

## Oregon Health Policy Board

### AGENDA

November 9, 2010

Market Square Building

1515 SW 5th Avenue, 9th floor

8:30 am to 1:00 pm

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

#	Time	Item	Presenter	Action Item
1	8:30	Welcome, call to order and roll call Consent agenda: 10/12/10 minutes	Chair	X
2	8:35	Director's Report	Bruce Goldberg	
3	9:00	Oregon Blueprint for Health: Draft vision and structure	Jeanene Smith Gretchen Morley	
4	10:00	Report from Health Equity Policy Review Committee	Tricia Tillman	
	10:30	Break		
5	10:45	Report for Board consideration: Health Improvement Plan Committee	Tammy Bray Lila Wickham Staff	X
6	11:45	Draft Report from the Medical Liability Committee	Mic Alexander Joe Siemienczuk Staff	
7	12:45	<i>General Public Testimony</i>	Public	
8	1:00	Adjourn		

### Upcoming

November 16<sup>th</sup>, 2010

Market Square Building

8:30 am to 1 pm

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**Oregon Health Policy Board**  
**DRAFT Minutes**  
**October 12, 2010**  
**Legacy Emanuel Medical Center, Lorenzen Center**  
**2801 N Gantenbein Ave, Portland**  
**8:30am – 4:30pm**

**Item**

**Welcome and call to order**

Chair Eric Parsons called the Oregon Health Policy Board (OHPB) meeting to order. All Board members were present. Oregon Health Authority (OHA) staff members present were Bruce Goldberg and Tina Edlund.

**Consent agenda –**

***Minutes from August 10 and September 14, 2010 meetings***

The August 10 and September 14, 2010 minutes were reviewed.

***Update on the Comprehensive Plan***

The update has been transmitted to the Board.

***Agenda for the remaining meetings in 2010***

The Board reviewed the agenda for the rest of 2010.

All items on the consent agenda were approved by unanimous voice vote.

**Director's Report – Bruce Goldberg, MD**

- Dr. Goldberg noted that there were two corrections to the written report.
  - ❖ The date should be October 12, 2010.
  - ❖ The first bullet listed under the Health Policy Equity Review Committee section should be listed under the Health Insurance Exchange section.
- Since August, there has been an additional shortfall estimate of \$377 million, which equates to another 8% cut for OHA. Fortunately, Medicaid match enhancements were passed that offset the reduction in funds.
- The prediction from the state economist is that the anticipated recovery will be slower and shallower than originally thought. For the 2011-2013 budget, a decrease of \$560 million is expected.
- The Board noted that cuts made now may end up costing money down the road, to which Dr. Goldberg responded that the state cannot continue to sustain 10%-12% increases in health care costs when revenues grow by 2%-3%. This has to drive the work the Board does.
- September 23 marked the six month anniversary of federal reform. There are four reforms that have taken effect.
  - ❖ Guaranteed issue for children
  - ❖ New healthcare plans must cover preventive care without co-pays or deductibles
  - ❖ No lifetime limits on health care
  - ❖ Decisions on removing people from health care that shows fraud
- The regulations regarding guaranteed issue for children have caused some carriers to no longer offer children-only policies.
  - ❖ Healthy Kids is working to continue to enroll children without health insurance. Enrollment periods are synched with the open enrollment of the private plans.
  - ❖ The Oregon Medical Insurance Board (OMIP) has voted to make the high risk pool available to children when enrollment in Health Kids is closed. This will require a statutory change.

↪ The Board asked for a list of carriers who are no longer offering child-only policies.

**Report on Public Forums and summary of public input on Health Insurance Exchange, Comprehensive Plan and Board agenda – Jeremy Vandehey**

- Summary of community meetings
  - ❖ Input was sought on the health insurance exchange. Community members participated

through e-mailed comments, six community meetings and a public input tool on the internet.

- ❖ The primary concerns were to contain costs and to expand coverage for all Oregonians
- ❖ When asked what they wanted from the health care exchange, participants responded that they wanted a balance of simplicity and choice. They wanted the exchange to drive innovation and they wanted both an exchange and an outside market.
- ❖ When asked about the direction OHPB is taking, the majority felt that the Board is taking the right steps to accomplish its vision.
- ❖ Overall, public input focused on evidence-based care, and cost savings that result in lower premiums and insurance costs.

*This presentation can be found [here](#), starting on page 37.*

- The Board felt these meetings were very well organized and effective.

### **Actuarial Comparison of OHA and HLC Value Based Benefit Packages – Jeanene Smith**

- Jeanene gave the Board an update on the Value-Based Essential Benefits Package (VBEBP).
- The main components of the VBEBP are value-based services with tiered benefits and evidence-based drug formulary.
- Staff used an earlier model developed for initial VBEBP design based on Medicaid data and applied it to commercial data for the first time. The data was pulled from Oregon Educators' Benefits Board (OEBB) ODS plan claims. The analysis shows that redistribution of effective care does save money.
- Focus groups are finishing up and that data will be available in November.

