

# Oregon Health Policy Board

## AGENDA

SOU/RCC Higher Education Center Room 132

101 S Bartlett St, Medford, OR 97501

September 9, 2014

Live web streamed at: <http://sou.edu/video>

#	Time	Item	Presenter	Action Item
1	8:30	Welcome, call to order and roll - <b>Action items:</b> 8/5/14 minutes Approval of workforce committee members	Chair	X
2	8:40	Panel: Coordinated Care Organizations		
		Lyle Jackson, MD Chief Medical Officer of AllCare Health Plan  Bill Guest Former CEO of Cascade Health Alliance Current CEO of Willamette Valley Community Health CCO  Jennifer Lind Regional Executive of Jackson Care Connect  Jennifer Johnstun Director of Quality Improvement at Primary Health of Josephine County, LLC		
3	9:35	Panel: Hospitals		
		Patrick Hocking Chief Administrative and Finance Officer of Asante Hospital Group  Christopher Pizzi Director of Finance of Providence Medford		
4	10:10	Break		

		Panel: Patient-Centered Primary Care Homes (PCPCHs)	
5	10:20	<p>Sarah Lamanuzzi, MD, FAAFP Director of Klamath Open Door FQHC</p> <p>Kristin Miller, MD Chief Medical Officer, Siskiyou Community Health FQHC</p> <p>Rick Williams, MD Mountainview Family Practice Clinic</p> <p>Mimi Choate, MD, MPH La Clinica</p>	
		Panel: Behavioral Health	
6	11:15	<p>Karla McCafferty CEO, Options for Southern Oregon</p> <p>Rita Sullivan, Ph. D. Executive Director, OnTrack</p> <p>Bob Lieberman CEO, Kairos NW</p> <p>Jim Shames, MD Medical Officer, Jackson County</p> <p>Mark Bradshaw, MD Behavioral Health Medical Director of AllCare Health Plan</p>	
7	12:20	Public Comment	
8	12:30	Adjourn	

**Next meeting:**

October 7, 2014

OHSU Center for Health & Healing

3303 SW Bond Ave, 3<sup>rd</sup> floor Rm. #4

1:00 p.m. to 5:00 p.m.

**Oregon Health Policy Board**  
**DRAFT Minutes**  
**August 5, 2014**  
**OHSU Center for Health & Healing**  
**3303 SW Bond Ave, 3<sup>rd</sup> floor Rm. #4**  
**1:00 p.m. to 5:00 p.m.**

**Item**

**Welcome and Call To Order**

Vice Chair Dr. Carla McKelvey called the Oregon Health Policy Board (OHPB) meeting to order.

Leslie Clement and Suzanne Hoffman were present from the Oregon Health Authority (OHA).

**Consent Agenda:**

The meeting minutes from June and July were unanimously approved.

Approval of new Healthcare Workforce Committee members. View the entire document [here](#)

**Director's Report – Suzanne Hoffman**

Suzanne reviewed recent stories regarding system challenges, including the number of Medicaid enrollees that came into the system all at once, and capacity issues that certain CCOs were experiencing. As of August 1, Cascade Health Alliance has re-opened to adults. Trillium is the only CCO with partial closure to adults and is working on a plan to accommodate larger capacity.

Suzanne also noted an innovation success related to Trillium: “Trillium Goes Beyond the Mark to Help Smokers” which brings together prevention and the public health piece of health system transformation. Trillium is going beyond the norm by giving more than 89,000 members access to counseling and pharmaceutical benefits and training counselors to work with tobacco cessation.

Quality Data was provided to the Board in the June meeting by Lori Coyner and there is continued positive coverage and feedback regarding the data being made available for the first time. Updated data will continue to be brought to future meetings.

**Technology Transition Update – Tina Edlund – Governor's Office**

Tina Edlund provided an update on the technology transition update, outlining the following key points:

- Last week was the release of the first Maximus Quality Assurance Report, which is an independent external review of the transition project.
- By November 15, 2014:
  - Oregonians eligible for commercial coverage and tax credits can apply, shop and choose a plan online all in one sitting at [healthcare.gov](http://healthcare.gov)
  - Oregonians eligible for Medicaid will have a more streamlined process to apply online through Oregon Health Authority

Tina spoke to accountability and oversight for the transition project and reviewed the Maximus Quality Assurance report; both can be viewed [here](#),

**Update on activities related to the 2013 OHPB Recommendations to the Governor – Leslie Clement, OHA**

Leslie Clement provided an update on the following committees:

### **Oregon's Health System Transformation Quarterly Progress Report**

- Going forward, Analytics will provide semi-annual reports to the Board, rather than quarterly
- The report in December 2014 will be presented to OHPB in early January, in time for the legislative session.
- The report in June 2015 (tied to the final 2014 performance and 2014 quality pool distribution) will be presented to OHPB in early July 2015.

