

Health Systems Transformation Team

AGENDA

Wednesday, February 16th, 2011

6 to 9 pm

NOTE LOCATION CHANGE

Cherry Avenue Training Center

3414 Cherry Avenue, Suite 150

Mt. Mazama Room ,

Keizer, OR 97303

#	Time	Item	Presenter
1	6:00	Welcome and agenda review	Bruce Goldberg Mike Bonetto
2	6:05	Accountable health and long-term care systems	Governor Kitzhaber By video conference: Donald Berwick, MD, MPP Administrator, Centers for Medicare and Medicaid Services (CMS)
3	6:30	Defining our population	Jeanene Smith
4	6:45	Elements of an accountable health and long-term care system	Bruce Goldberg, Mike Bonetto
5	7:00	<u>Breakout Groups</u> Elements of a Request for Proposals for Accountable Care Are these the right elements? What's missing? What needs clarification?	Diana Bianco and facilitators
6	8:15	Small group report back	Diana Bianco
7	8:45	Closing remarks and notes on next week	Mike Bonetto, Bruce Goldberg

Next Meeting:

Wednesday, February 23rd, 2011; 6:00 – 9:00 PM.

Willamette University

Putnam University Center, Cafeteria

6:00 pm to 9:00 pm

Health System Transformation Team

Minutes

February 9, 2011

Willamette University

Putnam University Center

6:00 PM to 9:00 PM

Item

Welcome and Introductions (6:03 PM)

- Mike Bonetto and Bruce Goldberg will facilitate.
- Tim Hartnett handed out an HBO documentary called “Addiction.”
- Meghan Caughey distributed work done on the concept of a Regional Health Authority in SW Washington.

Summary of break out sessions from February 2nd; Prioritized ideas and next steps. (6:04)

The summary of the breakout groups from Feb. 2nd can be found [here](#).

- We added immediate steps we can take regarding evidence based medicine, including some additional information from Dr. Dannenhoffer.
- We heard “loud and clear” the need for relief from regulatory requirements.
- Staff has developed a template to gather information about regulatory barriers to efficiency that will be sent out to Medicaid business partners: managed care organizations, mental health organizations, dental care organizations and hospitals.
- Dr. Goldberg will bring together Medicaid business and community partners to discuss how we may change the way we do business together.

We are moving forward on this.

Innovative models of accountability for the health of a population. (6:14)

There were two presentations about innovative models for greater accountability and integration. The issue here is how we can better integrate systems so that consumers and groups have better access to care and better health outcomes. Can we take the social model around long term care and make that the dominate model for how we deliver services? Can we move away from what has become a failed model – where we manage care by limiting it? These presentations will show models that aim to coordinate care and deliver correct and timely care to people.

The first presentation was given by Judy Mohr-Peterson. It can be found [here](#).

The second presentation was given by Ellen Garcia, from Providence ElderPlace. It can be found [here](#).

Questions and Discussion:

- ElderPlace cost structure: the program is given a fixed amount, and it works within that budget.
- The program is a whole different approach and method of management – it is not run like a hospital. It is set up as a different division, with separate management, philosophy, and medical model. It essentially “started over” when it was created and was built up from there (Greg Van Pelt).

- Medicaid question: Why is it that some counties are doing so much better than others? Why does it work so well in some places and not others?
- There is a great need for hard data – especially on costs and savings.

Breakout Sessions (7:10)

The breakout sessions covered innovative models of accountability for the health of a population. Groups were given consumer scenarios, which can be found [here](#) on page 29. They were then instructed to answer the following questions:

If an organization was accountable for the health and health care financing of a defined population:

1. How would it look different for the consumer?
2. What would your community need to do differently? What would be the key components?

Summary: Breakout groups report back (8:15)

The Team reconvened as a group to discuss some of the ideas and issues that were discussed during the breakout sessions. One major theme was the need for a navigator, or a support system, for the patient. Patients need a responsible entity that is advocating for their health needs and directing them in the right direction.

A summary of the break out group reports can be found [here](#).