*This presentation can be found [here](#), starting on page 55.*

- The Board asked that an analysis be run on either cardiac care or diabetes.

### Break

### **Draft Recommendations from the Incentives and Outcomes Committee – Committee Co-Chairs and Staff**

- The purpose of the Incentives and Outcomes Committee is to make recommendations to the Board about and continually refine statewide health care quality standards.
- Committee recommendations
  - ❖ Standardize payment methods (but not rates) to Medicare
  - ❖ Transform primary care delivery system
  - ❖ Focus measurement and payment efforts where the potential for improvement is greatest
  - ❖ Encourage the delivery system to become more patient and family centered
  - ❖ Initiate use of new payment incentives and methodologies
  - ❖ Set a global health care spending target

*This presentation can be found [here](#), starting on page 63.*

### Break

### **Publicly Owned Health Insurance Plan: Strategic Options – Bill Kramer**

- Bill presented a range of options for discussion. Can a publicly owned health insurance plan provide significant value, and if so, how?
- Plan options
  - ❖ Standalone plans – broad or narrow provider network
  - ❖ “Piggy-back” plans – link with Public Employees' Benefit Board (PEBB) or Oregon Health Plan (OHP)
- Key issues involve enrollment projections, economies of scale, start up costs, reserve requirements, financing of reserves and start-up costs, adverse selection and risks and uncertainties.

*This presentation can be found [here](#), starting on page 97.*

### **Public Testimony**

Peter Shapiro – Co-Chair of Health Care Committee of Portland Jobs With Justice

Mr. Shapiro supports the public plan not just as an option, but as something that should cover all Oregonians. He has been working with Representative Dembrow on drafting a bill to create a single payer system. The bill contains a comprehensive schedule of benefits that includes everything that's

medically necessary. There are no tiers and no deductibles. Funding would come from a dedicated tax. The draft was sent to Christina Dodd, who estimates that the money spent by Oregonians could be reduced by \$4.5 billion, mostly through administrative savings. Additional expenses would come from bringing people into the system who are under or uninsured. For the same amount of money we spend now, we could cover everyone who is uninsured and eliminate inequities in the system.

**Dr. Samuel Metz – Interim Chair of Portland Chapter of Physicians for National Health Care**  
Dr. Metz spoke about diffusing risk. He said that an exchange will not decrease cost or improve care as long as private providers continue to fragment the risk pool. An exchange can allow health care companies to set their own price, but they have to offer comprehensive benefits to everyone. The greater the risk pool, the lower the cost. No one wants to be put in the position of trying to guess what future diseases might affect them or their families and risk losing their houses or lives if they guess wrong. The public option needs one set of benefits and no impediment to primary care.

**Jennifer Valley**

Ms. Valley spoke about the need for safe access to medical marijuana. Two prime drivers of healthcare costs are chronic disease management and pain. Medical marijuana should be part of the public plan.

**Onofre Contreras – Representing Oregon Health Action Campaign**

Mr. Contreras urged the Board to take bold action and incorporate the public plan as a major focus in their legislative submittal.

**Morgan O’Toole – Member of the Payment Reform Subcommittee of the Incentives and Outcomes Committee**

Mr. O’Toole urged the Board to think more creatively about provider networks, citing them as obstacles in providing health care. They often fracture the coordination of care, which is the key source of potential cost savings.

**Jim Hauser – Owner of Hawthorne Auto Clinic in SE Portland, and Co-Chair of the Oregon Small Business Council**

Mr. Hauser recommended using State Accident Insurance Fund (SAIF) as a model for the exchange. It has extensive cost savings and the model allows for a mix of public and private insurance as well as self-insured coverage.

**Liz Baxter – Representing Archimedes Project**

Ms. Baxter urged the Board to look at the co-op option offered by the federal government and to consider incorporating it into the public option plan.

- The Board asked how the start up costs of the public plan would be funded. Bill responded that the obvious option is an appropriation from the state that would be paid back over time. There may be other options that haven’t yet been explored.
- The Board asked which option Bill felt would be the most advantageous. Bill said that piggy backing on an existing plan like PEBB or OHP would allow the state to save costs, particularly in administration, and still have a large number of enrollees.
- The Board asked Bill to do more analysis on the benefits of linking with OHP or PEBB.

### Break

#### **Future Health Planning and the Exchange – Eric Parson and Bruce Goldberg**

- When the Board met in February, they decided on four goals for the health insurance exchange: simplify, provide access, change the way services are paid for, and cost containment.
- Dr. Goldberg and the Chair presented strategies to achieve those goals
  - ❖ Maintain costs within a sustainable fixed rate of growth
  - ❖ Regionalize resources and accountabilities
  - ❖ Align coordination and consolidation of purchasing power
  - ❖ Standardize benefits, quality measures, contracting and other relevant areas.
- There is a great sense of urgency due to the budgetary problems the state has been facing and

will continue to face. This urgency can create momentum and really drive change.

