape changes and it is not possible to estimate total potential savings in the Oregon health care system by adding up these estimates. Many of these policies reinforce one another and target common instances of unnecessary costs. In many cases, the following estimates predict savings to Oregon's health care system as a whole and do not determine how savings might accrue to individuals, health care providers, carriers or payers.

Key ways that Oregon can bend the cost curve:

- **Focusing on prevention will yield significant returns on investment by improving health.**

Population health initiatives aimed at reducing the prevalence of chronic diseases would yield substantial returns on investments. For example, tobacco use prevention activities will save at least \$1.32 for every \$1 invested. Additional investments to create healthy environments, promote healthy lifestyles and

discourage alcohol abuse will likely generate savings on health care expenditures that more than outweigh the costs of these efforts. Please see page 34 for a more in-depth description of this strategy.

➤ **Using purchasing power to change how we deliver and pay for care will increase the value of health care while reducing costs.**

OHPB believes that OHA and the new public corporation that will administer the Oregon Health Insurance Exchange (discussed on page 41) can play a key role in bending the cost curve. Additionally, OHA purchases health insurance coverage for nearly one in four Oregonians, approximately 850,000 in total. The creation of the Oregon Health Authority allows the state to align purchasing policies across a patchwork of health care programs.

- » Beginning in 2011 with full implementation by 2013, OHA aligns provider payment with Medicare payment methodology (not rates) across all OHA jurisdictions. This includes Medicaid fee-for-service and managed care, Public Employees Benefit board and Oregon Educators Benefit Board. Legislative action in 2011 will extend these standards to payers statewide.
- » OHA will work with stakeholders in 2011 to identify specific health conditions and procedures where improvements have the greatest potential to affect cost, health equity, quality and patient experience. This work will serve as the basis for OHA and statewide implementation of quality improvement, payment, benefit design, and other reforms where alignment is important.
- » In 2012 and 2013, OHA will work with providers, purchasers and other stakeholders to target key cost, quality, and efficiency concerns. It will do this by introducing innovative payment methods that reward efficiency and outcomes (e.g., bundled payments, pay for performance and other methods) first within OHA programs and then throughout other health care programs.
- » By using purchasing power to drive value, OHA and the Exchange can help bring medical costs in line with what is affordable to the state, businesses and consumers. For example, we estimate that Oregon would save approximately \$500 million annually through the use of bundled or episode-based payment for treatment of 10 common acute and chronic conditions, which would prevent rehospitalizations and unnecessary care.

> **Moving to patient-centered primary care will improve care coordination and appropriate access to preventive services.**

These care improvements can reduce duplicative tests and services and prevent costly hospitalizations through better disease management. Current patient-centered primary care home proposals target specific subsets of the population. If Oregon were to provide primary care homes to the entire population and employ community health teams to link services and provide additional practice support, the state could expect to save approximately \$650 million or 1.9 percent of total health care expenditures per year after a five-year program initiation phase.

> **Standards for safe and effective care can reduce administrative costs and unnecessary care.**

Nationally it is estimated that about 30 percent of care provided to patients either is unnecessary or does not lead to improved health. We can improve health outcomes while reducing costs by creating and applying standards based on the most current research and technology.

For example, OHA can generate considerable savings by developing common processes to simplify and expedite various forms of health care administration. Estimates indicate that by encouraging providers and payers to adopt automated electronic communications and a uniform language for these communications, we could save approximately \$92 million to \$202 million a year upon full implementation. The Board has identified the following next steps:

- » Adopt “uniform companion guides” that establish a uniform language for automated communications between providers and health plan offices.
- » Phase in requirement for everyone to use electronic communications. Extending this requirement to clearinghouses and third-party administrators will require legislative action.

Similarly, developing a standard methodology for provider payment could significantly reduce providers’ efforts to ensure that they have been reimbursed according to their contracts with insurers and greatly simplify the ensuing negotiations.

Also, OHA could promote efficiency by improving the medical liability system. Encouraging integrated delivery systems to adopt a voluntary program to quickly disclose medical errors to patients and provide early offers to compensate those patients could reduce legal and administrative fees while treating patients with greater respect and fairness. The University of Michigan Health System found that instituting such a program led to a 59 percent decrease in average monthly cost of medical liability coverage.

➤ **Regional integrated health information systems increase efficiency.**

Developing and connecting regionally integrated health information systems can help ensure appropriate, responsive and cost-effective health care across the state. Local and regional health information exchanges (HIEs) are under development in a number of Oregon communities. HIEs are a key building block for system improvements to enhance population health and to improve the health care delivery system. A newly established Office for Health Information Technology (OHIT) will coordinate planning and implementation of health information exchanges. A “state-designated entity” (SDE), defined and enabled by legislation introduced in 2011, will connect local and regional health information exchange operations. These HIEs will efficiently leverage resources to maintain and promote statewide availability and secure transfer of electronic health information.

Sharing patient information in a secure, efficient manner has the potential to substantially reduce costs. It will support efforts to track patients’ medical outcomes, reduce errors and make medical processes more efficient. It can empower consumers to better understand their own health, choose high-quality providers and make healthier choices. Information sharing can vastly improve public health agencies’ ability to track disease and combat chronic illness, leading to improved population health. It is estimated that health information systems connected across Oregon will provide significant annual health care savings including:

- » \$57.7 to \$90.7 million per year for avoided laboratory testing and imaging services;
- » \$33.3 million per year for increased physician practice productivity.

➤ **Federal health reform will reduce health care costs for Oregonians.**

Finally, federal health care reform is expected to reduce the number of uninsured Oregonians by 75 percent while saving money for businesses and individuals. Current economic forecasts suggest that in 2019 annual individual and family health spending will fall by \$1.8 billion and businesses will save \$30 million annually. Also, as more people are able to access health insurance, Oregon will reduce the amount of providers’ uncompensated care. Hospitals alone could experience a \$360 million reduction in annual uncompensated care by 2015 and \$465 million by 2019. However, some hospitals will also experience partially offsetting reductions in Medicaid Disproportionate Share Hospital payments beginning in 2014.

For more information

Please see: www.oregon.gov/OHA/action-plan/

STRATEGY

2

Shift focus to prevention.*Improve health, lower costs and allow smarter allocation of resources*

It's not a new concept, but it is a powerful one: preventing diseases, injuries, and poor health is more effective and often far less expensive than treating illness when it occurs. To truly transform the health care system, we need to shift our focus from intervention to prevention.

Tobacco use and obesity are priorities because of their enormous impact on longevity and quality of life. It is estimated that chronic disease treatment accounts for 75 percent of our health care spending. The human toll of tobacco use in Oregon continues to dramatically surpass all other preventable causes of death and disease. Focused prevention efforts and evidence-based cessation benefits can provide a return of \$1.32 for every dollar Oregon spends on providing these treatments. One-third of the recent increase in medical costs in Oregon is attributed to obesity. The U.S. Centers for Disease Control and Prevention estimate that annual medical costs for individuals with obesity are \$1,429 higher than for those of normal weight. By reducing obesity and obesity-related chronic diseases such as diabetes, Oregon stands to realize a significant return on investment.

Similarly, alcohol and substance abuse have significant negative impacts on individual health, family well-being, and broader social and economic issues including public safety and worker productivity. Today, the number of Oregon eighth graders who have had a drink in the past 30 days is twice the national average. Addressing addictions is crucial to improving population health and reducing future chronic disease costs.

What we need to achieve

We need a health system that integrates public health, health care and community-level health improvement efforts to achieve a high standard of overall health for all Oregonians, regardless of income, race, ethnicity or geographic location.

To achieve this, we must:

- » Prevent chronic diseases by reducing obesity and tobacco use;
- » Stimulate innovation and integration among public health, health systems and communities to increase coordination and reduce duplication;
- » Focus resources for drug and alcohol addiction toward prevention and treatment;
- » Improve health equity and population health by improving social, economic and environmental factors.

Next steps

Almost 40 percent of deaths in the U.S. are caused by behaviors that can be changed: tobacco use, poor diet and lack of physical activity, and alcohol use. To realize the Triple Aim, the Board is calling for a focus on prevention both within the health care system and beyond it, in the places we live, learn, work and play. Reforms must occur in every one of those settings if we hope to improve lifelong health for all Oregonians.

- › **The Oregon Health Authority, in partnership with other state and local agencies, leads the way in improving the health of Oregonians** by making the healthy choice the most convenient choice. Key steps include:
 - » To help reduce obesity, legislative action in 2011 provides direction to the Department of Administrative Services to set minimum nutritional standards for food and beverages sold in cafeterias, stores and vending machines in state agencies, schools, universities.
 - › OHA will identify the standards, based on scientific evidence. It will consider standards already in use nationally, such as those used by the federal Centers for Disease Control and Prevention on their campuses.
 - » To help reduce tobacco use and exposure, OHA will:
 - › Adopt tobacco-free campus policies in 2011 for state agencies, addictions and mental health facilities contracting with OHA, and hospitals;

Stats: Influence of lifestyle factors on health

- » Unhealthy behavior patterns and environments, many of which can be modified by taking prevention actions, cause 70 percent of all deaths in the United States. (Director's message 4-2-2010)
- » Average Americans spend less than 0.1 percent of their time each year in a health care setting. The other 99.9 percent of the time is spent in daily behaviors and environments that are sometimes hazardous to our health. (Director's message 4-2-2010)
- » Nationally, 83 cents and 96 cents of Medicaid and Medicare dollars, respectively, are spent treating chronic diseases (RWJF - Chronic Conditions: Making the Case for Ongoing Care, September 2004 Update www.rwjf.org/files/research/Chronic%20Conditions%20Chartbook%2009-2004.ppt)
- » Hospitalization costs in Oregon for chronic diseases alone are estimated to exceed \$2.22 billion a year (Keeping Oregonians Healthy, Oregon Department of Human Services, 2007, adjusted for inflation. In this publication, chronic diseases include arthritis, asthma, cancer, diabetes, heart disease and stroke, and obesity.)

- › Support evidence-based tobacco prevention strategies such as raising the price of tobacco products and dedicating a portion of the proceeds to comprehensive, effective prevention efforts. Every dollar invested in tobacco prevention yields an estimated \$5 return on investment.
- » In future years, OHA will encourage private entities to align with public obesity and tobacco use prevention policies.
- › **Increasing the effectiveness and efficiency of Oregon’s public health system** in the following ways:
 - » Developing local frameworks for health, such as regional accountable health organizations. These entities would be responsible for local health policy, health improvement planning, priority setting, system development, financial investment, and health outcomes including reduction of health disparities. A key task for these regional entities would be to conduct community health assessments and, in partnership with local stakeholders, develop local health improvement plans focused on reducing obesity and tobacco use and improving chronic disease prevention and management. Such plans should include steps for evaluating the impact of recommended actions, including the impact on reducing disparities and achieving health equity.
 - » Ensuring that existing state data systems have capacity to collect, manage and analyze public health performance measures. These include demographic data on race, ethnicity, country of origin, language, employment, sexual orientation, ability, income and education level. These data should be tied to clinical, emergency and hospital data through state and regional health information exchanges wherever possible.
- › **Emphasizing prevention and effective treatment of alcohol and drug addiction.** As we shift our focus to prevention, we must also expand our perspective to include prevention and treatment of substance abuse as an integral part of ensuring health. The first step is to develop stronger connections among addictions, health care, and health promotion systems and to align their strategies.
- › **Advance health equity by:**
 - » Exploring the most effective ways to support schools and districts in addressing health-related barriers to learning. Decreasing health disparities for Oregon populations requires fundamental social, economic

and environmental changes. Key among these is the relationship between educational attainment and health. Poor health in childhood negatively affects educational attainment, which in turn reduces future income and decreases the practice of good health behaviors. Better student health, particularly for diverse populations, will help to increase high school graduation rates and improve health outcomes.