Closing remarks and notes on next week (8:30)

A brief, unfinished discussion ensued as to who is the target population for this Team.

Adjourn (8:35)**Next meeting:**

February 16, 2011

**3414 Cherry Avenue,
Suite 150 - Mt. Mazama Room ,
Keizer, OR 97303**

6:00 PM to 9:00 PM

Group Breakout Session Summary

Health System Transformation Team, 2-9-2011

Two (or sometimes more) best ideas from each group during break out sessions.

Red group (1):

First point: we can't do any of this with less money!

- 1) Different arms of the system reach out to patients – the problem is that the coordination, the “hand-offs” from one to the other is poorly executed, and people become “lost in the transitions.” For some people, it is as much a problem of proper social networking as it is poorly applied medical care.
- 2) Where are the points of accountability in the system? It would make sense for a point of accountability to be with a good primary care physician, but the incentives aren't set up for that doctor.
- 3) There must be generalized case management that looks at the person as a whole.
- 4) Lastly, there is a navigation problem within the system. It is hard, as a patient, to ask a question and receive a helpful answer in a well communicated way which would allow the patient to make an informed and healthy choice. Navigating the medical system is something that you must learn, and most patients simply do not know how to do it.

Green group (2):

- 1) These are not all medical issues – they are social systems issues. There is a need for people to support others. The medical system should look like a family social network. The patient should never feel alone.
- 2) Providers should be held accountable for outcomes: Financial, clinical, patient experience. They could be granted blocks of money based on accountability.

Yellow group (3):

- 1) Coordination; Data sharing; Choice.
- 2) The individual consumer is a key factor here, and they need to have choice – the ability to choose among plans, providers, etc. The individual wants to know that they are being heard, and that their needs are being met. Indeed, if that is the case, the provider will be rewarded with the consumer's business.

Pink group (4):

- 1) Easy access.
- 2) There should be a plan that identifies all of a patient's needs.
- 3) There should be a robust needs and asset assessment.
- 4) A breakdown of the silo model would lead to a complete redesign of the care system.
- 5) Need for a community integrator that can connect financing with care.

Blue group (5):

- 1) It is critical to work backwards from the individual – base our models around individual plans and what they need and that will help us design a larger system that meets patients' needs. For example, a system that will provide the correct transportation for those who may need that service.
- 2) There is a need for easy access, both when and where.
- 3) Models of communication that are relationship based.
- 4) Importance of aligning accountable care organizations to reflect a more natural community of care so that you can improve collaboration and coordination and better respond to an individual's needs.
- 5) Also addressed the access issue – it was brought up that cutting reimbursement rates will not make the access issue any better.