- The Board felt that the exchange could be used as a tool to implement the programs and benefits that have come up from the subcommittees as well as a tool to cut costs and provide better health care to a greater population.
- The Board had mixed opinions about the governing board of the exchange. The options are whether the make up of the board should be entered into statute and to have one or two boards. With two boards, one would be consumer advisory board and the other a governing board. There was also discussion about accountability of the board and possibility of removal of members if necessary.

### **Public Testimony**

Laura Etheron – Oregon State Public Interest Research Group (OSPIRG)

Ms. Etheron thanked the Board for their thoughtful consideration of how to structure the exchange. OSPIRG had concerns originally about the draft recommendations that were presented at the last Board meeting, but now that those recommendations have been discussed and revised, consumers and small businesses can get excited about the exchange. She asked that the Board continue to work on containing costs and recommended structuring the exchange in a way that provides accountability, as it is valued by consumers and businesses, particularly in this economic climate.

Dr. Samuel Metz – Interim Chair of Portland Chapter of Physicians for National Health Care

Dr. Metz asked the Board to keep in mind that people who participate in the exchange may be inexperienced in purchasing insurance. He asked that Board ensure that consumers won't buy inadequate policies without realizing it. He also urged making coverage as attractive to as many people as possible to spread risk fairly.

Jim Baker and Joe Hassett – Oregon Allergy Society

Mr. Baker and Mr. Hassett urged the Board to consider alternate forms of medicine, such as allergy treatments as they go forward with their work, particularly within the VBEBP.

**Adjourn** 4:22pm

### **Next meeting:**

**November 9, 2010**

**8:30am – 1:00pm**

**Market Square Building**

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

**Portland, OR 97201**

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**Monthly Report to  
Oregon Health Policy Board  
November 9, 2010**

*Bruce Goldberg, M.D.*

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**PROGRAM AND KEY ISSUE UPDATES**

**Planning**

Much of the work of the past month – exchange development, comprehensive plan, and committee reports – will be coming before the Board over the next 3 meetings. Staff members have been working hard on all of this.

**Healthy Kids Program**

**Enrollment**

- Through September, about 61,000 children have been enrolled.
  - This is 76% of our goal of 80,000 more children by the end of this year and a 23% increase in enrollment since June 2009 (baseline).
  - Just over 2,600 children are enrolled in Healthy KidsConnect.
  - See the chart below for a more detailed look at Healthy Kids enrollment.

**Outreach and Marketing**

- Enrollment in September picked up by 37% thanks to back-to-school outreach efforts and implementation of statewide media buy on September 1<sup>st</sup>.
- Outreach staff continue to do aggressive outreach to community organizations to enlist their help in spreading the word about Healthy Kids.

**Improvements**

- An improved application, developed with the Center for Health Literacy, has been finalized and is in production for roll out next month.
  - Significant policy changes have been incorporated into the new application to make the process easier for applicants, including a decrease in the amount of income documentation required.
  - The goal of the application is to streamline the application process and reduce the number of applications that are pended or mistakenly denied.
- Began using an innovative new strategy to simplify things - “Express Lane Eligibility” (ELE) - using SNAP (Food Stamp) data (i.e., use income information in SNAP data to automatically enroll children into Healthy Kids). So far, just over 400 children have been enrolled in Healthy Kids this way.
- Will also use ELE with the Free and Reduced Lunch applications from a handful of school districts at the end of the year.
- Continue to work on streamlining redetermination system, so that eligible families can keep their children enrolled quickly and easily.

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## **OHP Standard**

- Enrollment in OHP Standard is now **44,810** and many more applications are coming in each week.
- The biennial goal is to have an enrollment of 60,000 people in the OHP Standard program by June 30, 2011.
- There have now been twelve random drawings to date. The October 20, 2010 drawing of 20,000 names exhausted the reservation list. As approximately 2,000 new reservations are received each week, the next drawing will be November 17, 2010 for 10,000 names. Efforts are underway to “repopulate” the list.

## **Exchange Planning**

Oregon is increasingly viewed nationally as one of a handful of states moving forward quickly with planning for an exchange. We will be pursuing an opportunity for federal funding available to 5 states to help develop an information system for the exchange. Application is due in December. Given our work to date, we are in a good position to be successful.