- » Maximizing electronic health record adoption and connectivity and ensuring collection and reporting of race and ethnicity data to effectively track health disparities. This effort will include partnerships with the Oregon Health Information Technology Extension Center and with statewide health information exchange efforts under the Health Information Technology Oversight Council.

For more information

Please see: Oregon Health Improvement Plan Committee report and appendices at www.oregon.gov/OHA/action-plan/

Health Information Exchange Strategic and Operational Plans for Oregon at www.oregon.gov/OHA/action-plan/

Improve health equity.

Better health and lower costs for everyone

STRATEGY
3

Health inequities are unnecessary, unjust and avoidable. They are the result of health, economic and social policies that have disadvantaged communities of color, immigrants and refugees, and other diverse groups over generations. These disadvantages result in tragic health consequences for Oregon's diverse populations and increased health care costs for everyone.

In state comparisons, Oregon's African American diabetes mortality rate is surpassed only by West Virginia's. Only seven states have higher rates of African American stroke mortality than Oregon. African American Oregonians have a diabetes mortality rate that is 2.6 times the rate for white Oregonians, and a stroke mortality rate that is 1.7 times higher.

Also, Oregon is:

- » 26th in the percentage of African American and Latino live births by cesarean delivery; both are slightly better than U.S. averages

- » 25th in the percentage of African American and 30th for Latina mothers beginning prenatal care in the first trimester, both below U.S. averages.

As Oregon's population becomes increasingly diverse, we must develop a public health and health care system that effectively meets the needs of Oregon's diverse and geographically disparate populations:

- » The Latino population has almost doubled in the past 10 years, and is now the largest minority population with well over 400,000 people.
- » Asian Americans number more than 130,000 in the state.
- » American Indian and Alaska Native and African American populations number 67,000 and 63,000 respectively; both experience disproportionate health burdens that result in unacceptable costs for individuals, families, communities and health systems.
- » International migration is adding to the cultural and language diversity of the state, with the Russian community continuing to grow, along with Somali and Iraqi populations. Oregon is expected to add 197,000 through international immigration over a 30-year period ending in 2025.

These demographics create significant opportunities for improvement and challenge Oregon's health system to provide care in culturally appropriate ways, including developing a provider workforce that reflects our state's growing diversity. Recruiting and retaining a racially and ethnically diverse workforce is essential to ensuring effective health practices, access to care, and health outcomes for populations experiencing significant health burdens. Unfortunately, few of Oregon's medical school graduates represent minority communities. In 2009, only eight of 121 graduates were Latino, African American, Native American, or Pacific Islander. As these groups and other minority populations continue to grow, it is important to have health care providers who understand each minority population's cultural norms and expectations (including patients' values, beliefs, religion, and communication styles), and who speak the language or have high-quality translation and interpretation services available.

What we need to achieve

Reach the highest possible level of health for all people.

In implementing health care reform, the Oregon Health Policy Board and the Oregon Health Authority will strive to avoid creating or maintaining health policies that perpetuate or increase these avoidable and unjust health inequities. OHA and

its Board are committed to promoting health equity for all people in all regions of the state, inclusive of race, ethnicity, socioeconomic status, occupation, ability and sexual orientation. Tackling health inequities also requires looking at the ways in which jobs, working conditions, education, housing, social inclusion, media and even political power affect individual and community health. When health and societal resources are distributed equally, population health will be equitable as well.

Next steps to realizing health equity

Despite these challenges, many opportunities exist to create equitable health outcomes for all of Oregon's diverse populations. These are directly connected to the Board's other key foundational strategies.

- > **Using community health workers as team members for the delivery of primary care, behavioral health care, and community prevention improves health outcomes** because they are trained and trusted members of the communities in which they work and share culture, language, and experience with patients. This is especially important in communities of color or other underserved communities. Community health workers are already successfully providing culturally specific patient-centered preventive health care in some of Oregon's most underserved areas. Creating incentives that encourage the use of community health workers is a priority in OHPB's strategies for a healthy Oregon.
- > **Ensuring that health care providers receive ongoing training in cultural competence.** With Oregon's increasingly diverse population and strong evidence of racial and ethnic disparities in health care, it is imperative that health care professionals are educated to work effectively with diverse groups. Ongoing training in cultural competence will improve provider-patient communications, public health efforts and health outcomes.
- > **Doing more to collect and analyze data at the most granular levels of race, ethnicity, national origin, language, ability, sexual orientation, education and literacy level, and occupation** will help health systems, community groups, and consumers better understand quality and health outcomes. This helps to ensure that our efforts are improving the health and lives of diverse communities within Oregon.

For more information

Please see: Health Equity Policy Review Committee at www.oregon.gov/OHA/omhs/health_equity.shtml

STRATEGY

4

Establish a health insurance exchange to make it easier for Oregonians to get affordable health insurance.

Many Oregonians currently cannot afford insurance for themselves or their families. The uninsured put off needed care and are forced to seek emergency care when small issues turn into large ones due to inattention. The Health Insurance Exchange will help people get insurance coverage, which will allow them to seek care when they need it and in the most appropriate, lowest-cost settings for their needs.

An estimated 150,000 previously uninsured Oregonians will take up individual coverage through the Health Insurance Exchange. Thousands more will gain coverage through the exchange as members of small employer groups. As more Oregonians have health insurance, providers will not need to recoup the costs of providing uncompensated care to the uninsured by increasing charges to the insured population. The newly insured will benefit, as will providers and the currently insured.

What we need to achieve

A strong health insurance exchange that will coordinate purchasing strategies, with a mission-driven public corporation as the Exchange's legal entity

Oregon's Health Insurance Exchange must work for consumers and participating insurance carriers by: providing useful, comparative information on health plan offerings, benefits and costs; helping individuals, small employers and their employees to access insurance that meets their needs; helping people access premium tax credits; and simplifying options and processes across the industry. Health plans in the Exchange must offer exceptional outcomes and quality, and lower costs.

An exchange that proves its value to consumers and other stakeholders will flourish, ensuring access to high-quality, affordable health plans.

Next steps in implementing an exchange

An exchange will be most successful if developed consistently with the state's overall health reform goals. Together OHA and the Legislature can ensure that Oregon's exchange is consumer-oriented, easy to use and offers value now and in the future.

➤ **Establishing a mission-driven public corporation to coordinate purchasing strategies for all Oregonians, starting with a health insurance exchange for the individual and small group markets.**

Exchange legislation will ensure organizational accountability through strong public participation, annual reporting, and the use of consumer advisory groups and surveys to obtain systematic, reliable feedback. An exchange with the legislative authority to act as a strong purchaser can drive high value in the health care system. This organization will be built to be:

- » Publicly accountable and responsive to consumers, health plans and the state but fiscally separate from state budget cycles;
- » Flexible and agile;
- » An entity that effectively works with state and business partners to ensure access for Oregonians of all income levels and in all geographic areas of the state.

To optimize accountability to consumers, the general public, vendors, and state and federal governments, the Exchange charter should include a consumer-oriented mission statement and provisions such as: public meetings and records; public input processes; Governor appointment and Senate confirmation of Board members; annual reporting to the Governor and Legislature; consumer surveys; inclusion of voting ex-officio Board members (Oregon Health Authority and Department of Consumer and Business Services directors and a member of the Oregon Health Policy Board); and consumer advisory groups.

- **Governance of the Exchange.** The policy Board supports the establishment of a governing board that will guide its corporation, and ensure that the Exchange's mission is the organizing principle for operational planning, implementation and administration.
- » Board members will have experience and knowledge in individual insurance purchasing; business; finance; consumer retailing (especially web-based access for consumers); health benefits administration; individual and small group health insurance; and other areas to be identified.
 - » To ensure no conflicts of interest arise no more than two Board members can make their living from or be affiliated with the health care or health insurance industry. To ensure the Exchange's accountability to consumers and the state, OHPB recommends that the Exchange board will include two high level state employees as voting members: the directors of the Oregon Health Authority and the Department of Consumer and Business Services, as well a member of the Oregon Health Policy Board.

- **Conducting operational planning for the exchange based on the Health Policy Board’s vision and principles.** Under the Health Policy Board’s direction and the exchange legislation to be considered in 2011, continue developing plans to implement an exchange for use by the public by 2014.
- **Building the Exchange to advance health equity by taking into consideration the needs of Oregonians of various races, ethnicities, ages, geographies, physical and mental abilities and other considerations.** This includes but is not limited to the following efforts:
 - » Education and marketing must be targeted to various communities in order to help people understand the value of the exchange and to learn how to use it to improve their access to insurance and health care services.
 - » Community organizations of all types must be encouraged to become trained “navigators” that will help individuals and small businesses use the Exchange to determine eligibility for assistance, assess health plan options and enroll in coverage.
- **Improving access to care by ensuring that participating health plans are of high quality and value** for the consumer, and providing consumers with access to premium tax credits and cost-sharing assistance.
 - » Information on participating plans, including quality and access measures, will be readily available to consumers seeking to find or change a health plan. Reporting on measures such as access to care will help consumers determine which plan works best for them. Participation in the Exchange will be a sign to consumers that a health plan has high standards for quality and cost.
 - » Plans participating in the Exchange will provide value to consumers and purchasers through innovative payment methods (e.g., bundled payments, pay-for-performance), evidence- and value-based benefit designs, and standards for primary care, care coordination, and other elements..
 - » The Exchange will be the conduit through which individuals with incomes up to 400 percent of the federal poverty level (\$88,200 for a family of four in 2010) will access the federal premium tax credits that will make health insurance much more affordable for many people. In addition, individuals with income up to 250 percent of the federal poverty level will gain access to cost-sharing assistance through the Exchange.

For more information

Please see: Health Insurance Exchange Report and appendices at www.oregon.gov/OHA/action-plan/

Reduce barriers to health care.

Adequate insurance, providers with the right training for the right places, and easy access to care

STRATEGY

5

Today, 17 percent of Oregonians are uninsured. We project that, by 2014, 93 percent of all Oregonians will have access to health care coverage as a result of insurance market reforms, expansions of Medicaid, creation of state health insurance exchanges, and federal tax credits that help make coverage offered through exchanges more affordable. The Kaiser Family Foundation estimates that Oregon's Medicaid enrollment will increase by 60 percent.