Medicaid in Oregon

Defining the Population

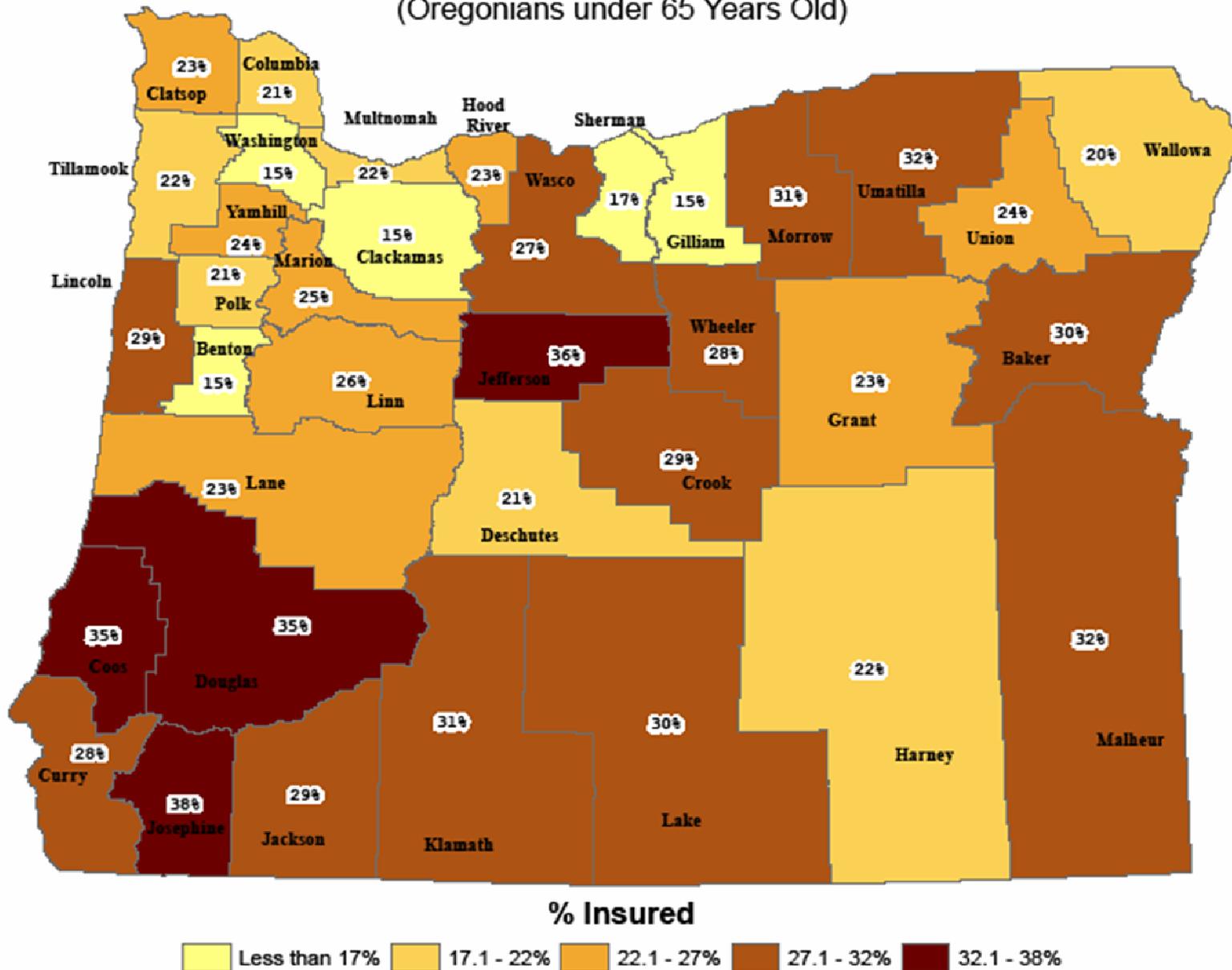
Health System Transformation Team Meeting
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Oregon Health Plan's Reach

- About 2 million people have had their health care covered by OHP since it began in 1994 (unduplicated count)
- Nearly one in three of all Oregonians have been on OHP at some point in their lives
- Approximately 40 percent of Oregon's births in 2007 were covered under OHP

Oregon Health Plan (OHP) as Percent of Total Insured (Oregonians under 65 Years Old)



Data were provided by: DHS website, http://www.oregon.gov/DHS/healthplan/data_pubs/enrollment/2010/1110/main.shtml;
Oregon population statistics provided by Portland State University.