## **Upcoming**

### **Next OHPB meeting:**

**Tuesday, November 16, 2010**

**Market Square Building, Portland, OR**

The next Oregon Health Policy Board meeting is in one week, on Tuesday, November 16<sup>th</sup>. Topics covered will include reports on: the Health Insurance Exchange and a Publicly Owned Health Insurance Plan; the Oregon Blueprint for Health; the Incentives and Outcomes Committee; the Public Employers Health Purchasing Committee; the Workforce Committee; and next steps for the Value Based Benefit Package.

## Healthy Kids Enrollment

	OHP Net Enrollment	HKC Net Enrollment	Total Net Enrollment	Target Enrollment Increase	Actual Net Increase	Progress Towards Goal	Monthly Enrollment Goal	Monthly net enrollment change	% of Monthly Goal Achieved
Jul-09	271,493	0	271,493	5,000	3,648	73%	5,000	3,648	73%
Aug-09	276,712	0	276,712	10,000	8,867	89%	5,000	5,219	104%
Sep-09	281,374	0	281,374	15,000	13,529	90%	5,000	4,662	93%
Oct-09	289,015	0	289,015	20,000	21,170	106%	5,000	7,641	153%
Nov-09	294,459	0	294,459	25,000	26,614	106%	5,000	5,444	109%
Dec-09	298,600	0	298,600	30,000	30,755	103%	5,000	4,141	83%
Jan-10	303,026	0	303,026	33,333	35,181	106%	3,333	4,426	133%
Feb-10	305,785	205	305,990	36,666	38,145	104%	3,333	2,964	89%
Mar-10	309,047	549	309,596	39,999	41,751	104%	3,333	3,606	108%
Apr-10	312,191	923	313,114	43,332	45,269	104%	3,333	3,518	106%
May-10	314,933	1,133	316,066	46,665	48,221	103%	3,333	2,952	89%
Jun-10	316,891	1,338	318,229	50,000	50,384	101%	3,333	2,163	65%
Jul-10	319,878	1,662	321,540	55,000	53,695	98%	5,000	3,311	66%
Aug-10	322,694	1,948	324,642	60,000	56,797	95%	5,000	3,102	62%
Sep-10	326,545	2,335	328,880	65,000	61,035	94%	5,000	4,238	85%
Oct-10		2,617*		70,000			5,000		
Nov-10				75,000			5,000		
Dec-10				80,000			5,000		

\*HKC enrollment as of Oct. 22nd; OHP October enrollment data not yet available

## Office of Private Health Partnerships: Summary Snapshot as of November 1, 2010

### OPHP Active Enrollment

<b>HKC</b>	2,700	<i>HKC = Healthy KidsConnect; Enrollment as of 10/29/2010 Healthy Kids (age 0-18) with Federal Poverty Levels over 200%; 201%-300% receive premium subsidies. HKC data is updated weekly with the next update on 11/5/2010.</i>
<b>FHIAP</b>	6,884	<i>FHIAP = Family Health Insurance Assistance Program; Enrollment as of 11/1/2010 - includes 1,400 members also enrolled with OMIP and 52 enrolled with FMIP. Provides premium subsidies for kids and adults up to 200% of FPL. FHIAP data is updated weekly with the next update on 11/8/2010.</i>
<b>OMIP</b>	14,033	<i>OMIP = Oregon Medical Insurance Pool; enrollment of 14,033 is as of 10/25/2010 State High risk insurance pool that provides access to insurance for Oregonians with high risk or chronic conditions. OMIP data is updated monthly with the next update on 11/10/2010.</i>
<b>FMIP</b>	225	<i>FMIP = Federal Medical Insurance Pool; enrollment as of 9/30/2010 - 38 of 225 have coverage effective 10/1/2010. FMIP data is updated monthly with the next update on 11/10/2010.</i>
<b>Total OPHP</b>	<b>22,390</b>	<i>Total OPHP enrollment is adjusted by the 1,400 FHIAP members that are also enrolled with OMIP and 52 enrolled with FMIP.</i>

### Average Payments

Per Person Per Month	Premium	Subsidy	Claims	
<b>HKC</b>	\$249	\$227	**	<i>OPHP is receiving claim data for HKC from the five participating carriers, and anticipate reporting claims costs when there is more claims experience (program started in February 2010).</i>
<b>FHIAP</b>	\$330	\$301	no data	
<b>OMIP</b>	\$507	\$0	\$960	<i>Amounts are based on paid claims for Calendar Year 2010 through September. The difference between the expenditures and revenues is covered by an assessment on Oregon insurance companies.</i>
<b>FMIP</b>	\$482	\$0	\$977	

Age	HKC		FHIAP		OMIP		FMIP		Total OPHP
<b>Children (0-18)</b>	100%	2,700	29%	2,028	6%	801	1%	3	<b>24%</b>
<b>Adults (19+)</b>	0%	0	71%	4,856	94%	13,232	99%	222	<b>76%</b>