We have a responsibility to ensure that the newly covered can find health care providers and a moral obligation to make certain that the remaining uninsured still have access to care. Decisive action must be taken now to ensure that Oregon has a health care workforce capable of meeting the demand for quality services in 2014 and beyond.

What we need to achieve

All Oregonians should be able to get safe and effective care that is coordinated locally, using statewide resources when necessary, from a team of appropriately trained health care providers.

While health insurance expansions will provide unprecedented levels of coverage, they will also put unprecedented pressure on the delivery system. We also know that having health insurance is not the same thing as having access to care. To ensure that Oregonians can get the health care they need, when and where they need it, we must:

- » Foster the development of local and regional solutions for health care access that include Oregon's traditional safety-net providers;
- » Improve the capacity and distribution of the primary care workforce;

- » Expand education and training opportunities;
- » Train, recruit and retain a workforce that is diverse, culturally competent, and prepared to change the way health care is delivered; and
- » Successfully implement insurance expansions.

Next steps

The strategies below address both our current health care workforce needs and the needs Oregon might have in the future, when health care delivery looks different than it does today.

> **Promote local and regional accountability for health and health care.**

Communities and regions, accessing statewide resources when necessary, are uniquely qualified to develop locally relevant strategies to improve health outcomes and address the health disparities that exist within their populations. Oregon's traditional safety net providers' expertise would benefit any regional frameworks because they have significant experience providing health care services to diverse populations with fixed resources. Development and implementation of frameworks such as regional accountable health organizations will reduce fragmentation and improve access by locally integrating physical, behavioral, and oral health, and long-term care.

> **Revitalize the state's primary care practitioner loan repayment program** to help meet the demand for care and to support a renewed emphasis on preventive and primary care across the health system. Loan repayment effectively encourages providers to choose primary care and to practice in rural and underserved communities. Oregon's Primary Care Services Program, which provides partial loan repayment to primary care providers in return for service time in rural or underserved areas, should be financed as soon as possible at a level that would bring at least 30 additional primary care professionals to rural and underserved areas each year.

- » The Legislature and the Office of Rural Health should investigate sustainable financing mechanisms.

> **Align student requirements for clinical training.** To streamline and increase capacity in the final stages of training for health professionals, OHA will work with relevant stakeholders to:

- » Standardize administrative requirements for student clinical placement (drug testing, criminal background check, HIPAA training, etc.) via a student "passport" (2011).

- » Establish uniform standards for student clinical liability to reduce the time and expense of contract negotiations between educational institutions and training sites; also explore ways to encourage more community-based and outpatient practices to serve as clinical training sites (2012).
- > **Revise policies that prevent public educational institutions from responding quickly to health care workforce training needs.** Current interpretation of a law designed to ensure that public investment does not adversely affect private business means that private entities can block development of new public training programs or program locations even if they do not intend to offer the training themselves. The result is that training programs for high-demand health care occupations may not be equally available to rural and urban students or to rural or underserved communities. OHA will convene stakeholders in 2011 to draft revisions to the policy.
- > Use a range of methods to **recruit and retain a workforce that is racially and ethnically diverse and culturally competent.** Improving the diversity and cultural competence of Oregon's health care workforce will produce a range of benefits including increased access to care for vulnerable populations, improved patient-provider communication and quality of care, and expanded availability of living-wage careers for racial and ethnic minorities.
 - » OHA will collaborate with health care professional regulatory boards and professional societies to identify the best methods of ensuring that licensed health care professionals receive ongoing training in cultural competency.
 - » OHA will incorporate incentives for using community health workers into primary care payment reform and implementation of patient-centered primary care home standards.
- > **Adopt payment systems that encourage use of the best provider (or provider team) for a given care need.** Payment structures such as fee-for-service tend to encourage higher-level practitioners to see patients even when the same care could be provided as well or better — and less expensively — by other qualified providers. This means we are not using our health care workforce optimally, which reduces access and increases the overall cost of care. Rapid transition to more comprehensive and accountable payment systems, particularly in primary care, will enable practices to build teams that use the best combination of providers to efficiently meet patient needs.

- > **Expand health care workforce data collection.** Complete and accurate information about all licensed providers is essential for design and evaluation of strategies to improve access, including efforts to increase workforce diversity. This will require:
 - » Legislative action in 2011 to extend the requirement to participate in Oregon’s health care workforce database to all health professional licensing boards. Reporting would begin with the boards governing licensed mental and behavioral health care professionals.

- > **Successful implementation of insurance expansions.** In order for the expansion of coverage via Medicaid and a new health insurance exchange to be successful, Oregonians must know what their insurance options are and how to access them. This will entail:
 - » Developing outreach and marketing plans that effectively enlist community partners;
 - » Implementing application assistance strategies;
 - » Implementing efficient electronic eligibility and enrollment systems that will increase current system capacity;
 - » Developing a strategy to clearly communicate information about eligibility and coverage for public and private insurance options; and
 - » Assessing eligibility and enrollment requirements to ensure that current policies do not create inequities or unnecessary burdens.

For more information

Please see: Health Care Workforce Committee Report and appendices at www.oregon.gov/OHA/action-plan/

STRATEGY

6

Set standards for safe and effective care.

Primary care homes, electronic health information, evidence-based care, and addressing medical liability

The health care each individual receives varies for a number of reasons. This leads to less-than-optimal health outcomes in some instances and overuse of care in others. We need to create the standards and other tools that will ensure

that high-quality, effective care is uniformly provided to everyone. Oregon's health professionals must pool their knowledge to create systems of care based on experience and evidence about outcomes, and must then act within these standards to deliver increasingly safe and effective care. Public and private health care purchasers must expect this level of excellence and build these expectations into contracts.

We need standards to achieve:

- **A sustainable system that links payment to achieving improved value.**
 The Board envisions a health care system in which the tools are available to pay for quality while living with a budget; a system that holds providers responsible for the quality and efficiency of care they provide, rewards good performance and keeps total spending to a fixed growth rate. Restructured payments and incentives that reward care coordination in new delivery models such as patient-centered primary care homes (PCPCHs) are key examples. Designed to put patients at the center of their relationship with the delivery system, PCPCHs can reduce unnecessary emergency department visits and hospitalizations while increasing adherence to treatments and improving self-care.
- **Electronic health information and administrative data available when and where they are needed.**

 - » Increase the quality and safety of health care with better information at the point of care;
 - » Increase the efficiency of the health care system with standard electronic processes for claims and payments;
 - » Improve population health through better surveillance of disease outbreaks, immunization records, and quality and cost variations by community; and
 - » Ensure that patients have access to their personal health information so they can share it with others involved in their care and make better health care and lifestyle choices.
- **Health care that is consistently high quality, evidence-based, and safe.**
 Care should be guided by evidence-based practice guidelines built on the best available research in order to reduce inconsistency, improve health outcomes, and eliminate unnecessary costs. Additionally, our medical liability system should be a more effective tool for improving patient safety, and should efficiently and equitably compensate patients who are injured due to medical errors.

- > **Health insurance that pays for high-value services that produce the best health results for the money spent.** Value-based benefit plans place a priority on preventive care and other effective (or high-value) health services. Conversely, such plans create disincentives for less effective services or ones that have little impact on health.

Next steps

- > **Move decisively to patient-centered primary care.** Patient-centered primary care homes (PCPCHs), in which teams of health care providers offer coordinated, comprehensive care in collaboration with patients, are fundamental to achieving Oregon's Triple Aim.
 - » All payers and primary care providers need to be involved to realize the full benefits of this care model but transformation will begin with OHA, which will take the lead by adopting existing Oregon PCPCH standards and a payment structure aligned with those standards.
 - » In regions where it has significant purchasing power, the state will begin to implement PCPCHs for OHA lives (including Medicaid recipients, state employees, and educators) in 2011. The ultimate goal is of statewide adoption of the PCPCH model by 2015.
- > **Continue to identify and continuously refine a core set of health and health care quality and efficiency measures.** Such measures can be used in the Oregon Scorecard and elsewhere to assess Oregon's progress towards the Triple Aim. They should align with the measures used in focused quality improvement and cost containment initiatives but would be broader in scope to reflect the range of health and health care reforms under way in the state.
- > **Create a realistic and marketable health plan by refining elements of the value-based benefit package.** Focus groups found significant administrative, operational and educational challenges to successful implementation. Even so, participants gave positive feedback about the concept of value-based benefit design. Implementation steps include:
 - » Assigning accountability within OHA for developing plans to implement the value-based benefit plan by January 2012 across OHA programs—including Medicaid fee-for-service and managed care, Public Employee's Benefit Board, and the Oregon Educators Benefit Board. Consider the use of pilot programs, a phased implementation and/or implementing the most appropriate elements of the design

for different populations. This would also include assessing what could be implemented now and what can be implemented in the new Oregon Health Insurance Exchange in 2014.

- » Creating a sophisticated actuarial tool with which purchasers can compare their current benefits with the value-based essential benefit plan and assess how it will reduce their health care expenditures. This will include additional actuarial work on each value-based service to weigh costs and savings for each intervention.
 - » Examining how benefit design can be coupled with payment incentives to increase the use of effective services and treatments to improve health.
 - » Working with affected stakeholders to address administrative and operational concerns.
- > **Develop and set health information exchange (HIE) policies, requirements, standards and agreements** to further the exchange of health information among health care providers, hospitals, medical labs, pharmacies, ambulatory surgery centers, long-term care facilities, and state and local health departments. This would include privacy and security requirements for the secure and appropriate exchange and use of health information.
 - > **Develop uniform methods for payers to make clinically significant decisions, such as prior authorization of diagnosis or treatment and approval of referrals for further care.** Prior authorization and referral requirements are important means for health plans to ensure that they pay only for appropriate care. However, these processes are unnecessarily time-consuming and costly for providers and plans. In 2011, OHA will lead a process for developing uniform methods for requesting authorization and uniform approval standards that are consistent with good medical practice.
 - > **Change state law to remove barriers that discourage physicians and facilities from disclosing medical errors and discussing them with their patients.** A critical first step in patient-centered reform is ensuring that when a patient suffers unanticipated harm in the course of treatment, a thorough investigation is done and any errors are disclosed to and discussed with the patient and the patient's family. Disclosure to patients is the first step both for involving patients in managing their own care and in negotiating fair payments to compensate for negligence without unnecessary legal costs.

The following steps will be taken to remove barriers to disclosure:

- » We will allay physician fears that discussing an error with a patient will be treated as non-cooperation by the physician's malpractice insurer. We will do this through legislative action to forbid insurers from refusing to defend a lawsuit or cancelling a policy because a physician discloses an error.
- » We will allay concerns that discussing errors with patients will be used to establish liability for medical negligence. We will do this by legislation to amend the state's apology law, which currently protects physicians, so that it protects health care facilities as well.

