

OREGON HEALTH FUND BOARD – Delivery Systems Committee

April 17, 2008
1:00 – 5:00 pm

CCC - Wilsonville Training Center Room 111- 112
29353 Town Center Loop East
Wilsonville, Oregon

MEMBERS PRESENT: Dick Stenson, Chair
Maribeth Healey, Vice-Chair
Doug Walta, MD, Vice-Chair
Mitch Anderson
Tina Castanares, MD
Vickie Gates
David Ford
Bill Humbert
Dale Johnson
Carolyn Kohn
Diane Lovell
Bart McMullan, MD
Stefan Ostrach
Ken Provencher
Lillian Shirley, RN
Mike Shirtcliff, DMD
Charlie Tragesser
Rick Wopat, MD

MEMBERS ABSENT: Vanetta Abdellatif

STAFF PRESENT: Jeanene Smith, MD, Administrator, OHPR
Tina Edlund, Deputy Administrator, OHPR
Ilana Weinbaum, Policy Analyst
Zarie Haverkate, Communications Coordinator

ALSO ATTENDING: Quality Institute Work Group Members:
Jim Dameron, Administrator, Oregon Patient Safety Commission
Gwen Dayton, Oregon Association of Hospitals and Health
Services
Ralph Prows, Chief Medical Officer, Regence of Oregon

Others:
Susan Tolle, Center for Ethics in Healthcare, OHSU

- Call to Order/Review of 03/31/08 Meeting Minutes
- Invited Testimony – American Health Association/American Stroke Association
- Recommendations from the Quality Institute Work Group
- Review of Additional Strawperson Recommendations
- Public Testimony

These minutes are in compliance with Legislative Rules. Only text enclosed in italicized quotation marks reports a speaker's exact words. For complete contents, please refer to the recordings.

- Chair Stenson**
- I. Call to Order/Approval of 03/31/08 Meeting Minutes (See Exhibit Materials 1)**
- Meeting was called to order. There was a quorum.
- Motion** to approve minutes is seconded. **Motion passed unanimously.**
- Beth Gebstadt**
- II. Invited Testimony – American Heart Association/American Stroke Association**
- Beth Gebstadt, MPH, MS, with Phil Donovan, both of the American Heart/American Stroke Association and Dana Kaye, Executive Director of the American Lung Association presented testimony. (See Exhibit Materials 2).**
- Focus on two areas: Tobacco Use and Obesity
- Tobacco Use
 - Noted that funding was lost in 2003 in Oregon for tobacco prevention programs and was recently reinstated in 2007. Members and presenters discussed diversion of the funds between 2003-2007 and requests that some of these unobligated funds be used for tobacco prevention although none have been.
 - Obesity
 - Related skyrocketing rates of obesity in Oregon.
 - Stakeholders are developing an obesity prevention program using the CDC best practices model.
 - Approaches include setting minimum minute standard for PE requirements but funding needs to be designated for this.
 - Progress made in removing junk food from schools.
 - Adult onset of diabetes and costs to healthcare are discussed.
 - Both of these areas contribute to the five major diseases that impact healthcare spending.
 - Question about other partners that could be included in efforts to prevent and reduce obesity.
 - Public health program would start at the Division of Health Services of Public Health Division.
 - Funding could go to county level, county health departments, nonprofit agencies, community health partnerships, before and after school programs, and is also looking at childcare.
 - Connecting young people with the physical environment and partnering with outside entities, e.g. Department of Forestry. Related reports that connection with physical environment leads to more physical exercise (e.g., hiking, walking, camping).
 - Difficulties of developing effective strategies for obesity are discussed. Difficult to create environmental change and a cultural shift toward walking/bicycling.
 - Debate over whether appropriate for employers to charge employees who smoke or are overweight more for their premiums.

III. Recommendations from the Quality Institute Work Group (See Exhibit Materials 3 (PowerPoint presentation) and 4).

Quality Institute (QI) members Vickie Gates, Chair, and Maribeth Healey, Vice Chair overviewed the group's recommendations