### **APAC Measurement Framework**

- The measurement framework report schedule will be updated following the Board Planning Session, in order to ensure that reports are being provided in the most useful and actionable format with the most relevant content.

### **OHPB Healthcare Workforce Committee**

- Ann Buchele, Cathryn Cushing and Marc Overbeck from OHA will discuss with the Board a policy options memo and a report on strategies to align provider incentive programs.

### **Sustainable health care expenditures workgroup (SHEW)**

- John McConnell will provide the Board some background information and updates on the workgroup.

### **Coordinated Care Model Alignment and Spread**

- The first meeting will be August 13
- In addition to describing the workgroup's charge, the focus will be on developing an understanding of the Coordinated Care Model and its implementation status on the non-Medicaid side. The group will also engage in a discussion about the barriers, opportunities, and needs of their market segment as they begin to think about innovative purchasing strategies, with an eye toward the CCM.
- Over the next few months they will focus on developing an environmental scan that will be informed by the PEBB, OEBC, Cover Oregon, and the market segments represented among our committee members. This environmental scan will highlight alignment efforts across various purchasers.

### **Oregon Insurance Division**

- Laura Cali will provide an update on rate review

### **Workforce Committee Update – Ann Buchele, Chair; Cathryn Cushing, OHA, Marc Overbeck, OHA**

- Cathryn Cushing presented the Health Care Workforce Committee presentation on Expanding Graduate Medical Education report, which can be viewed [here](#).
- The Board accepted the Policy Options memo for expanding graduate medical education and agreed to move forward with due diligence to explore the creation of the consortium. The Board expressed support for the direction that the Committee has suggested and encouraged the relevant entities to follow-up on the recommendations.
- Marc Overbeck presented the Health Care Workforce Committee presentation on the Financial Incentive Programs in Oregon report, which can be viewed [here](#), starting on page 10.
- The Board accepted and endorsed the recommendations in the Financial Incentive Programs Report.

## **Medicaid Advisory Committee Report on Strategies to mitigate and reduce churn – Janet Patin, MD, Co-Chair; Oliver Droppers, OHA**

Dr. Patin addressed churn and why it's an issue, estimates of churn between Insurance Affordability Programs under the ACA and committee processes, principles and recommendations.

- Churn is the involuntary movement of individuals from one health plan or system of coverage to another.
- Churn is an issue for multiple reasons:
  - Coverage gaps can lead to increased use of the ED and hospital for ambulatory sensitive conditions, poorer management of chronic disease, and lower rates of preventive care.
  - Differences in benefit coverage and provider networks can lead to fragmented, lower quality health care and increased costs.
  - Decreased affordability, i.e. higher out-of-pocket costs as individuals churn out of Medicaid into commercial coverage.
  - Undermines incentives for health plans/providers to invest in long-term health improvements.
  - Difficult to measure and compare quality across health plans over time.
  - Increased administrative expenses for state Medicaid programs and health plans.
- As of June 2014, 971,000 Oregonians were on the Oregon Health Plan
- Recommendations to Reduce and Avoid Churn in 2015:
  - Simplify and streamline OHP eligibility, enrollment and redetermination processes.
  - Align OHP income eligibility and QHP tax credits' income budget periods.
  - Conduct a cost-benefit analysis of adopting 12-month continuous eligibility for OHP income-eligible adults.
  - Adopt transparent eligibility and enrollment performance indicator(s) to monitor churn in OHP.

The Board accepted the report as it was presented.

View the entire presentation: Addressing Churn: Coverage Dynamics in Oregon's Insurance Affordability Programs [here](#)

## **CCO Presentation: InterCommunity Health Network – Kelley Kaiser and Kim Whitley**

Kelley Kaiser provided an overview of the InterCommunity Health Network (IHN) Coordinated Care Organization (CCO). The model used by IHN to achieve system transformation will demonstrate:

- Engagement of staff at all levels;
- Involvement and knowledge of providers
- Buy-in of provider/team/patient.

IHN's mission as a CCO:

- Legislated by Oregon HB 3650 to transform how health care is delivered
- Community-based management with global budget for physical, mental and dental health and non-emergent medical transportation
- Coordinate health initiatives
- Seek efficiencies through blending of services and infrastructure
- Engage all stakeholders to increase the quality, reliability and availability of care.