In addition, with the Legislature's assent, we will invite physician practices to participate in the Patient Safety Commission's error reporting program, which helps physicians learn to assess the cause of errors, how to prevent them from happening again, and how to disclose them to their patients.

- > **Identify and develop 10 sets of Oregon-based best practice guidelines and standards** that can be uniformly applied across public and private health care to drive down costs and reduce unnecessary care. This work will be conducted by the Oregon Health Services Commission and the Oregon Health Resources Commission in close collaboration with providers, the Center for Evidence-Based Practice, and other key stakeholders.
- > **Explore the potential of evidence-based guideline safe harbors.** OHA has received federal funding to consider using evidence-based guidelines to replace the traditional medical malpractice rules in specific situations. In other words, for carefully described situations in which there is strong evidence that patients do better when physicians follow a particular course of treatment, the malpractice law could require physicians to use best practices rather than just avoiding substandard care. The hope is that by adopting guidelines clarifying expectations for providers and giving physicians that follow them a safe harbor from malpractice liability, medical errors and legal costs both can be reduced. During 2011, OHA will continue to investigate the value of the concept and discuss it with a broadly representative group of Oregonians.

For more information

On primary care home and payment reform please see:

Oregon patient-centered primary care home standards at
www.oregon.gov/OHA/action-plan/

Incentives and Outcomes Committee Report and appendices at

www.oregon.gov/OHA/action-plan/

On electronic health technology and exchange, please see:

Health Information Exchange Strategic and Operational Plans for Oregon.

Health Information Technology Oversight Committee.

www.oregon.gov/OHPPR/HITOC/Documents/hitoc_reports.shtml

On administrative simplification, please see:

Administrative Simplification Work Group Report and appendices at

www.oregon.gov/OHA/action-plan/

Oregon Health Policy and Research

www.oregon.gov/OHA/action-plan/

On value-based benefit design, please see:

- » Presentations to the Health Policy Board in August and October
www.oregon.gov/OHA/OHPB/meetings/2010/index.shtml
- » Health Services Commission's Sets of Value-based Services
www.oregon.gov/OHPPR/HSC/VBS.shtml
- » Oregon Cost-sharing Workgroup website
www.oregon.gov/OHPPR/HEALTHREFORM/CostSharing/CSW.shtml
- » Oregon Health Fund Board's Benefits Committee Report
www.oregon.gov/OHPPR/HFB/Benefits/FinalRecommendation.pdf
- » Health Services Commission's Prioritized List of Health Services
www.oregon.gov/OHPPR/HSC/current_prior.shtml

STRATEGY

7

Involve everyone in health system improvements.*Consumers, patients, health partners and regional health care organizations*

The fragmented and fragile health care system we have now is on the verge of collapse. Patients often demand and get care that does not improve their health, and never know the true cost of their care. Employers frequently purchase health insurance coverage based on price alone, not on quality or evidence. Health care providers are responsible for patients in their own facilities, but coordination with outside facilities and providers is typically lacking. Our mental health, substance abuse, and oral health care needs are too often unaddressed or under-addressed by a fragmented and complicated system that is insufficiently tailored to meet the diverse needs of Oregon's population. Our public health and medical systems operate separately, so that efforts to improve health in the medical sector are too often disconnected from prevention at the community level.

What we need to achieve

- > **A transformed and coordinated health system in which every Oregonian has high-quality health care and the patient is at the center of the innovations.**

The Board proposes an infrastructure of partners to support our transformed health care system — one in which existing players may have new roles and functions, while new entities are created to further the Triple Aim.

Strategic and coordinated communication about the changes Oregon is making, and active engagement of patients and consumers in the design and implementation of those changes will be critical to the success of this *Action Plan* for Health.

Next steps to inclusive innovation

The Board recognizes the truism that “all health care is local” is particularly relevant in a state as geographically, politically and increasingly racially diverse as Oregon. By establishing a framework in which locally based innovation and creative problem-solving can thrive, Oregon can advance delivery system reforms that meet the unique health needs of the local or regional populations, while ensuring that the consumer and patient needs remain at the center of all these efforts.

- > **Design a framework to foster public-private partnerships.** Each of these partners for health has a specific role to play; some current partners may have different or evolved responsibilities, while new entities are created to fill gaps in the existing system. These partners include:

» ***The Oregon Health Authority***

The Oregon Health Authority, which purchases health care for almost 850,000 people, or almost 1 in every 4 insured Oregonians, will use purchasing power to change care delivery and improve costs across the state's health programs, including public health, the Oregon Health Plan, HealthyKids, employee and educator benefits and public-private partnerships. This alignment allows OHA to focus on health and preventive care, provide access to health care, reduce health inequities, and reduce waste in the health care system. OHA can provide technical and policy assistance to local communities as they transition to being accountable for their own health and health care delivery systems. As a major health care purchaser, OHA can coordinate and partner with the private sector to create and implement system-wide care improvement, tailored approaches to reduce health inequities, and cost reductions.

The Oregon Health Policy Board and the Oregon Health Authority leadership, in consultation with the Governor's office and Legislature, are responsible for setting annual and long-term targets for Oregon's Triple Aim goals, and for tracking all statewide progress toward achievement of these goals. This includes population health goals, such as reducing obesity and tobacco use, as well as improved patient outcomes. Plans for achieving Triple Aim goals also must take into account Oregon's changing demographics and the fiscal realities facing the state.

The Oregon Health Authority also has a responsibility to provide the statewide support and oversight needed to assist local communities and regions to focus on world-class health. OHA will collaborate with local and regional partners to identify the best clinical preventive services for the health care system, provide technical assistance to communities seeking to assess and plan for better health outcomes, and review and implement policies, like the Indoor Clean Air Act and menu labeling, that can affect the health of all Oregonians.

» ***The Oregon Health Insurance Exchange***

The Exchange should be established with a broad mission to be accountable for organizing the purchasing of health insurance for everyone, beginning with individual and small group insurance markets. It also will be responsible for achieving all elements of the Triple Aim. As well as managing and maintaining a global health care

budget for individuals using the corporation's services, it should have the flexibility to expand to serve additional publicly and privately insured populations that want to use it. The corporation should be responsible for:

- › Ensuring that all health insurance contracts are aligned to achieve the same outcomes and administrative efficiencies.
 - › Selecting benefit designs for small groups and individuals and the health plans qualified to administer them for the federal insurance exchange.
 - › Serving as the fiduciary entity for all revenue received and distributed for people using the corporation's services.
 - › Supporting policies that further locally accountable care.
- » ***Local and regional accountability***

The Board believes that regions hold great promise for fundamental change through organizing an efficient use of resources and tailoring health improvement initiatives to meet the needs of their residents. The actual organization of some of these regional entities is beginning to develop and several communities around the state are working to organize planning efforts at the local level. The development and implementation of these local or regional entities accountable for health and health care should be a priority of the Oregon Health Authority.

The Board envisions local entities that will establish governance structures to:

- › Create relationships and contracts with providers in a health system that integrates physical, behavioral and public health;
- › Assume accountability for quality of services delivered and health outcomes;
- › Create a collaborative environment in which the local integrated health systems can innovate toward local achievement of Triple Aim goals while staying within the local health budget.
- › Create a culture of health in their locality, including programs or initiatives that help people make healthier lifestyle choices;
- › Set, measure, and track local progress on Triple Aim goals.

» **Public health infrastructure**

Local and state public health systems will lead and support other partners in shifting their focus to prevention. The Oregon Health Authority can provide the science, data, tools and technical assistance needed to assist partners and communities in creating a culture of health and improving and tracking overall health outcomes. OHA also will remove policy barriers that hinder health promotion efforts and will implement statewide policies that support them. At the community level, public health organizations will be active participants in locally accountable health entities and key resources for development and implementation of local health improvement plans.

» **Qualified health plans**

Federal health reform will dictate the baseline for qualified health plans. Oregon will have an opportunity to set higher standards, particularly for those plans contracting with the new public corporation, to orient their services towards achieving Triple Aim goals while still offering risk management, care coordination and administrative support services.

» **Health care providers**

Health care providers are key partners in health system reform. Their insight and experience will be critical in changing system incentives in ways that improve the coordination of care and health outcomes, reduce or eliminate unnecessary or duplicative care, and ultimately control costs in a transformed and accountable health system.

They also have a vital role in engaging patients in their own health, as well as integrating and coordinating public health activities with their clinical practices.

» **Patients and the public**

The people of Oregon are our most important partners.

- > **Encourage the health care delivery system to become more patient- and family-centered.** This is one of the key strategies to improve health care quality, because system performance improves when patients and families participate as full partners with health care professionals. As a first step, OHA will support the development of primary care homes so that every Oregonian has access to patient-centered primary care. OHA will also work closely with communities and providers to develop standard measures of patient engagement and experience, so we can see where improvements are needed.

- > **Engage patients in their own care.** Patients are the largest health care workforce available. When patients have the knowledge and resources to manage their health conditions effectively, they can avoid crises and thereby reduce the need for more intensive professional care. In implementing patient-centered primary care homes, OHA will work to incorporate evidence-based chronic disease self-management programs and community health workers to help patients bridge clinical and community-level care. OHA also will explore ways to give provider organizations the technical assistance they may need to involve patients and their families in issues beyond their own care. We will not reach our quality goals without engaging patients and families as advisors in quality improvement and practice design.
- > **Develop a comprehensive communication and outreach plan for all health reform activities.** This is different than branding efforts or marketing plans, though it includes those elements, along with educational materials. The changes we are beginning to make are far-reaching and complex and support from patients and consumers will be critical to their success. Communication and outreach must begin immediately so that we can build consumer confidence and patient trust in advance of the large-scale changes to come.
- > **Effective consumer education** is vital to realizing the potential of value-based benefit designs. For the financial incentives and disincentives of such designs to work, consumers need clear and specific information about what is covered and what their costs would be for a given service. It will be important for OHA to partner with other public and private sector experts and stakeholders to broadly distribute consumer education and decision aids when such value-based benefit plans are made available.
- > **Continually improve the public input process** to ensure that we get needed feedback from a wide range of Oregonians throughout the implementation process.

For more information

Please see:

Incentives and Outcomes Committee Report and appendices at www.oregon.gov/OHA/action-plan/

Oregon Health Improvement Plan Committee Report and appendices at www.oregon.gov/OHA/action-plan/

Health Insurance Exchange Report and appendices at www.oregon.gov/OHA/action-plan/

Measure progress.

Timely data and meaningful information

STRATEGY

8

The best-run and most successful businesses always know where they stand: what raw materials cost, how much inventory they have, how many orders they have for their goods or services, and a clear plan or vision of where they want their business to be in a year, five years or 10 years. If Oregon is to transform its health care system, it needs to know these same types of things. This *Action Plan* is the clear vision and plan. A variety of metrics will help us assess whether we are achieving that vision and implementing plans successfully.

What we need to achieve

Timely, meaningful information about our health and how well Oregon's health system is performing.