### OPHP Demographics

Gender	HKC	FHIAP	OMIP	FMIP	Total OPHP
<b>Female</b>	48%	59%	57%	54%	<b>56%</b>
<b>Male</b>	52%	41%	43%	46%	<b>44%</b>

Ethnicity	HKC	FHIAP	OMIP	FMIP	Total OPHP
Alaskan Native/ Native American	2%	1%	1%	1%	1%
Asian/ Pacific Islander	4%	6%	2%	2%	4%
Black	2%	2%	1%	4%	1%
Hispanic	17%	5%	4%	6%	6%
White	69%	78%	91%	86%	84%
Other or Unknown	6%	9%	1%	1%	4%

*\* OMIP, FHIAP, FMIP applications ask one race/ethnicity question with categories defined as above; HKC's application ask separate questions for race and ethnicity. For the purposes of this report, if an HKC member indicated "hispanic" for ethnicity, then that took precedence over their indicated race.*

# **Oregon Health Policy Board**

Committee updates and meeting reviews  
November 9, 2010

## **Oregon Health Improvement Plan (HIP) Committee**

**Next meeting: None scheduled at this time.**

### Recent committee decisions/agreements

The October 8<sup>th</sup> discussion focused on reaching consensus on the following items:

- Population health measures and definitions;
- Review of HIP Plan revisions from the September 10<sup>th</sup> meeting; and
- Plan actions were staged for 2011, 1-3 years and 5-8 years based on committee survey results and discussion

### Issue areas discussed

The focus was on moving forward toward the final draft plan and public input process:

- Summary of chair and staff meetings with non-OHA committees re the health improvement plan;
- Metrics (overall measures and goal areas);
- Staging of actions, time line for implementation; and
- Next steps for member review and public input on the draft plan

### Points of agreement

- Metrics: Overall health measure good to excellent health; educational attainment measures; chronic disease measures; and system measures with communities, health departments and health care organizations
- The focus reducing consumption – of tobacco, alcohol and sugar-sweetened beverages
- The committee members agreed that there is consensus on the plan goals, strategies and most of the actions
- Several actions were re-worded but there were no conceptual changes
- Addition of an action related to improving early intervention through prompt access to mental health services to health achieve overall health as well as educational and vocational attainment
- Members acknowledge that while some actions cannot be mandated by the OHPB and OHA and might be outside their domain, members support partnerships and collaborative action at the state and local levels to improve the population's health

### Areas of contention (for continued discussion)

- Concern that the proposed disability adjusted life year (DALY) population health measure might be negatively interpreted as being related to a disability condition rather than chronic disease related disability. Post meeting decision that the DALY measure would not be used, due to this concern and the difficulty in calculation. Premature death is the revised measure.
- Continued discussion about Goal I: Achieve health equity and population health by improving social, economic and environmental factors. Key questions raised by committee members:
  - Is the focus just on educational attainment or is it broader?

- How is the built environmental and environmental health supported in Goal I actions?
- The above issues were resolved by defining specific actions to impact youth and schools through early intervention for mental health services and health impact assessments for building and transportation projects near schools
- Concern was expressed about the political will, economic context, and infrastructure related to implementation of HIP Plan actions

#### Next steps for the committee in October and November

- Share plan revision with committee members based on 10/8 meeting decisions
- Conduct a committee member survey on the draft plan to determine if the draft accurately reflects the work and decisions of the committee
- Conduct a Public Input survey on the committee website from mid – end of October
- The November 2<sup>nd</sup> Regional PLACE MATTERS Conference in Portland, 9:30 am – 11:00 session am provides an opportunity for public input on the draft plan
- Compile Public Input Survey comments for Board presentation on November 9th

#### Next steps for the Board

- HIP Committee presentation to the Board on November 9
- Conduct OHA Public Input period November 9 – 19

## **HITOC (Health Information Technology Oversight Council)**

### **Legal and Policy Workgroup**

**October 12, 2010 Meeting Summary**

**Next Meeting: November 9, 2010.**

### **Recent committee decisions/agreements:**

The HITOC Legal and Policy Workgroup has not made any decisions or agreements at this time.