Kim Whitley, the Chief Operating Officer for InterCommunity Health Network CCO was excited to talk about one of their greatest successes which are the engagement of the community in how healthcare is delivered in the Tri-County area. Kim reviewed where the CCO is at today which along with the entire presentation can be seen [here](#).

### **Examination of Health Care Cost Trends and Cost Drivers – John McConnell, OHSU Center for Health Systems Effectiveness**

John provided a presentation on health care cost trends and cost drivers. John reviewed data from Kaiser Family Foundation and the Centers for Medicare & Medicaid Services (2011); for total per capita health care spending, Oregon ranked 34<sup>th</sup> overall. He also reviewed health care growth rates where Oregon ranked 12<sup>th</sup> per capita.

View the Examination of Health Care Cost Trends and Cost Drivers [here](#).

### **Affording High Cost Prescriptions – Tom Burns – OHA Director of Pharmacy Programs**

Tom addressed the Board's concerns regarding high cost prescriptions and technology and how they will affect the Board's overall goal of controlling the cost of health care. We are facing an issue of coming out of a time when the cost of prescription drugs remained relatively constant.

The Oregon Health Plan spends \$750 million on the biennium for prescription drugs and there are many pressures on that number, one of those being rebates.

Tom gave an example of an upcoming issue: the Hepatitis C drug Sovaldi, which is effective but very expensive. The Pharmacy and Therapeutics Committee have met in order to restrict the drug to only those who need treatment immediately. Tom reviewed options for better management of prescription drugs, which can be seen [here](#) on page 3.

### **OID Rate Review Update for 2015 – Laura Cali – OID**

Laura Cali, Insurance Commissioner, reviewed the rate review process that health insurers will be charging individual and small business consumers for the upcoming year. On average, insurance rates will be lower in 2015 than they were in 2014. Insurance companies have been notified of the insurance commission's decisions and final decisions will be rendered within the next few weeks. All of the information related to this process can be viewed on the Insurance Commissioner's website: <http://www.oregon.gov/dcbs/insurance/Pages/index.aspx>

### **Public Testimony**

Chris Alman, physician, commented on the pricing of pharmaceuticals. She passed out a draft commentary that will be in an upcoming issue of the Lund Report and referenced an equation that is used for the pricing of pharmaceuticals which is totally out of line with Sovaldi. Prices are being brought forward that have nothing to do with the reality of the cost of the medicine. She wants everyone to take a long hard look at what's happening with profiteering.

Nancy Armand, licensed marriage and family therapist, has been told she can only see patients that have an open card. Only 20% of the population have open card in Oregon. Some of those that were on open card have been changed back to managed care through the CCOs. She currently sees two individuals for free as they refuse to go to the CCO. Nancy has tried to talk to Umpqua Health Alliance and they referred her to the mental health provider in the area, Community Health Alliance, and they will not work with her. Leslie Clement and Nancy Arman will have further conversation to work through why there is a barrier between the CCO and the community providers.

### **Adjourn**

**Next meeting:**

September 9, 2014

8:30 a.m. to noon

RCC/SOU Higher Education Center

101 South Bartlett

Medford, OR. 97501

# OHPB CCO – Transformation Strengths and Challenges

September 9, 2014

Lyle Jackson, MD  
Chief Medical Officer  
ljackson@mripa.org

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## AllCare Health Plan Service Area



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## AllCare Transformation Update

- Increase in Enrollment: (39% enrollment increase since 12/31/13)
- Maintained Capacity: 1) >97% of the PCP network in our region – not solely relying on FQHCs 2) biggest challenge has been dental access– direct contracted with La Clinica dental providers and Advantage opened dental clinic in Brookings.
- Quality Improvement Highlights: 1) ↓ED utilization; 2) maternal health incentive; 3) early prenatal care; 4) Telemedicine in ED (Providence) and psychiatry.
- Population Health in our Community: 1) Funding a position at WHC – assesses all pregnant women for high risk factors; 2) Helped recruit a primary care provider for an outpatient mental health clinic – sees all people regardless of payer; 3) Opioid Prescriber Group – Josephine/Jackson County – developing structure and processes for providers and members; 4) JHIE – major sponsor since 2011; 5) provided scholarships to CHW training; and 6) paid for embedded staff at Gospel Rescue Mission to aid people in getting proof of identity (helped 112 people since 03/2013).