All participants in the health care system — consumers, providers, employers, insurers and others — need timely, accurate information that they can use to help direct their actions and assess the results. Meaningful data will inform public policy decisions, serve as a resource for patient engagement and development of local solutions, and will help drive broad-based improvements in clinical quality and efficiency.

Next steps

The Oregon Health Policy Board and the Oregon Health Authority are working on three levels to develop strong measurement tools and infrastructure.

- » **Oregon Scorecard:** At the big picture level, OHPB is developing an Oregon Scorecard that will provide a simple statewide overview of the performance of Oregon’s health system with respect to the Triple Aim — improve the health of all Oregonians; increase the quality, reliability, and availability of care; and reduce or control costs so that care is affordable for everyone.

An early draft of what might be included in an Oregon Scorecard is provided in appendix C. This is a work in progress, intended to provide a starting point for discussion. The indicators may change as health reform progresses or as new data sources and measurement methods are developed. As the Scorecard matures, it should serve as one of many resources for informing policy decisions, setting targets for future performance, and evaluating the impact of reform strategies.

- » **Standard quality measures:** On a more operational level, OHPB and OHA are working on standard quality measures that can be used by public and private entities to evaluate the effect of delivery system changes on health outcomes, quality of care, and return on investment.
- » **Improved data sources.** OHA is developing key data sources that are expected to significantly improve the state’s capacity to measure health care quality and cost:
 - › *Demographic data.* Improving and expanding collection of detailed information on race, ethnicity, language and other demographic factors across all data systems will help OHPB and OHA identify and address health disparities. This is critical because the data that are available for different population groups reveal unacceptable inequities. For example, the rate of tobacco or obesity-related chronic disease is 39 percent among the general population in Oregon but is 58 percent among African-Americans and 56 percent among American Indians and Alaska Natives. Similarly, low-income Oregonians are significantly less likely than middle- or higher-income residents to get recommended cancer screening such as mammograms (52 percent vs. 73 percent). Improving and expanding collection of accurate demographic data, will allow us to see if our efforts are truly improving the health and lives of all Oregonians.

- › *The Oregon All-Payer, All-Claims (APAC) reporting system.* By 2012, this system will consolidate health care claims from Medicare, Medicaid, commercial insurers, third-party administrators and pharmacy benefit managers. The dataset will include information on diagnoses, procedures, charges, and payments, as well as member demographics and provider information. When the system is fully in place, we will have more timely and detailed cost information and the ability to construct claims-based quality indicators that reflect the experience of almost all insured individuals in Oregon. The dataset also will enable OHA to see how performance varies among the state's geographic areas and health systems.
- › *Oregon Health Information Exchange.* Oregon's plans to develop a statewide system of exchanging electronic medical information will result in vast improvements in the availability and quality of data about health care processes and patient health outcomes. As clinical data — including data from electronic health records or EHRs — become more accessible and better connected, measurement plans likely will be revised to take advantage of this rich information source.

Appendix A – Oregon Health Policy Board (OHPB) Committee Reports and Policy Documents

For further reading on recommendations and the policy considerations behind them, please see the full OHPB Committee Reports and policy documents available at: www.oregon.gov/OHA/action-plan/.

- » **Administrative Simplification Report**
www.oregon.gov/OHA/action-plan/rpt-admin-smp.pdf
- » **Health Information Exchange Strategic Plan**
www.oregon.gov/OHA/action-plan/pln-heix-str.pdf
- » **Health Information Exchange Operational Plan**
www.oregon.gov/OHA/action-plan/pln-heix-op.pdf
- » **Health Insurance Exchange Business Plan**
www.oregon.gov/OHA/action-plan/pln-heix-bn.pdf
- » **Healthcare Workforce Committee Report**
www.oregon.gov/OHA/action-plan/rpt-hwc.pdf
- » **Incentives and Outcomes Committee Report**
www.oregon.gov/OHA/action-plan/rpt-ioc.pdf
- » **Medical Liability Recommendations**
www.oregon.gov/OHA/action-plan/rec-medliab.pdf
- » **Patient-Centered Primary Care Standards Report**
www.oregon.gov/OHA/action-plan/rpt-pcpc.pdf
- » **Public Employers Health Purchasing Committee Report**
www.oregon.gov/OHA/action-plan/rpt-pehpc.pdf
- » **Statewide Health Improvement Plan Report**
www.oregon.gov/OHA/action-plan/pln-sthi.pdf

Appendix B – Full Timeline

Actions 		2011	2012	2013	2014	2015
Set a target for health care spending in Oregon		Foster innovation and efficiency to achieve target				
Aligned purchasing						
<ul style="list-style-type: none"> Standardize certain provider payments to Medicare methodology (not rates) to set the stage for future payment reform 		Legislature passes standards and authorizes statewide application OHA begins to implement its own purchasing	Public and private implementation continue	Statewide implementation achieved		
	<ul style="list-style-type: none"> Focus quality and cost improvement efforts in areas with the greatest potential for improvement to achieve critical momentum 	OHA identifies focus areas; continues work on uniform quality and efficiency measures	Focus areas incorporated into all OHA reform work (quality improvement, payment reform, benefit design, etc.) OHA explores technical assistance to help providers engage patients and families as advisors			
<ul style="list-style-type: none"> Introduce innovative payment methods that reward efficiency and outcomes 		OHA establishes P4P metrics and 5-10 service bundles OHA explores stopping payment for “never events”	Implement innovative payment methods in OHA’s focus areas and lines of business	Work with partners to extend innovative payments beyond OHA	Refine and expand	
	Reduce administrative costs in health care	DCBS adopts “uniform companion guides” Legislature authorizes DCBS to apply standards statewide OHA begins to implement	First set of standards phased in; public and private standardization by Oct. 2013 OHA workgroup develops standards for additional kinds of transactions		Administrative simplification continues OHA finds ways to ensure that administrative savings are passed on to health care purchasers and consumers	
Decrease obesity and tobacco use		OHA: - sets nutrition standards for public institutions - makes all state facilities tobacco-free - supports other evidence-based tobacco prevention	OHA works with partners to extend nutrition standards and tobacco policy statewide			
	Establish a mission-driven public corporation to serve as the legal entity for Oregon Health Insurance Exchange	Legislature authorizes exchange and public corp. Governor appoints corp. board	2012-2013: Implementation work, including marketing and education 2013: Federal government approves Oregon’s exchange plan		Enrollment and coverage begin Jan. 1	

Actions

	2011	2012	2013	2014	2015
Promote local and regional accountability for health and health care	OHA explores and develops regional frameworks with stakeholders				
Build the health care workforce					
<ul style="list-style-type: none"> Use loan repayment to attract and retain primary care providers in rural and underserved areas 	Legislature and Office of Rural Health develop financing plan	Implement and expand loan repayment; revise eligibility in line with workforce needs			
<ul style="list-style-type: none"> Standardize prerequisites for clinical training via a student "passport" 	OHA partners develop consensus requirement	Introduce passport Explore standardizing students' clinical liability			
<ul style="list-style-type: none"> Revise "adverse impact" policy to enable public educational institutions to respond to workforce training needs 	OHA partners revise policy				
<ul style="list-style-type: none"> Improve diversity and cultural competency of health care workforce 	OHA and partners identify best methods to ensure ongoing cultural competency	OHA incents use of Community Health Workers in primary care homes			
<ul style="list-style-type: none"> Extend participation in Oregon's Healthcare Workforce Database to all health professional licensing boards. 	Legislature authorizes database expansion	Incorporate reporting from new health care professional licensing boards as data needs dictate and board readiness allows			
Move to patient-centered primary care, first for OHA lives (Medicaid recipients, state employees, educators) and then statewide	OHA implements Patient-Centered Primary Care Homes (PCPHs) where it has significant purchasing power	Implementation expands	75% of all Oregonians have access to PCPCH		
Introduce value-based benefit designs that remove barriers to preventive care	OHA does additional design and modeling work OHA develops roll-out plans include education and outreach	OHA and partners offer value-based benefit package (VBBP) in OHA coverage	VBBP offered in Oregon Exchange		

Expand the use of health information technology (HIT) and exchange (HIE)	<p>OHA consolidates HIE planning in new Office of Health Information Technology (OHIT)</p> <p>Legislature establishes a public-private state-designated entity for HIE</p>	Transition HIE services and operation to the state-designated entity	Widespread adoption and use of electronic health records Leverage HIE to support quality of care, including care coordination
Develop Oregon guidelines for clinical best practices	OHA and partners create 10 sets of Oregon-based best practice guidelines and standards of care	OHA and partners use standards to increase appropriateness of care and reduce costs	
Strengthen medical liability system performance	<ul style="list-style-type: none"> Remove insurance concerns as barriers to full disclosure of adverse events by providers and facilities 	Legislature enacts law removing barriers to disclosure	OHA and partners use standards to increase appropriateness of care and reduce costs
<ul style="list-style-type: none"> Clarify that statements of regret or apology may not be used to prove liability in negligence cases 	Legislature amends Oregon's "apology" law		
<ul style="list-style-type: none"> Explore alternative systems 	OHA pursues funding or team to study alternative compensation system for medical errors		
Performance measurement	<p>OHPB finalizes Scorecard with Oregon standard quality measures</p> <p>OHA sets common standards for diversity data in its systems</p>	Ongoing: OHPB reviews, revises, and holds reforms accountable to Scorecard 2012-14: OHA rolls out diversity data standards in its systems and works to extend them to private sector	

The Board's agenda and ongoing action items are continuing to be developed.