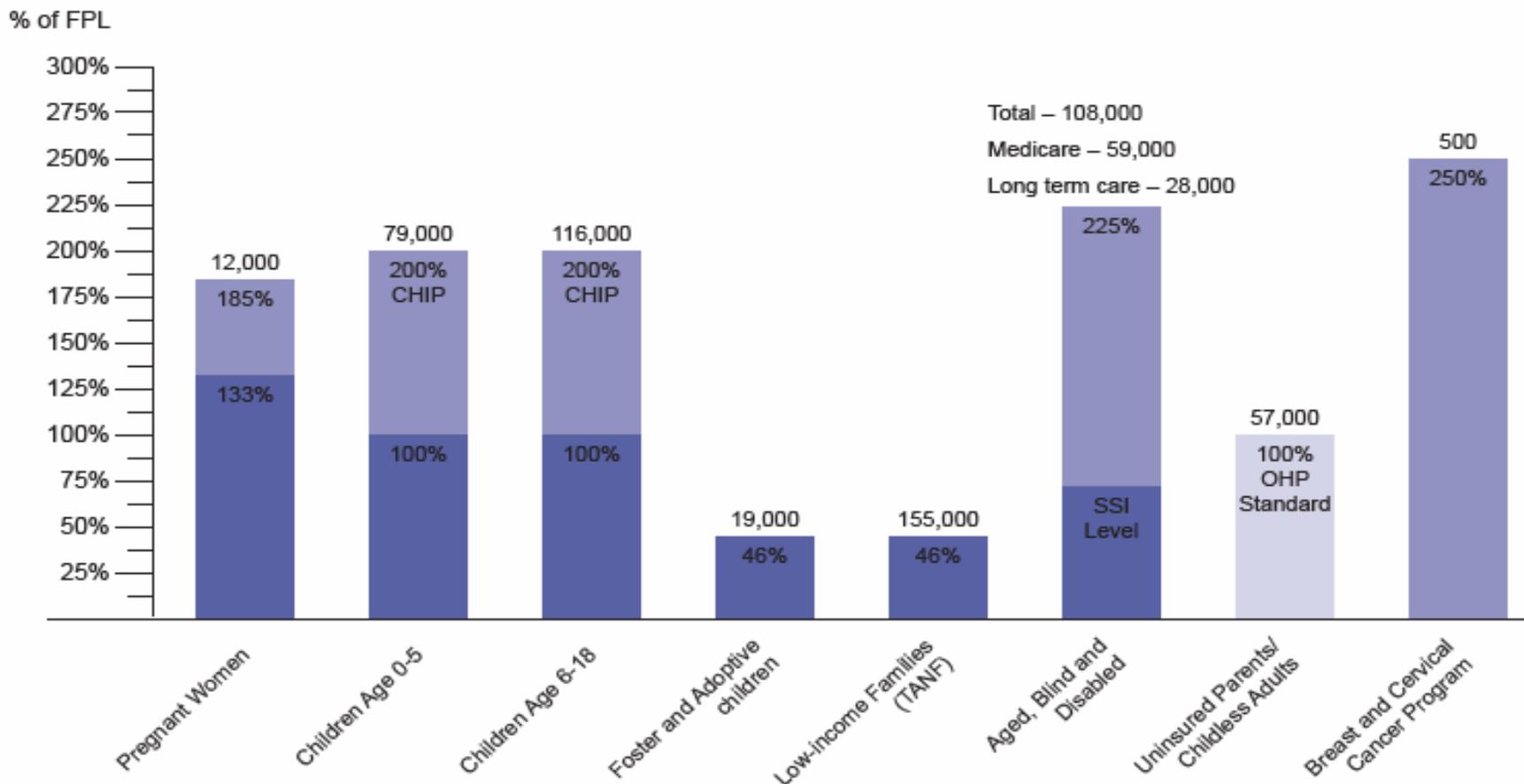
In Oregon, Medicaid touches about a half a million lives

- Today, OHP is the health insurance provider for approximately 15 percent of all Oregonians and almost 38 percent of all Oregon children
- This is almost 500,000 lives

And

- Oregon's Medicaid enrollment is expected to increase by almost 60% by 2019

Health System Transformation Medicaid Eligibility Groups



* Aged, blind, and disabled populations meeting long-term care criteria are eligible up to 300% of the SSI level (which is equivalent to approximately 225% of the FPL); otherwise, these populations are eligible up to the SSI level.