### **Issue areas discussed:**

- 1. HIPAA:** The scope of what it permits and applies to:
  - a. Purposes: treatment, payment, and healthcare operations (TPO)
  - b. Covered entities: providers, insurers, and those who have business associate agreements with covered entities
  - c. Data type: Individually identifiable data only; not de-identified data
  - d. Gives equal protection to all protected health information, except psychotherapy notes, which it does not permit to be exchanged without authorization
- 2. Specially protected health information (SPHI):**
  - a. Articulation of the concerns and risks related to SPHI being unavailable to treating providers, including potential drug interactions, allergies, and the general necessity of having all possible health related information on a patient in order to make informed treatment decisions
  - b. Clearly defining how and when SPHI statutes/administrative rules impose restrictions on the exchange of information for purposes permitted by HIPAA. The data/records that cannot be exchanged in Oregon for TPO are:
    - i. Substance abuse in federally-funded treatment programs (from federal regulation 42 CFR part 2)
    - ii. Mental health or substance abuse in specified state-funded programs (ORS 179.505)
    - iii. HIV test results:
      1. Conflict of state statute and rule regulating the disclosure of HIV test results has resulted in a situation whereby it may be permitted to disclose HIV *positive* test results for TPO without patient consent, but not HIV *negative* test results. Because of this conflict and the confusion around this, state-level legislative changes are needed to create a consistent policy around HIV test results disclosure. Until that legislative clarity is established, many providers will not consider it permissible to disclose any HIV test results without patient consent.
  - c. Patient control, preferences, and needs, versus doctor control, preferences, and needs pertaining to the sharing of SPHI
- 3. Culture:**
  - a. How practice, policy, and/or interpretation of law (HIPAA and Oregon's SPHI) often differ from, and are more restrictive than, actual legal requirements

- b. Providers tend to err on the side of not sharing data without patient consent, even when it is permitted by law, because of the uncertainty and difficulty of interpreting statute, practices that developed before HIPAA was established, and the fear of violating HIPAA and Oregon's SPHI laws.

**4. Consent policy:**

- a. The importance of the technology strategy (repository vs. federated models) as a variable influencing the appropriateness of any consent model, and particularly how to treat SPHI
- b. How the consent policy will be incorporated as a standard in the Accreditation Program: will the consent policy adopted by HITOC be a floor or a ceiling in terms of the policies that organizations will be permitted to implement?
- c. Defining the applicable scope in terms of time horizon and use cases:
  - i. We're focusing on meeting meaningful use for 2011-2012, which requires exchange of patient care summaries across unaffiliated organizations, for the initial phase of our HIE efforts. Later we will examine and develop policies applicable to pull technologies and other entities outside the health care system (e.g. public health and law enforcement).
  - ii. Secondary use cases, such as quality reporting, clinical research, and public health efforts, raise important questions about desired goals and how to accommodate these goals in the current consent discussion and policy.

**Points of agreement:**

- The workgroup members agreed that they need more information about the HIE technology strategy in order to better understand and inform their recommendations around a consent policy.

**Areas of contention:**

- A variety of opinions and perspectives were shared around the various consent models, and how specially protected information should be handled within those consent models.

**Next steps for the committee:**

- The next meeting, on October 20, 2010, will consist of further discussion, and ultimately recommendations, on the consent model, how SPHI will be handled within that consent model, legislative proposals (if any), as well as the operational components of the recommended consent policy.

**Next steps for the Board (only if applicable):**

- The Health Policy Board will review the various recommendations that come out of the Workgroups and HITOC as those recommendations are made.

## **HITOC (Health Information Technology Oversight Council)**

### **Legal and Policy Workgroup**

**October 20, 2010 Meeting Summary**

**Next Meeting: Nov. 9, 2010**

#### **Recent committee decisions/agreements:**

- The Workgroup agreed that they need additional meeting time to discuss the issues around consent before they can formulate recommendations to HITOC.

#### **Issue areas discussed:**

##### **1. Technology:**

- a. "Push" vs. "pull" health information exchange (HIE) technologies
- b. The technical capabilities of excluding specially protected health information (SPHI) from HIE
- c. If and how the state HIE technology plan includes central repositories of data
- d. If and how a patient's electronic health records are combined
- e. What information about HIE transactions we can track and audit

##### **2. Consent:**

- a. Operational components of implementing consent:
  - i. The HIPAA-required Notice of Privacy Practices (NPP) could be used to inform patients that the provider participates in an HIE and that their record will be exchanged via HIE. Amending the NPP in this way would allow providers to exchange information that is already allowed by HIPAA, but it would not satisfy the requirements for authorization for disclosure of SPHI.
  - ii. If there is an Opt Out model, it is important that patients be educated about what an HIE is, which may require more than giving them a document they may or may not read.
- b. Scope of the consent policy:
  - i. For what purposes, how often a patient's consent status should have to be renewed, and whether consent should be required at all for purposes that are already allowed by HIPAA (treatment, payment, and healthcare operations), or whether we want or need to erect new consent barriers where they do not currently exist for other modes of transmission (fax, telephone, mail, etc.)
- c. Specially protected health information (SPHI)
  - i. Both state and federal-level regulations around specially protected health information were reviewed, with discussion and diversity of opinion around whether Oregon-specific SPHI categories should be expanded to include currently unprotected categories, reduced or eliminated to better align with HIPAA, or left unchanged.
  - ii. The need for representation and engagement from communities of color in this discussion and on the Consumer Advisory Panel. Additional outreach with communities of color is being conducted by staff and workgroup members.