Appendix C – Draft Oregon Health Scorecard, with data sources and notes

Oregon Scorecard Potential Indicators as of December 2010					
Indicator	Oregon	National	Data year	Data source	Notes
IMPROVE THE HEALTH OF ALL OREGONIANS					
Percent of adults reporting good or excellent health status	87.1 percent	84.9 percent	2009	BRFSS ¹	Nat'l data from: www.cdc.gov/brfss/index.htm
Percent of adults with a tobacco- or obesity-related chronic disease	39.0 percent	Not available	2009	BRFSS ¹	Current diagnosis of arthritis, asthma, CVD, or diabetes (calculated by PHD)
Percent of Oregonians who currently smoke (adults / 8th graders)	17.5 percent / 9.9 percent	17.9 percent / not available	2009	BRFSS ¹ / OHT ²	Current smokers, minimum 100 lifetime days smoking/ Nat'l data from: www.cdc.gov/brfss/index.htm
Percent of Oregonians who are considered obese (adults / 8th graders)	24.1 percent / 11.2 percent	27.2 percent / not available	2009	BRFSS ¹ / OHT ²	BMI >= 30 /Nat'l data available for 9th-12th graders but figure (12.0%) is not directly comparable
Percent of Oregonians who are physically active (adults / 8th graders)	56.7 percent / 57.5 percent	50.6 percent / not available	2009	BRFSS ¹ / OHT ²	Active defined by CDC guidelines, see: http://www.cdc.gov/physicalactivity/everyone/guidelines/index.html/ Nat'l data available for 9th-12th graders but figure (37.0%) is not directly comparable
Oregon high school graduation rate	66.2 percent	<i>tbd</i>	2008 - 9 cohort	Oregon Dept. of Education	4-year cohort rate; students entered high school in 2005-6
Percent of babies born at low birthweight	6.2 percent	8.2 percent	2009 (prelim.)	Oregon and national Vital Statistics	4-year cohort rate; students entered high school in 2005-6
INCREASE THE QUALITY, RELIABILITY, AND AVAILABILITY OF CARE					
Access					
Percent of Oregonians who do not have health insurance					
Overall	17.0 percent	15.1 percent	2009	American Community Survey	
Children 0 - 18	10.9 percent	9.0 percent	2009		
Adults 19 - 64	22.9 percent	20.7 percent	2009		
Primary care provider density	Available Jan. 2011	—	—	OHPR ³	
Percent adults who had a routine check-up in the last year	67.8 percent	Not available	2008	BRFSS ¹	
Percent adults who had a dental visit (for any reason) in the last year	71.4 percent	71.2 percent	2008	BRFSS ¹	Dental visit for any reason
Hospital and acute care quality					
Percent of patient rating hospital quality of care as "high"	67.0 percent	66.0 percent	2008 - 2009	CMS Hospital Compare	
Blood stream infections from central lines (CLABSIs) (per 1,000 line days)	0.86	1.92	2009	OHPR ³	Medical/surgical ICU rate per 1,000 line days
Hospital deaths related to:					
CABG (coronary artery bypass graft)	2.9 percent	2.2 percent	2009	OHPR ³	
Hip fracture	2.9 percent	2.2 percent	2009		

Indicator	Oregon	National	Data year	Data source	Notes
Prevention and chronic disease care quality					
Percent 2-year olds who are up to date on immunizations	73.8 percent	71.3 percent	2008	Oregon immunization program / National Immunization System	This is 4:3:1:3:3:1 series. Oregon numbers are constructed population-based rates, not perfectly comparable to NIS numbers
Percent women (40-69 years) who got a mammogram to check for breast cancer	73.5 percent	64.0 percent	2008 - 2009	Oregon Quality Corp.	See: www.partnerforqualitycare.org
Percent adults (50 years +) who have ever been screened for colorectal cancer	66.8 percent	61.8 percent	2008	BRFSS ¹	% adults 50+ who have EVER had sigmoidoscopy or colonoscopy
Percent diabetics who got an HbA1C test for blood sugar in the last year	86.0 percent	75.0 percent	2008 - 2009	Oregon Quality Corp.	See: www.partnerforqualitycare.org
INCREASE THE QUALITY, RELIABILITY, AND AVAILABILITY OF CARE					
Avoidable cost drivers					
Hospital admissions that could have been prevented (per 100,000)	—	—	—		
For chronic heart failure (a chronic disease example)	206.6	415.5	2009		Among adults age 18+, adjusted for age and sex, nat'l rate is 2007
For pneumonia (an acute condition example)	237.7	374.8	2009	OHPR ³	
For asthma (among kids)	47.6	134.8	2009		Among children 0-17 years, adjusted for age and sex
Percent patients with low back pain who got MRIs before more conservative care	36.2 percent	32.7 percent	2008		Data are Medicare FFS data only and not risk-adjusted
Hospital readmission rates (ratio of actual to expected readmissions):				CMS Hospital Compare	Data are for Medicare FFS only and are reported as hospital-specific risk ratios (observed:expected readmissions). State and nat'l figures cited here are hospital medians; should transition ASAP to a risk ratio computed statewide.
For chronic heart failure	23.5	24.7	2006 - 2009		
For heart attack (AMI)	19.1	19.9	2006 - 2009		
For pneumonia	17.1	18.3	2006 - 2009		
Infrastructure					
Rate of EMR adoption (ambulatory settings)	65.0 percent	44 percent	2009	Oregon HITOC survey	This rate is for ambulatory practices: 65% of MDs, PAs, NPs are in practices with an EHR system
REDUCE OR CONTROL THE COST OF CARE					
Percent adults reporting that they didn't get medical care because of cost	10.5 percent	Not available	2008	BRFSS ¹	Change data source to Oregon Health Insurance Survey in 2011
Average monthly health insurance premium for a family	\$1,069	\$1,085	2009	Nat'l Medical Expenditure Survey	Change data source to Oregon All-payer All-claims database in 2012
Per capita expenditures for personal health services	\$4,880	\$5,283	2004	CMS Nat'l Health Accounts	
Average annual growth in per capita expenditures	7.7 percent	6.7 percent	1991 - 2004	CMS Nat'l Health Accounts	
Per capita personal medical expenditures for:				CMS Nat'l Health Accounts	Change data source to Oregon All-payer All-claims database in 2012
Hospital care	\$1,671	\$1,931	2004		
Physician and professional services	\$1,433	\$1,341	2004		
Rx	\$569	\$757	2004		
Dental care	\$354	\$277	2004		

1 - Behavioral Risk Factor Surveillance System 2 - Oregon Healthy Teens Survey 3 - Office for Oregon Health Policy & Research.

Appendix D – Overview of Public and Stakeholder Input into the *Action Plan*

The Oregon Health Policy Board’s community engagement efforts included staff members meeting with more than 300 stakeholders in at least 29 counties; six community meetings with more than 800 participants; an online input website that received approximately 1,500 visits; and regular roundtable discussions with stakeholder and consumer groups. The themes heard by staff and the Board through the community input process support Oregon’s *Action Plan for Health*.

- » **Local accountability.** Local communities believe they best understand the health and problems of their residents, as well as the possibilities for innovation to achieve the Triple Aim. Health reform policies must take into account the differences between different regions across the state. Innovation will occur when there is local control and accountability rather than one-size-fits-all policy decisions.
- » **Coordinated care and streamlined purchasing.** Funding streams often unintentionally create barriers to achieving the Triple Aim goals. Local communities feel they could better work to achieving statewide goals if funding streams were consolidated and reporting requirements were streamlined. There is also support for integrating care delivery, such as integrating behavioral and mental health with physical health. However, the ways in which health care services are paid for need to support integration that results in high quality, patient-centered care and improved health.
- » **Ongoing consumer and patient engagement.** While the state has included the voices and input of thousands of Oregonians in its plans for health reform, the role of consumers and patients will only become increasingly important. OHA should continue to engage consumers in policy decisions, as well as decisions about their own health and the services they receive. Patients need the tools to make informed decisions, and the system must be patient-centered and provide high quality care that improves health and contains costs.

- » **Focus on prevention and chronic disease management.** Prevention must be addressed from multiple angles. There should be incentives that encourage patient responsibility and choices which improve health and contain costs. However, it is also important to remember the differences between communities and to encourage innovative community-based preventive efforts.
- » **Access.** Access means more than coverage. The lack of appropriately trained providers in all areas of the state is directly affecting health, costs and quality of care. OHA must ensure that communities have access to the providers they need, regardless of geographic location, income, health status, or other social and economic factors.
- » **Ensuring health equity.** To achieve the Triple Aim and a healthy population, the current disparities in health and health care delivery must be eliminated, including ensuring access to culturally-competent care. As Oregon's population becomes increasingly diverse, policies and health reform must take into account the state's changing demographics.

Appendix E – List of References Used in the *Action Plan*

Introduction

An urgent call to action

- > The cost of health care accounts for an estimated 16 percent of Oregon’s state General Fund spending in a time when we are facing a \$3.5 billion shortfall.

Source:

- » Oregon Health Authority: Legislative Fiscal Office, Highlights of the 2009-2011 Legislatively Adopted Budget, August 2009, and Analysis of the 2009-2011 Legislatively Adopted Budget;
 - » Department of Human Services Seniors and People with Disabilities: DHS Budget and Policy SPD Budget Administrator (Bob Gebhardt), SPD 2009-2011 Legislatively Adopted Budget, produced 8-26-10;
 - » Department of Corrections: Legislative Fiscal Office, Analysis of the 2009-2011 Legislatively Adopted Budget, Public Safety Program Area, August 2009, www.leg.state.or.us/comm/lfo/2009-11_budget/PUBLIC_SAFETY.pdf;
 - » Briefing to the Legislature, Office of Economic Analysis, November 2010.
- > Nationally, it is estimated that about 30 percent of care provided is either unnecessary or does not lead to patient health.

Source:

- » Kaiseredu.org, “U.S. Health Care Costs,” March 2010, available at www.kaiseredu.org/Issue-Modules/US-Health-Care-Costs/Background-Brief.aspx.
- > Thirty-five percent of minority women in Oregon have no regular care provider, as compared to 18 percent for white women, and the life expectancy for African Americans and American Indians/Alaska Natives in Oregon is two years less than for Caucasians.

Source:

- » Kaiser Family Foundation, “Putting Women’s Health Care Disparities on the Map: Examining Racial and Ethnic Disparities at the State Level,” June 2009, www.kff.org/minorityhealth/upload/7886.pdf.

Foundational strategies in brief

Strategy 1. Use purchasing power to change how we deliver and pay for health care.

- > Health care accounts for an estimated 16 percent of Oregon’s state General Fund budget, which is currently threatened by a \$3.5 billion shortfall.
 - » Oregon Health Authority: Legislative Fiscal Office, Highlights of the 2009-2011 Legislatively Adopted Budget, August 2009, and Analysis of the 2009-2011 Legislatively Adopted Budget;
 - » Department of Human Services Seniors and People with Disabilities: DHS Budget and Policy SPD Budget Administrator (Bob Gebhardt), SPD 2009-2011 Legislatively Adopted Budget, produced 8-26-10;
 - » Department of Corrections: Legislative Fiscal Office, Analysis of the 2009-2011 Legislatively Adopted Budget, Public Safety Program Area, August 2009, www.leg.state.or.us/comm/lfo/2009-11_budget/PUBLIC_SAFETY.pdf;
 - » Briefing to the Legislature, Office of Economic Analysis, November 2010.

Strategy 2. Shift focus to prevention.

- > Almost 40 percent of deaths in the U.S. are caused by modifiable factors such as tobacco use, poor diet and physical inactivity and alcohol use, and 75 cents of every health care dollar is spent on the treatment of chronic conditions.

Source:

- » Ali H. Mokdad, James S. Marks, Donna F. Stroup, Julie L. Gerberding, JAMA. 2004;291(10):1238-1245;
- » Kaiseredu.org, “U.S. Health Care Costs,” March 2010, available at www.kaiseredu.org/Issue-Modules/US-Health-Care-Costs/Background-Brief.aspx.

Strategy 3. Improve health equity.

- > NA

Strategy 4. Establish a health insurance exchange to make it easier for Oregonians to get affordable health insurance.

- > The health insurance exchange will be the conduit through which individuals with incomes up to 400 percent of the federal poverty level (\$88,200 for a family of four in 2010) will access the federal premium tax credits that will make health insurance much more affordable for many people. In addition, individuals with incomes up to 250 percent of the federal poverty level will gain access to cost-sharing assistance through the exchange.
- > Additionally, certain small business purchasing through the exchange may be eligible for tax credits of up to 50 percent of their contribution to employee insurance premiums.