Medicaid Eligible Groups

- **OHP Plus** covers about 490,000 people (mandatory Medicaid)
 - About 65% are under age 19
 - All must qualify for a “category” to be eligible
 - Low-income pregnant women
 - Low-income children
 - Low-income foster children
 - Families receiving Temporary Assistance for Needy Families (TANF);
 - Low-income elderly, blind & disabled

Medicaid Eligibly Groups:

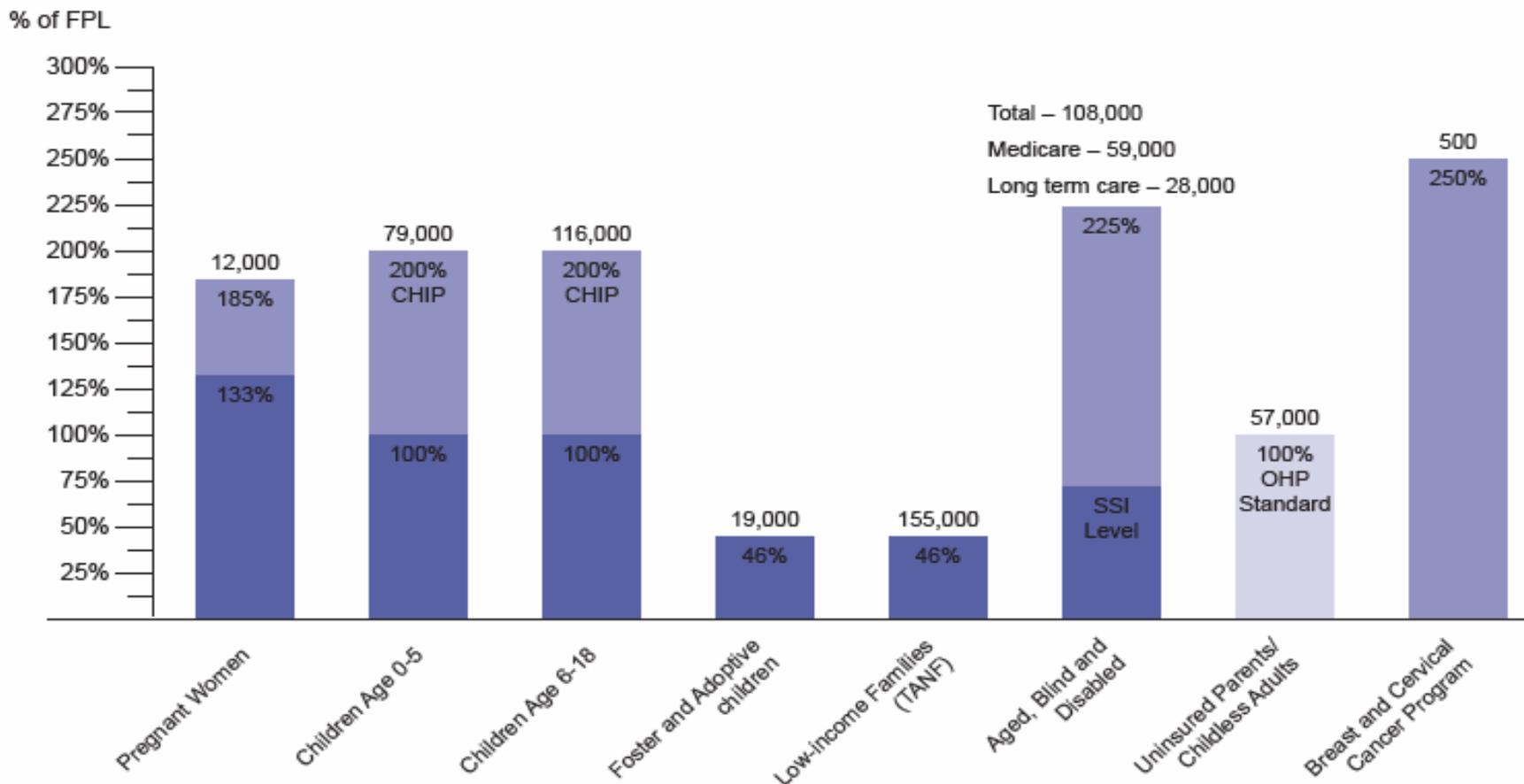
Medicaid and Medicare linkages

- Approximately 59,000 very low-income seniors and younger people with disabilities are enrolled in both Medicare and Medicaid
- Those with both Medicare and Medicaid represent only 14% of Medicaid enrollment, but account for 27% of Medicaid spending in Oregon
- 84% of the spending for this population was for long-term care services