**Points of agreement:**

- The Workgroup agreed that they need additional meeting time to discuss the issues around consent before they can formulate recommendations to HITOC.

**Areas of contention:**

- Whether Oregon-specific SPHI categories should be expanded to include currently unprotected categories, reduced or eliminated to better align with HIPAA, or left unchanged.
- Whether the consent policy should apply only to treatment purposes, or for the purposes of treatment, payment, and healthcare operations as permitted by HIPAA.
- The preferred consent model for Oregon HIE. The list of models preferred by various members of the Workgroup included:
  - No consent required for exchange of PHI that is already permitted by state and federal law for other modes of transmission (fax, phone, mail, etc.).
  - Full opt out: all patient PHI, except that prohibited by federal law, will be exchanged unless and until the patient denies consent by opting out.
  - Opt out excluding SPHI: all patient PHI, except that prohibited by federal and state SPHI laws, will be exchanged unless and until the patient denies consent by opting out.
  - Full opt in: no patient PHI will be exchanged unless and until a patient affirmatively provides consent to exchange all of their data, including SPHI protected by federal and state law.

**Next steps for the committee:**

- The Workgroup staff and chairs will work together to adapt the workplan for the next meetings to accommodate the Workgroup's need for more meeting time to discuss and develop recommendations on consent, beginning with the next meeting on Nov. 9, 2010.

**Next steps for the Board (only if applicable):**

- To review the Workgroup's and HITOC's recommendations on a consent policy for Oregon HIE as those recommendations are made.

## **HITOC (Health Information Technology Oversight Council)**

### **Technology Workgroup**

**Oct. 13, 2010 Meeting Summary**

**Next Meeting: November 18, 2010**

#### **Recent Committee Decisions/Agreements:**

- As of October 2010, the HITOC Technology Workgroup has not made any decisions or proposed any recommendations at this time.

#### **Issue Areas Discussed:**

- Key terminology and concepts were reviewed and discussed including: Health Information Exchange (HIE), HIE Participant, Health Information Organization (HIO), HIE Core Services, HIE Centralized Services, and HIE Ancillary Services.
- Recognition of the need to work closely with the HITOC Finance Workgroup to complete the ONC financial sustainability plan for HIE in Oregon.
- Review of Oregon's proposed HIE technology architecture including national and/or federal standards for robust HIE.
- For interstate HIE, Oregon's HIE standards should allow and support interoperability. Need to ensure that Oregon's standards for HIE harmonize with neighboring states in terms of adoption and use of HIE standards.
- Discussion around "Provider Directory." Question as to whether the State of Oregon might provide access to other states' provider directories, for example, as a core service.
- Review of potential HIE ancillary services: Personal Health Record (PHR) Interface import/export capability, Record/Patient lookup service, quality reporting, public health reporting, NHIN Gateway, record access audit, and pseudo-HIE services.
- Initial discussion around the value proposition(s) of a Provider Registry and HIE Trust Services.
- Recognition by Workgroup members that technology standards will need to support Oregon's consent model (i.e. opt-in with restrictions, full opt-out, or full opt-in).

#### **Points of Agreement:**

- General agreement that "Provider and HIO" directories should be considered as a core centralized service.

#### **Areas of Contention:**

- No areas of contention to report at this time.

#### **Next Steps for the Committee:**

- Technology Workgroup members have been invited to join the next HITOC Finance Workgroup meeting on November 10, 2010, to further discuss the HIE Core Services
- At the next regular meeting, scheduled November 18, 2010, the Technology Workgroup will focus on an in-depth review of HIE standards and framework(s) for standards,

gather feedback on preliminary HIE Core Services specifications, and explore how best to integrate standards into existing HIO and HIE activities in Oregon.

- Technology Workgroup will also further review and consider additional HIE ancillary services.

**Next Steps for the Board (only if applicable):**

- The Health Policy Board will review the various recommendations that come out of the Workgroups and HITOC as those recommendations are made.

**HITOC (Health Information Technology Oversight Council)**

**Finance Workgroup**

**October 19, 2010 Meeting Summary**

**Next Meeting: November 10, 2010**

**Recent committee decisions/agreements:**

- The workgroup members are familiarized with the status of the other workgroups, the proposed statewide HIE technical architecture, the potential core and ancillary services, and the scope and role of the workgroup in the recommendation process.
- Members expressed a desire for further discussion of potential statewide HIE services, including feedback from the Technology Workgroup and the HIO Executive Panel regarding HIE services, priorities, and value propositions.
- The group requested that members from the Technology Workgroup attend the next Finance Workgroup meeting.