Source:

- » Patient Protection and Affordable Care Act (P.L. 111-148).

Strategy 5. Reduce barriers to health care.

- > By 2014, it is estimated that 93 percent of all Oregonians will have access to health care coverage.

Source:

- » Oregon Health Authority, “Estimates of Coverage Expansions from Federal Reform,” August 2010, available at www.oregon.gov/OHA/OHPB/meetings/2010/100810-st-fin-fed-refm.pdf.

Strategy 6. Set standards for safe and effective care.

- > NA

Strategy 7. Involve everyone in health system improvements.

- > NA

Strategy 8. Measure progress.

- > NA

Key actions

- > NA

What will be different after the *Action Plan for Health*?

- > Insurance premiums have increased 125 percent over 10 years, and health care costs continue to outpace what we can afford.

Source:

- » Oregon Health Authority, “A Healthy Oregon,” November 2010, p. 3, available at <http://www.oregon.gov/DHS/aboutdhs/docs/brochure-oha.pdf?ga=t> (accessed 11/7/10).
- » Oregon Department of Consumer and Business Services, “Health Insurance in Oregon,” January 2010, p. 3, available at www.cbs.state.or.us/external/ins/health_report/3458-health_report-2010.pdf (accessed 11/1/10).

Taking advantage of federal reform opportunities for real change

- > Federal law now allows adult children to stay on their parents’ health insurance plan until the child is 26.
- > Considerable funding for expansions of health insurance coverage options. This additional funding includes expansion of Medicaid to low-income adults up to 138 percent of the federal poverty level, and federally-funded tax credits for individuals up to 400 percent of the federal poverty level to purchase insurance through a state Health Insurance Exchange.

Source:

- » Patient Protection and Affordable Care Act (P.L. 111-148).

Foundational strategies in action

Strategy 1. Use purchasing power to change how we deliver and pay for health care.

- > Health care accounts for 16 percent of the state’s General Fund budget, which is currently threatened by a \$3.5 billion shortfall.

Source:

- » Oregon Health Authority: Legislative Fiscal Office, Highlights of the 2009-2011 Legislatively Adopted Budget, August 2009, and Analysis of the 2009-2011 Legislatively Adopted Budget;
- » Department of Human Services Seniors and People with Disabilities: DHS Budget and Policy SPD Budget Administrator (Bob Gebhardt), SPD 2009-2011 Legislatively Adopted Budget, produced 8-26-10;

- » Briefing to the Legislature, Office of Economic Analysis, November 2010.
 - » Department of Corrections: Legislative Fiscal Office, Analysis of the 2009-2011 Legislatively Adopted Budget, Public Safety Program Area, August 2009, www.leg.state.or.us/comm/lfo/2009-11_budget/PUBLIC_SAFETY.pdf;
- > Had Oregon successfully implemented strategies to reduce the rate of medical inflation by two percentage points over the last five years, it would have saved \$6.3 billion or 6 percent of total health care expenditures.¹

Source:

- » Centers for Medicare and Medicaid Services, Health expenditures by state of residence, 1991-2004 (September 2007), available at www.cms.gov/NationalHealthExpendData/downloads/resident-state-estimates.zip.
- > Had we successfully contained the growth of obesity during the last five years, Oregon would have saved approximately \$1 billion in health care expenditures.

Source:

- » National Center for Chronic Disease Prevention and Health Promotion, Behavioral Risk Factor Surveillance System, Prevalence and Trends Data;
 - » Oregon – 2005-2009, Overweight and Obesity (BMI) System, available at apps.nccd.cdc.gov/BRFSS/display.asp?cat=OB&yr=2005&qkey=4409&state=OR;
 - » Population Research Center, PSU, March 2010, available at www.pdx.edu/sites/www.pdx.edu.prc/files/media_assets/Population%20Report%202009_tables_web2.xls;
 - » Finkelstein, E., Trogdon, J., Cohen, J., and Dietz, W., July 2009, “Annual Medical Spending Attributable to Obesity: Payer- and Service-Specific Estimates,” *Health Affairs*, available at obesity.procon.org/sourcefiles/FinkelsteinAnnualMedicalSpending.pdf (accessed 11/7/10).
- > Instituting bundled or episode-based payments for care related to 10 common acute and chronic conditions in 2005 could have reduced expenditures by approximately \$2.25 billion over the last five years.²

¹The price of consumer goods increased at an average rate of 2.4 percent per year between 2005 and 2009 according to the Bureau of Labor Statistics Consumer Price Index (CPI). In contrast, Oregon’s total health care expenditures increased at an average rate of 7.7 percent per year between 1991 and 2004 according to the Center for Medicare and Medicaid Services National Health Expenditure Data. Although more recent health expenditure data are not available, if health care expenditures were held at 5.7 percent rather than continued on at 7.7 percent, Oregon would have saved over \$6.34 billion from 2005-2009 even after accounting for new medical spending attributable to population growth rather than the price of health care.

Source:

- » Expenditure and Savings per Episode: PROMETHEUS Payment Evidence-Informed Case Rate Playbooks available at www.prometheuspayment.org/Content/ContentDisplay.aspx?ContentID=111 (accessed 10/8/10).
- » Number of Episodes among Non-Elderly Adults in Oregon:
 - » Oregon Hospital Inpatient Discharge Data;
 - » CDC Behavioral Risk Factor Surveillance System (BRFSS);
 - » CDC National Health and Nutrition Examination Survey (NHANES);
 - » CDC National Health Interview Survey (NHIS).
- > Holding the growth in insurance companies' general administrative expenditures to CPI could have saved \$36 million to \$119 million over the last five years.

Source:

- » Consumer and Business Service Department, "Health Insurance in Oregon, 2007-2010," available at www.cbs.state.or.us/external/ins/health_report/health-report_intro.html.
- » Bureau of Labor Statistics, Consumer Price Index: All Urban Consumers, 1991-2010, available at data.bls.gov/PDQ/servlet/SurveyOutputServlet.
- > Tobacco use prevention activities will save at least \$1.32 for every \$1 invested.

Source:

- » American Lung Association in Oregon, Smoking Cessation: The Economic Benefits, Oregon Facts, www.lungusa.org/stop-smoking/tobacco-control-advocacy/reports-resources/cessation-economic-benefits/states/oregon.html.
- > The Oregon Health Authority purchases health insurance coverage for nearly one in four Oregonians, approximately 850,000 in total.

Source

- » Total covered lives under Medicaid, PEBB, OEBC, OMIP and FHIAP divided by total population.
- > We estimate that by paying for care for 10 common acute and chronic conditions using bundled or episode-based payments, Oregon would save approximately \$500 million annually by preventing re-hospitalizations and unnecessary care.

Source:

- » Expenditure and Savings per Episode: PROMETHEUS Payment Evidence-Informed Case Rate Playbooks available at www.prometheuspayment.org/Content/ContentDisplay.aspx?ContentID=111 (accessed 10/8/10).

²Acute conditions include hip replacement, knee replacement, bariatric surgery and acute myocardial infarction. Chronic conditions include asthma, chronic obstructive pulmonary disorder, congestive heart failure, coronary artery disease, diabetes and hypertension.

- » Number of Episodes among Non-Elderly Adults in Oregon:
 - » Oregon Hospital Inpatient Discharge Data;
 - » CDC Behavioral Risk Factor Surveillance System (BRFSS);
 - » CDC National Health and Nutrition Examination Survey (NHANES);
 - » CDC National Health Interview Survey (NHIS).
- > Oregon could expect to save approximately \$650 million or 1.9 percent of total health care expenditures per year after a five-year program initiation phase if Oregon were to provide primary care homes to the entire population and employ community health teams to link services and provide additional practice support.

Source:

- » Vermont Blueprint for Health: 2009 Annual Report, January 2010, available at http://healthvermont.gov/prevent/blueprint/documents/Blueprint_AnnualReport_2009_0110rev.pdf.
- > Nationally it is estimated that about 30 percent of care provided to patients is either unnecessary or does not lead to improved health.

Source

- » Kaiseredu.org, “U.S. Health Care Costs,” March 2010, available at www.kaiseredu.org/Issue-Modules/US-Health-Care-Costs/Background-Brief.aspx.
- > Estimates indicate that by encouraging providers and payers to adopt automated electronic communications and a uniform language for these communications, we could save approximately \$92 million to \$202 million a year upon full implementation.

Source:

- » Oregon Health Authority, Office for Oregon Health Policy and Research, “Oregon Administrative Simplification Strategy and Recommendations: Final Report of the Administrative Simplification Work Group,” June, 2010, available at www.oregon.gov/OHPPR/HEALTHREFORM/AdminSimplification/Docs/FinalReport_AdminSimp_6.3.10.pdf.
- > The University of Michigan Health System found that instituting such a program led to a 59 percent decrease in the average monthly cost of medical liability.

Source:

- » Kachalia, A., Kaufman, S., Boothman, R., Anderson, S., Welch, K., Saint, S., et al. (2010). Liability Claims and Costs Before and After Implementation of a Medical Error Disclosure Program. *Annals of Internal Medicine*, 153, 213-221.

- It is estimated that health information systems connected across Oregon HIE services will provide significant annual health care savings including:
 - » \$57.7 to \$90.7 million per year for avoided laboratory testing and imaging services;
 - » \$33.3 million per year for increased physician practice productivity.

Source:

- » Witter & Associates. (2010, May). Health Information Exchange Adoption Impact: Potential Avoidable Service and Productivity Savings from Widespread Adoption. Oregon Health Information Technology Oversight Council. Available at www.oregon.gov/OHPPR/HITOC/Documents/ORSavingsPotential.pdf.

- Finally, federal health care reform is expected to halve the number of uninsured Oregonians while saving money for businesses and individuals. Current economic forecasts suggest that in 2019 annual individual and family annual health spending will fall by \$1.8 billion and businesses will save \$30 million annually.

Source:

- » Oregon Health Authority, “Estimates of Coverage Expansions from Federal Reform,” August 2010, available at www.oregon.gov/OHA/OHPB/meetings/2010/100810-st-fin-fed-refm.pdf.

- Also, as more people are able to access health insurance, Oregon will reduce the amount of uncompensated care that providers experience. Hospitals alone could experience a \$360 million reduction in annual uncompensated care by 2015 and \$465 million by 2019 (however, some hospitals will also experience partially offsetting reductions in Medicaid Disproportionate Share Hospital payments beginning in 2014).

Source:

- » Oregon Health Authority, Office for Oregon Health Policy and Research, “Hospital Financial Data Reports, 2009,” last updated 12/7/2010, available at www.oregon.gov/OHPPR/RSCH/docs/Hospital_Financials/2009_Margins_FINAL_120710.xls;
- » American Community Survey, 2009.

Strategy 2. Shift focus to prevention.

- It is estimated that chronic disease treatment accounts for 75 percent of our health care spending.