- Overviewed the process and inputs that were provided to the group during the development of their recommendations.
- Page 11 - Overview of the definition of quality.
- Page 12 - Transparency definition related.
- Page 12-13 – Problem statement discussed.
- Strategies for increasing transparency (page 14) related.
- Quality Institute roles (pages 14-15).
- Quality Institute funding and structure
 - Would be chartered as a public-private corporation, not a State agency.
 - Board members would be appointed by the Governor and would not be State employees.
 - Funding from private and public entities discussed. Must be stable and substantial public funding, supplemented by private funding.
 - QI will partner with another organization to reduce administrative costs.
 - Funding request explained.
 - Collaboration with other stakeholders and strategic investments in collaborative initiatives.
- Logic model presented.
- Reference to letters from Patient Safety Commission (**See Exhibit Materials 5**) and the Quality Corporation (**See Exhibit Materials 6**) is related.
- **Gwen Dayton, Oregon Association of Hospitals and Hospital Systems** discussed her experience working with the group.
 - Explanation of National Surgical Quality Improvement Project. Presented as an example of a strategic partnership that could be expanded with state support.
 - Dialogue on maintaining public and private stakeholders, looking at what is being done in others states, leveraging information from both public and private sectors.
 - Appreciation to Jeanene Smith, M.D., of the OHPR staff for the efforts and results produced.
 - Assertion that this is a long-term process that will take time.
- **Jim Dameron, Administrator of the Oregon Patient Safety Commission**, outlined his involvement in the work group and how the Patient Safety Commission provided a model for the work group to consider. Discussed the structure and funding of the Commission.
- Stable and significant public funding and a state commitment to long term funding is necessary.
- Need to look outside of the U.S. to see what other countries are doing in quality improvement. It was related that part of the Institute's role would be to bring the best of all work to the state.
- Breadth of the Quality Institute in relation to value, cost and transparency of expenditures discussed.
- Committee member questions why we need a new organization and new board when there is the Oregon Health Policy Commission, Health Policy Research Office, the Health Fund Board, etc? Suggested that will not be able to get ten-year funding from the legislature.

- Quality Institute Work Group believes there needs to be a well-funded, dedicated organization to lead and coordinate efforts. These responsibilities cannot be given to an existing organization without the funds and resources to support the work.
- Questions regarding simplification: What is the standard that quality is being measured against? (Is that something you see the QI establishing?) How will you compel and who will you compel? How will QI relate to Accountable Care Organizations (ACOs)?
 - Compelling is about the submission of data and about the ability to have the kind of decisions to make improvements in a transparent way.
 - The ACOs would be part of the commitment to use data to improve quality.
- Member suggests that in business, when one finds a better use of funds, something is “turned off” in another area. Suggestion to look at opportunities to redirect funds. Several members comment that state government is not currently investing enough funds in quality improvement to allow for redirection.
- Recommendation that Quality Institute must be closely linked to accountable care organizations. Report should relate that efforts of the Quality Institute shouldn’t just focus on giving the healthcare system the data and support it needs to evaluate itself, but needs to create a system that supports community evaluation of performance.
- Recommendation that role of the consumer is made stronger in the document.
 - Definition of transparency needs to include “understandable to general public.”
 - It was observed that statements in the recommendation regarding consumers are always the last bullet point and it comes across as an afterthought. Recommendation that bullets should be reordered to reflect higher priority.
- Discussion about whether Committee is comfortable having an organization driven by political appointments.
- It was suggested that Quality Institute has to play a significant role in setting standards for how data is collected to reduce duplication.
- Quality Institute will use the best of the work out there to develop and set standards. Discussion of Hospital Association initiatives to develop common measures, as an example of work that might be endorsed by the Quality Institute rather than replicated.
- Discussion on lack of program evaluation around OHP. Measuring effectiveness of changes of reform once it is implemented is necessary.

Motion to recommend QI report is seconded.

Chair Stenson

IV. Public Testimony

- Dan Klosterman, from Wilsonville, provided testimony on using a systems approach and the need to identify measurement goal first or money will be wasted. Testified on needing to educate and linking measure to well-being of state.

Call for the Question. Motion to approve QI recommendations is passed unanimously.

Presentation by Dr. Susan Tolle, OHSU, on the 18th Annual Kinsman Ethics Conference in Medford, Oregon (See Exhibit Materials 10).

- Susan Tolle presented background on the Kinsman Conference and an overview of the conference paper.
- Committee discussion on ethics of health care reform
 - Setting limits and making decisions about what won't be covered.
 - The rising cost of health and need to identify ineffective care currently delivered.
 - Universal access can only be achieved if tough decision-making is done.
 - Aggressive treatment at end-of-life.
 - Individual mandate (page 8).
 - Health care for immigrants (page 8).
 - Shifting funds for societal gain.
 - Universal access vs. universal care, shared responsibility vs. individual responsibility and issue of payment based on severity of illness.
 - Paying for research through patient care dollars.
 - "Too emotionally difficult" for providers to tell patient/family that something will not be funded. It was debated, however, that patients are frequently told they cannot have a procedure because they don't have the money. It was asserted that having the line defined would allow providers to be able to communicate this with patients.
- Members expressed difficulty in defining delivery system without having the Benefits Committees' recommendations on what would be covered.
 - Dissention on the role of Committee in addressing limits and priority setting.
 - Staff will provide the Benefits' Committee draft report.