Medicaid Eligibility Groups

- **OHP Standard** covers about 57,000 clients (expansion population)
 - Parents and childless adults under 100% FPL who don't qualify for a "category" of OHP Plus
- About 500 women receive treatment through the **Breast and Cervical Cancer Program (BCCP)**

Health System Transformation Medicaid Eligibility Groups



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Oregon
Health
Authority

**FOR DISCUSSION BY HEALTH SYSTEM TRANSFORMATION TEAM:
Elements for Accountable Health and Long-term Care Services**

Design Requirements:

- Capped total spending and financial management
- Defined population
- Local accountability for care, cost, and health and well-being
- Quality improvement and performance monitoring

Goals	Essential Elements for Implementation	Notes
<p>Accountable entities improve the quality of care, lower cost and improve health and well-being.</p> <p>Accountable entities allocate resources and deploy strategies to achieve the Triple Aim, reducing duplication and unnecessary capacity.</p>	<ol style="list-style-type: none"> 1. The global budget is set to reflect community values (<i>needs clarification</i>), what we can afford, and evidence about what promotes health. 2. There is a risk-adjusted population-based global budget for all care and support services that reflects health risk and functional limitations of clients. 3. For maximum accountability, all payers operate under the same budget. 4. The community sets performance goals using statewide standard measures for each facet of the Triple Aim. 5. Payment systems support providers to work together for best outcomes. 6. Providers are paid so as to support care team activities that are not currently billed under a code. 7. Provider payment rewards efficiency and quality and result in savings. 8. Unnecessary capacity (buildings, equipment, workforce) is eliminated and redeployed. 9. Value of capital investments is evaluated from a Triple Aim perspective, not the financial perspective of an individual provider. 	

Goals	Essential Elements for Implementation	Notes
<p>Accountable entities are responsible for the health and well-being of a clearly defined population.</p> <p>Care and services reflect community needs and values and are delivered in collaboration with the community, clients and their families, and providers.</p>	<ol style="list-style-type: none"> 10. The population for which accountable entities are responsible is geographically defined. 11. Accountable entities know their communities, including resources and gaps in services. 12. Accountable entities and providers know their population’s health needs, functional status, demographic factors such as race, ethnicity, culture, language, religion. 13. Accountable entities target populations with multiple chronic conditions, cultural needs, or other unique factors to ensure services/supports are tailored. 14. Accountable entities increase prevention efforts, collaborating with public health. 15. Accountable entities partner to support community health teams, community health workers, and others to conduct community health assessments, and develop and execute plans. 	
<p>Health equity is prioritized and disparities are reduced.</p>	<ol style="list-style-type: none"> 16. Local leadership and governance <ul style="list-style-type: none"> • Governance and leadership of accountable entities support health equity. • Governing boards represent community diversity and include substantial client representation. 17. Access and outcomes for subpopulations are measured, including those defined by race, ethnicity, religion, age and disability. 18. The accountable entity works with community organizations, patients, and families. 19. Communication is in the client’s language 	

Goals	Essential Elements for Implementation	Notes
<p>Patients/clients have a consistent and stable relationship to a care team.</p>	<p>and delivery system approach is culturally appropriate.</p> <p>20. Clients and their families have a long-standing relationship with a care team of providers and community resources appropriate to the individual's needs as a whole person. A navigator helps ensure a client will always know assistance is available.</p> <p>21. Accountable entities involve clients and families through transparency, education, shared decision making, and individual empowerment.</p> <p>22. Clients are able to choose their providers.</p>	
<p>Accountable entities manage the full spectrum of patient/client services and settings ensuring continuity of care for the population/clients.</p>	<p>23. The care team works with the client to navigate the system and develop an individual care and service plan.</p> <p>24. Care team leadership and composition vary according to client needs.</p> <p>25. Clients receive information supporting their involvement in managing their own care—including long-term care services and treatment choices.</p> <p>26. There is an adequate provider network.</p> <p>27. All network providers are educated about and committed to the integrated approach.</p> <p>28. Accountable entities build the capability and infrastructure necessary to support patient-centered primary care homes and care teams.</p> <p>29. There is a defined way for providers to access and communicate timely information.</p> <p>30. Providers have, use, and exchange electronic health information.</p>	