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## AllCare Transformation Update (continued)

- Service Area: 1) rural 2) Two of the poorest counties in Oregon (Josephine and Curry); 3) Sense of community – CHIPs already have work groups with consumers taking the lead in tackling the primary areas;
- Alternate Payment Methodology – 1) 3-pronged approach 2) starting with primary care and peds (specialists, behavioral health and dental to follow) 3) aligning payment with quality of care; 4) NEMT – ties payment to specific quality metrics
- Containing Cost – 1) least costly option; 2) avoid inpatient and ED services; 3) increase PCP utilization and 4) increase preventative care (for mental, dental and physical health)

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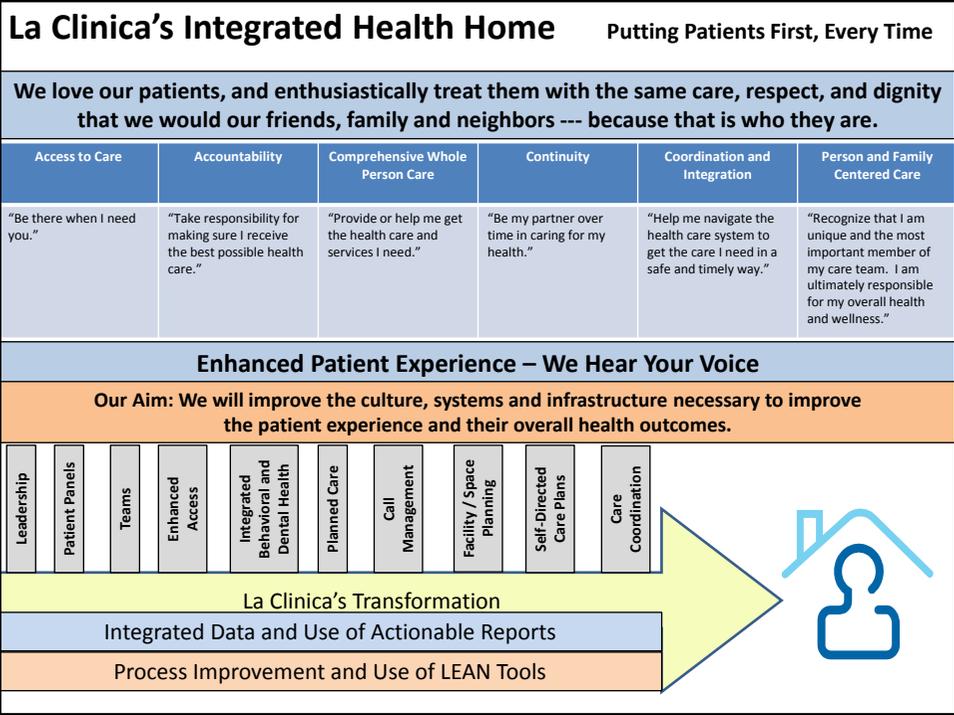


## Needed Policy Change Considerations:

- Allow flexibility in the designation of PCPCH – in rural primary care offices;
- Mental Health medications under the CCOs;

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## FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs) AND THE PATIENT-CENTERED PRIMARY CARE HOME (PCPCH)

Sarah Lamanuzzi, MD, FAAFP  
Klamath Health Partnership  
September 9, 2014

### WHAT IS AN FQHC?

#### ○ Health Centers are:

- **Located in (or serve) a high need community**
- **Governed by a community board** (51% or more are patients of the clinic)
- **Providers of comprehensive primary health care** (including things like education, translation and transportation)
- **Open to all** (fees adjusted based on ability to pay)
- **Accountable to many performance requirements** (including clinical/quality, administrative, and financial operations requirements)



WHAT IS A PCPCH?  
 OREGON'S PATIENT-CENTERED  
 PRIMARY CARE HOMES  
 HAVE SIX CORE ATTRIBUTES:



- **Accessibility:** “Be there when we need you”
- **Accountability:** “Take responsibility for us to receive the best possible health care.”
- **Comprehensive Care:** “Provide (or help us get) the health care & information we need”
- **Continuity:** “Be our partner over time in caring for us.”
- **Coordination & Integration:** “Help us navigate the system & get the care we need safely & in a timely fashion.”
- **Patient & Family Centered:** “Recognize that we are the most important part of the care team, and we are responsible for our overall health and wellness.”

Patient centered statements from Dr. Evan Saulino's PCPCH presentation at OAFP.

HOW IS AN FQHC IDEALLY SUITED FOR  
 PATIENT-CENTERED CARE?