Jeanene Smith

V. Review of Additional Strawperson Recommendations (See Exhibit Materials 7 and 8).

Decision support recommendations (See Exhibit Materials 7)

- **Recommendation 1**
 - Debate on suggestion in 2nd sentence to add "within the defined evidenced-based benefits package" after "alternate treatments and patient preferences" to add "within the defined evidenced-based benefit package." Decision to leave as written.
 - Add advanced directives to last sentence.
- **Recommendation 2**
 - First sentence - remove "codes" from first sentence and replace with "methods."
 - First sentence – make entire statement apply to both public and private health plans and purchasers.
 - Dissention on using incentives expressed. Treatments at end-of-life discussed. Current system penalizes providers for having conversations with patient.
- **Recommendation 3**
 - Rationale for stressing advanced chronic illnesses is related to the high costs involved.
- **Recommendation 4** – Question as to whether registry should include advance directives.
- Further testimony by Susan Tolle, MD:

- Philanthropic dollars are being used to create a POLST registry with emergency communications system housed at OHSU.
- Other models that use advance directives are not working.
- HIPAA and privacy rules limit access to registry.
- Studies related that 25% of the time POLST information is not available when needed.
- Registry could be implemented by July 2009.

Motion to support the concept of the decision making recommendations with the changes discussed is seconded.

Further discussion on POLST:

- Four sections of the POLST form are overviewed including the 2nd section as being most powerful for impacting care as it guides intervention efforts.
- Difference between advanced directive and POLST form. POLST form is for persons with advanced illness. POLST includes physician orders and allow EMTs to follow patient wishes.
- Staff will provide members copies of advanced directive and POLST forms.
- POLST program (not registry) is being replicated in 15 other states.

Call for the question. **Motion passed unanimously.**

Payment Reform Recommendations (See Exhibit Materials 8)

- **Recommendation 1** stated.
- **Recommendation 2**
 - Legality of a single price for all purchasers. Does this imply price fixing?
 - Suggestion to change to more general statement requiring transparency of prices.
 - Debate around effectiveness of posting prices, price competition and regulatory measures.

Motion to remove recommendation #2. **Motion rescinded.**

Motion to retain first sentence of recommendation #2 and remove remainder of recommendation is seconded.

Discussion:

- Assumptions are being made and the impact of requiring greater price transparency is not known.
- Complexity of changing compensation structure of delivery system and strategy to be permissive rather than prescriptive. First line is permissive.
- Must align with work of the QI (see recommendation 1).

Call for the question. **Motion passed** by majority with two dissenting votes.

- **Recommendation 3**
 - Example of an MD who changed his practice to include more contact through email, etc. is related. Did not change payment structure and was able to save money.
 - Concern expressed that it is framed around primary care rather than a holistic approach.
 - Several members expressed concern about move to global budgets.
 - Committee consensus that payment recommendations need additional work but agreed on the basic principles. Agreement that need to be more permissive and less prescriptive.
 - Concern that just setting up another commission, without changing the way things are done.
 - Staff to reconvene payment reform staff review panel.
 - Members are asked to submit comments to staff.

Chair Stenson

VI. Public Testimony

- **Craig Hostetler, Oregon Primary Care Association (OPCA)**, encouraged the Committee to explicitly identify goals of payment reform and related that he has been working with a national group on defining patient-centered medical homes.
 - Discussion on capitated payments to community health care clinics and moving away from the visit-based mentality.
 - Payment incentives should be available to all members primary care team and not just the physician.
 - Build towards process and outcome measures and then establish global payment. Global payment without the right measures for accountability would be difficult.
 - Culture shift in primary care discussed.
 - Mr. Hostetler will send letter with information and suggestions to Committee.

Chair Stenson

IX. Adjourn

Chair Stenson adjourned the meeting.

Next meeting is April 28, 2008.

Submitted By: Paula Hird

Reviewed By: Ilana Weinbaum

EXHIBIT SUMMARY

1. Minutes from 03/31/08.
2. Reducing the Demand for Healthcare
3. Quality Institute Recommendations (PowerPoint)
4. Quality Institute Recommendations (Written)
5. Letter from Jim Dameron of the Oregon Patient Safety Commission
6. Letter from Nancy Clark, Executive Director, Quality Corporation
7. Decision support strawperson
8. Payment reform strawperson
9. Public Health Strawperson
10. 2008 Kinsman Ethics Conference Summary