Goals	Essential Elements for Implementation	Notes
	31. Handoff protocols are adopted and followed to address care transitions. 32. Access and service level standards are identified and met (i.e., 24/7 support). 33. Care and services are evidence-based.	
Providers work together to develop and test best practices to improve processes for care and service delivery	34. The accountable entity works with providers across silos and licensures to develop agreed upon processes of care where opportunity is greatest. 35. Improvement targets are set and performance measured.	
Improvement is driven by setting objectives, measuring, reporting, and rewarding quality	36. Providers develop capacity to measure, report, set goals and act on metrics using clinical and administrative data 37. Information about client and provider experience is collected 38. Per capita cost of care and quality measures for each population are defined, measured, and made transparent. 39. A data aggregator shares quality and cost information with providers, accountable entities, and clients	

Public Input for the Oregon Health Policy Board and
Health System Transformation Team
February 7, 2011 to February 14, 2011

Doc #	Summary	Comment Type	Writer
1	There are inefficiencies in the pediatric rehabilitation sector that could very easily be rectified, with just a few changes. It would save money and work hours.	Email Submitted: 2/8/2011	Janice Cockrell, MD Legacy Emanuel
2	In support of different utilizations of Electronic Health Records, as well as other innovations. Writer supports Governor Kitzhaber's efforts to reach out to Oregonians and ask for support and ideas about healthcare reform.	Email Submitted: 2/8/2011	William R Andrews
3	A request to stop airing the anti-smoking advertisement featuring "Debi" the smoker. It is appalling and nauseating.	Email Submitted: 2/10/2011	Norma Jean Peterson
4	The Clackamas, Multnomah and Washington County Boards of Commissioners strongly support the health delivery system redesign efforts. Integrated and accountable local healthcare management will be critical. These 3 counties comprise about 50% of the OHA's insured customers, and hope to offer expertise and commitment in helping redesign Oregon's healthcare delivery system.	Letter dated 2/9/2011	Chair Lynn Peterson, Clackamas County Board of Commissioners Chair Jeff Cogen, Multnomah County Board of Commissioners Chair Andy Duyck, Washington County Board of Commissioners
5	There is a widespread problem of hospitals administering primary care in the Emergency Department, at great financial expense. Perhaps a system could be created that would address that issue, such as a list of specified diagnoses that differentiated between emergent episodes and non emergent episodes.	Email Submitted: 2/11/2011	Greg Dilkes
6	The Oregon Alliance of Senior & Health Services is supportive of moving the health system towards one with a greater emphasis on home and community based services, but in this email it raises a number of questions that must be considered throughout the process.	Email Submitted: 2/12/2011	Ruth Gulyas
7	There are successful models of long term care delivery in Oregon that are superior to those from other states that were presented last week. The Oregon LTC system needs some adjustments, but let's not "throw the baby out with the bathwater."	Email Submitted: 2/13/2011	Michael Saslow
8	The abandoned comprehensive annual statistics reports on hospitals, nursing homes, and assisted living facilities should be restored.	Email Submitted: 2/13/2011	Michael Saslow

9	The single most costly aspect of our health care system is the lack of integrated electronic medical records (EMR). Using EMR will reduce errors, save time, and reduce redundancies.	Email Submitted: 2/14/2011	Chris Betts
10	Recent experience in assisted living indicated that the facility was too quick to order costly medical assistance.	Email Submitted: 2/14/2011	L.M. Reese
11	Stop reimbursing for high risk home births.	Email Submitted: 2/14/2011	Molly Blaser
12	Submitted by the grandmother of a disabled 3 year old boy who has Medicaid coverage. There are not funds to provide the in-home care that is needed. The family is forced into placing the grandchild in a nursing facility, which the state will pay for, but which is much more costly than providing in-home services and allowing the child to remain with his family.	Email Submitted: 2/14/2011	Patricia Ramirez