- **Accessibility:**
  - Expected to have extended hours of service. (KHP: 8-6 m-f, 8-12 sat, hospital 24/7)
- **Accountability:**
  - Monitored yearly on numerous Quality of Care measures (16 medical measures for 2014).
- **Comprehensive:**
  - Expected to have medical care, preventive care, mental health care, nurse case management, and patient outreach as well as partnerships for care that cannot be provided on-site.
  - KHP: medical, dental, obstetric, mental health, enabling services, procedures, outreach, education, nurse case management

## HOW IS AN FQHC IDEALLY SUITED FOR PATIENT-CENTERED CARE?

- **Continuity:**
    - Primary Care Panels ensure evaluation and follow-up by a “team” of providers with whom the patient can establish a long-term relationship.
  - **Coordination & Integration:**
    - Expected to provide supplementary services including referrals, substance abuse counseling, mental health care, enabling services, education, and case management. (KHP: panel mgmt, case mgmt, preventive screening also.)
  - **Patient & Family Centered:**
    - Case Management: individual appointments with RNs for education regarding diet, medication management, insulin use, tobacco cessation, wound care, etc.
- 

## CHALLENGES TO CREATING PCPCH

- **Time**
    - Whole person care requires time from all staff and patients as well
  - **Staff**
    - Changing staff perspectives on providing care
    - Recruiting dedicated caring staff members
  - **Monetary Resources**
    - Not all services are “paid for” and the staff members that provide those services must be covered by other means
  - **Community Partnerships**
    - Time and dedication go into maintaining partnerships with community for better patient care
- 

## BOARD-APPROVED MISSION: OUR BOARD IS “ON-BOARD” WITH PCPCH!

### ○ Mission 1998:

- “We are dedicated to serving the community by providing excellent health care to all in a culturally sensitive manner with special emphasis on reaching those who are underserved.”

### ○ Mission 2005:

- “Our mission is to serve our community by offering excellent care and eliminating barriers to health.”

### ○ Mission 2012:

- “Our mission is to provide accessible, culturally sensitive, affordable, quality-driven, patient-centered health services to the community, with an emphasis on the underserved.”



**OHPB**  
**CCO – BEHAVIORAL AND PHYSICAL HEALTH INTEGRATION**  
**MEDFORD, OREGON**

**SEPTEMBER 9, 2014**

**MARK BRADSHAW, MD**  
**BEHAVIORAL HEALTH MEDICAL DIRECTOR**  
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## AllCare Behavioral Health Integration Update

### Successes:

- Curry, Josephine, and Jackson Counties -Primary Care services embedded in the CMHPs.
- Women’s Health Clinic – embedded mental health and A & D services
- Expanded A & D services to Primary Care offices in rural areas
- Embedded behavioral health workers in FQHC-La Clinica del Valle
- Behavioral Health Prevention Efforts: Early interventions for high risk families – Trauma Informed Care-Community wide trainings
- ER Provider meetings -**Increased Coordination = ↓ED visits ;**

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## AllCare Transformation Update (continued)

- Challenges:
  - 1) shortage of psychiatric providers
    - Limits key component of integration-supervision
    - Limits Access= >need for higher level behavioral health services
  - 2) models for integrating care in rural, small independent provider offices;
  - 3) providing services for individuals with non-SPMI;
  - 4) required matrix data gathering and documentation for MOTTs and DOJ
  - 5) EMR – data sharing.
  - 6) Specific Populations: TBI, dementia, DD, co-occurring disorders, personality disorders and in general, severity of illness

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## Needed Policy Change Considerations:

- Review policies for populations with non-covered mental health diagnoses
- Continued efforts for documentation simplification
- Mental Health medications

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# Options for Southern Oregon

Karla McCafferty, CEO

## Medical Home within Adult MH Clinic

- MH and Medical services wrapped around the individual.
- All providers know what is happening-daily “huddles”.
- Greater awareness of interactions and the impact of physical and psychiatric medications.
- Increased preventative care to help avoid metabolic syndrome that may result from psychiatric medications.

## MH Clinicians on-site at PCP Offices

- ✓ Engagement of high-risk pregnant women into mental health treatment quickly and efficiently.
- ✓ PCP's supported in real time with therapist on-site and timely psychiatric consultation.
- ✓ ER use averted.
- ✓ Improvements made in relationships and communication between medical and mental health practitioners.

## Priority 1 (P1) Meetings

Weekly cross-community staffing that focuses on "high-risk" individuals who interface with multiple community resources.

- Crisis Resolution Center clinicians
- CCO medical/behavioral health specialists and PCPs
- Public Safety/Corrections
- Mental Health/Co-occurring Disorders personnel, schools and other relevant community members
- ER personnel
- The individual's significant others

## Overdose deaths in US compared to motor vehicle accidents