Source:

- » Kaiseredu.org, “U.S. Health Care Costs,” March 2010, available at www.kaiseredu.org/Issue-Modules/US-Health-Care-Costs/Background-Brief.aspx.

- > The human toll of tobacco use in Oregon continues to dramatically surpass all other preventable causes of death and disease.

Source:

- » American Lung Association in Oregon, “Tobacco Prevention, Education and Policy,” available at www.lungoregon.org/tobacco/.

- > Focused prevention efforts and evidence-based cessation benefits can provide a return of \$1.32 for every dollar Oregon spends on providing tobacco cessation treatments.

Source:

- » American Lung Association in Oregon, Smoking Cessation: The Economic Benefits, Oregon Facts, www.lungusa.org/stop-smoking/tobacco-control-advocacy/reports-resources/cessation-economic-benefits/states/oregon.html.

- > One-third of the recent increase in medical costs in Oregon is attributed to obesity.

Source:

- » Northwest Health Foundation, “The Impact of Obesity on Rising Medical Spending in Oregon from 1998 to 2005,” April 6, 2009, p. 10, available at nwhf.org/images/files/Thorpe_Oregon_Obesity_Study.pdf.

- > The Centers for Disease Control and Prevention estimate that medical costs for individuals with obesity are \$1,429 higher annually than those of normal weight. By reducing obesity and obesity-related chronic diseases like diabetes, Oregon stands to realize a significant return on investment.

Source:

- » Finkelstein, E., Trogon, J., Cohen, J., and Dietz, W., July 2009, “Annual Medical Spending Attributable to Obesity: Payer- and Service-Specific Estimates,” Health Affairs, available at obesity.procon.org/sourcefiles/FinkelsteinAnnualMedicalSpending.pdf (accessed 11/7/10).

- > Today, the number of Oregon eighth-graders who have had a drink in the past 30 days is twice the national average.

Source:

- » Alcohol and Drug Policy Commission, “Improving Oregon’s Alcohol and Drug Prevention and Recovery Strategy, Report to Governor Ted Kulongoski,” May 2010, p. 2, available at www.ohcs.oregon.gov/DHS/mentalhealth/tools-policymakers/adpc/documents/ad-report2gov.pdf?ga=t (accessed 11/7/10).

- > Almost 40 percent of deaths in the United States are caused by behaviors that can be changed: tobacco use, poor diet and lack of physical activity, and alcohol use.

Source:

- » Ali H. Mokdad, James S. Marks, Donna F. Stroup, Julie L. Gerberding, JAMA. 2004;291(10):1238-1245.

Strategy 3. Improve health equity.

> Oregon is:

- » Forty-seventh in the number of African American diabetes deaths per 100,000 population by race/ethnicity (60.5 per 100,000 compared to 40.2 per 100,000 in the United States);
- » Forty-seventh in the number of African American deaths caused by stroke and other cerebrovascular diseases per 100,000 population (73.1 per 100,000 in Oregon compared to 61.7 per 100,000 in the U.S.);
- » Twenty-sixth in the percentage of African American and Latino live births by cesarean delivery, though both are slightly better than U.S. averages;
- » Twenty-fifth in the percentage of African American and 30th for Hispanic Latino mothers beginning prenatal care in the first trimester, both below U.S. averages.

Source:

- » Kaiser Family Foundation, statehealthfacts.org, Oregon, www.statehealthfacts.org/profileglance.jsp?rgn=39.
- > As Oregon's population becomes increasingly diverse, we must develop a public health and health care system that effectively meets the needs of Oregon's diverse and geographically disparate populations:
- » The Latino population has almost doubled in the last 10 years, and is now the largest minority population with well over 400,000 people;
 - » Asian Americans number over 130,000 in the state;
 - » American Indian and Alaska Native and Black/African American populations number 67,000 and 63,000 respectively but experience disproportionate health burdens that result in unacceptable costs for individuals, families, communities, and health systems;
 - » International migration is adding to the cultural and language diversity of the state, with the Russian community continuing to grow, along with Somali and Iraqi populations. Oregon is expected to add 197,000 to state population through international immigration over a 30-year period ending 2025.

Source:

- » U.S. Census Bureau, U.S. Populations Projections, "Population Projections for States by Age, Sex, Race, and Hispanic Origin: 1995

to 2025,” October 1996, available at www.census.gov/population/www/projections/ppl47.html.

- > In 2009, only eight of Oregon’s 121 medical school graduates were Latino, African American, Native American, or Pacific Islander.

Source:

- » Association of American Medical Colleges, Data Warehouse: Student File, 2002-2009, available at <http://www.aamc.org/data/facts/enrollmentgraduate/start.htm>.

Strategy 4. Establish a health insurance exchange to make it easier for Oregonians to get affordable health insurance.

- > An estimated 150,000 previously uninsured Oregonians will take up individual coverage through the Health Insurance Exchange. Thousands more will gain coverage through the exchange as members of small employer groups.

Source:

- » Oregon Health Authority, “Estimates of Coverage Expansions from Federal Reform,” August 2010, available at www.oregon.gov/OHA/OHPB/meetings/2010/100810-st-fin-fed-refm.pdf.
- > The exchange will be the conduit through which individuals with income up to 400 percent of the federal poverty level (\$88,200 for a family of four in 2010) will access the federal premium tax credits that will make health insurance much more affordable for many people. In addition, individuals with incomes up to 250 percent of the federal poverty level will gain access to cost-sharing assistance through the exchange.

Source:

- » Patient Protection and Affordable Care Act (P.L. 111-148).

Strategy 5. Reduce barriers to health care.

- > Today, 17 percent of Oregonians are uninsured.

Source:

- » American Community Survey, 2009.
- > We project that, by 2014, 93 percent of all Oregonians will have access to health care coverage as a result of insurance market reforms to remove barriers, expansions of Medicaid, creation of state health insurance exchanges, and federal tax credits to help make coverage offered through exchanges more affordable.

Source:

- » Oregon Health Authority, “Estimates of Coverage Expansions from Federal Reform,” August 2010, available at www.oregon.gov/OHA/OHPB/meetings/2010/100810-st-fin-fed-refm.pdf.

- > The Kaiser Family Foundation estimates that Oregon’s Medicaid enrollment will increase by 60 percent.

Source:

- » Kaiser Family Foundation Commission on Medicaid and the Uninsured, “Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL,” May 2010, p. 41, available at www.kff.org/healthreform/upload/Medicaid-Coverage-and-Spending-in-Health-Reform-National-and-State-By-State-Results-for-Adults-at-or-Below-133-FPL.pdf.

- > Despite these gains, 7 percent of Oregonians will remain uninsured.

Source:

- » Oregon Health Authority, “Estimates of Coverage Expansions from Federal Reform,” August 2010, available at www.oregon.gov/OHA/OHPB/meetings/2010/100810-st-fin-fed-refm.pdf.

Strategy 6. Set standards for safe and effective care.

- > NA

Strategy 7. Involve everyone health system improvements.

- > NA

Strategy 8. Measure progress.

- > The percentage of adults with a tobacco or obesity-related chronic disease is 39 percent among the general population in Oregon but is 58 percent among African Americans and 56 percent among American Indians and Alaska Natives.

Source:

- » Custom analysis of BRFSS data for the “Draft Oregon Health Improvement Plan: 2011-2020,” October 2010.

- > Similarly, low-income Oregonians are significantly less likely than middle- or higher-income residents to get recommended cancer screenings, such as mammograms (52 percent vs. 73 percent).

Source:

- » Oregon Department of Human Services, “Keeping Oregonians Healthy: Preventing Chronic Diseases by Reducing Tobacco Use, Improving Diet, and Promoting Physical Activity and Preventive Screenings,” July 2007, p. 83, available at www.oregon.gov/DHS/ph/hpcdp/docs/healthor.pdf?ga=t.

Additions to Appendix E – References

OHPB committee websites

For the latest information on the work of these committees, please visit their websites. These sites also have agenda, minutes and materials for all meetings.

- » Administrative Simplification Work Group
www.oregon.gov/OHPPR/HEALTHREFORM/AdminSimplification/AdministativeSimplificationWorkgroup.shtml
- » Healthcare Workforce Committee
www.oregon.gov/OHPPR/HPB/Workforce/HealthCareWorkforceCommittee.shtml
- » Health Equities Policy Review Committee
www.oregon.gov/OHA/omhs/health_equity.shtml
- » Incentives and Outcomes Committee
www.oregon.gov/OHPPR/HPB/HealthIncentives/HealthIncentivesandOutcomesCommittee.shtml
- » Medical Liability Task force
www.oregon.gov/OHPPR/HPB/MedicalLiability/MedicalLiabilityTaskForce.shtml
- » Patient-Centered Primary Care Standards Advisory Committee
www.oregon.gov/OHPPR/HEALTHREFORM/PCPCH/PCPCHStandardsAdvisoryCommittee.shtml
- » Public Employer Health Purchasing Committee
www.oregon.gov/OHA/OHPB/committees/pub-hlt-bn-prch.shtml
- » Statewide Health Improvement Plan Committee
www.oregon.gov/DHS/ph/hpcdp/hip/index.shtml

Other Oregon Health Authority websites

The board also drew from the work of other Oregon Health Authority committees, commissions, councils, workgroups and task forces in developing *Oregon's Action Plan for Health*. Please visit the websites for the latest information on their efforts.

- » Health Information Technology Oversight Council
www.oregon.gov/OHPPR/HITOC/index.shtml
- » Health Services Commission
www.oregon.gov/OHPPR/HSC/index.shtml
- » Health Resources Commission
www.oregon.gov/OHPPR/HRC/index.shtml
- » Medicaid Advisory Committee
www.oregon.gov/OHPPR/MAC/MACwelcomepage.shtml

Other Oregon Health Authority information

Several elements of *Oregon's Action Plan for Health* are built on work done outside a formal committee structure. For more information on these topical areas, link to the specific websites.

- » Safety net issues and concerns (Oregon Health Policy and Research website)
www.oregon.gov/OHPPR/SNAC/index.shtml
- » Value-based essential benefits (OHPR website)
www.oregon.gov/OHPPR/HPB/VBEBP/index.shtml
- » Bending the cost curve policy brief (2011 OHPR legislative web page)
www.oregon.gov/OHPPR/

Other sources

- » KaiserEDU.org, [www.kaiseredu.org/Issue-Modules/US-Health-Care-Costs/Background-Brief.aspx#How percent20is percent20the percent20U.S. percent20health percent20care percent20dollar percent20spent?](http://www.kaiseredu.org/Issue-Modules/US-Health-Care-Costs/Background-Brief.aspx#How%20is%20the%20U.S.%20health%20care%20dollar%20spent?) Accessed December 9, 2010.
- » United States Department of Health and Human Services (US DHHS), Centers for Disease Control and Prevention, National Center for Health Statistics. Compressed Mortality File 1999-2007. CDC WONDER On-line Database, compiled from Compressed Mortality File 1999-2007 Series 20 No. 2M, 2010. Accessed at www.wonder.cdc.gov/cmfi.html on Nov 22, 2010.