**Issue areas discussed:**

- HIE technical architecture, core and ancillary services, value propositions, differential values between statewide HIE and local HIOs, gap strategies

**Points of agreement:**

- Additional information needed from Technology Workgroup on use cases for and value propositions of Core Central Services

**Areas of contention:**

- Relative value propositions, funding sources

**Next steps for the committee:**

- The next meeting is on November 10, 2010. The agenda will include discussion of statewide HIE services, priorities and value propositions, local HIO financing considerations, gap strategies, and financing options for start-up, value and utility services.

**Next steps for the Board (only if applicable):**

- The Health Policy Board will review the various recommendations that come out of the Workgroups and HITOC as those recommendations are made.

## **Health Incentives & Outcomes Committee**

**Next meetings: No further Committee meetings are scheduled for 2010.** Future meeting schedule to be determined based on Health Policy Board policy decisions and directions to the Committee.

The full Incentives and Outcomes Committee met on October 27.

Issues areas discussed:

- Committee chairs reported on the presentation of draft recommendations to the Health Policy Board on October 12.
- Committee members discussed the content of their draft final report for 2010.

Points of agreement:

- Oregon should start addressing each of the recommendation areas at once, even if work within those areas is staged.
- The report should acknowledge the Committee's conviction that payment incentives can be used to help the system change course and transform but that they are not a panacea.
- The report needs a little more about the rationale behind several of the recommendations.
- The recommendation to standardize payment methods for physician and professional services to Medicare should be clarified. (The intent was to say that everyone who uses the RBRVS method should use it in the same way, not that all professional services should be paid on that method.) There should also be a stronger statement of the need for flexibility in the case of more accountable or comprehensive payment methods.
- The recommendation on areas of focus needs to say more about opportunity for improved efficiency—not just opportunity for eliminating defects.

Areas for further discussion:

- In some cases, additional work is necessary before implementation plans can be made:
  - The payment standards for Recommendation #1 need to be developed. A first step would be to identify what decisions need to be made.
  - The focus areas for payment and quality work (Recommendation #4) need to be determined. Exactly what role the Committee will play in that will become clearer after the Board retreat in January.

Next steps:

- Staff will make changes to the report as suggested by the Committee.
- Committee members will review the straw timeline and let staff know of any major concerns by noon Monday November 1<sup>st</sup>.
- The final 2010 report will go to the Health Policy Board about a week in advance of their November 16<sup>th</sup> meeting.

## **Public Employers Health Purchasing Committee**

**Last meeting: Monday, October 25<sup>th</sup>, 2010.**

**Next meeting: Conference call, Nov. 29, 1-4 pm**

### **Issues areas discussed:**

- The Committee reviewed reports from the Health Improvement Plan Committee, the Administration Simplification Workgroup, and the Incentives and Outcomes Committee, as well as an update on the Value Based Benefits Package.
- The committee also reaffirmed the best way to address other groups' recommendations and how to most effectively demonstrate and (when appropriate) implement its support (the suggested approaches were distributed at the September 2010 meeting).
- *Administrative Simplification* – Discussed how best to improve claims in an electronic and standardized way. Everyone agreed that “getting rid of paper” was a worthy goal. Most members want to see the companion guidelines for actual implementation of admin simplification, but understand those will be under development for a while. One question that was brought up was whether it makes sense to move forward with this, knowing that federal guidelines will be coming out soon? It was felt that moving ahead could allow us to influence what the federal guidelines end up looking like.
- *Patient Safety standards* –OEBB contracts with patient safety standards have been finalized, and PEBB contracts are in the process of being finalized. Members thought it was a good idea to have contract provisions relating to patient safety, and recommend that public employers include patient safety standards in their contracts.

### **Agreements/Decisions:**

- The Committee unanimously passed a motion to approve the policy recommendations of the administration simplification workgroup, with the caveat that changes may have to be made per forthcoming federal guidelines.
- The Committee unanimously passed a motion to approve the patient safety standards.
- By unanimous vote\*, the Committee endorsed the Incentives and Outcomes Committee Recommendation #1: Standardize payment methods (but not rates) to Medicare. Furthermore, the Committee supports an implementation plan for this recommendation that begins with the development of a standardized, statewide Diagnostic-Related Group (DRG) methodology for reimbursement of hospital inpatient services at DRG hospitals.

The Committee will review implementation steps for the other recommendations as they are more fully developed.

**\*The text of this motion is pending a vote by email by the PEHPC members.**

### **Areas for further discussion:**

- HIP Committee recommendations were pended until early 2011 as the committee wanted to get additional information, and had concerns about endorsing specific programs.

- How and to whom (which insurers) would we want to distribute the patient safety recommendations?
- Invite carriers to present how they are moving forward with patient centered primary care homes.
- Continue to evaluate value-based benefit package options.
- Review the specific contract language in PEBB/OEBB regarding health information exchange and meaningful use standards

Next steps:

- Work by email to approve a year-end committee report for the OHPB. There will be a conference call meeting on November 29 to finalize the report.

**Health Equity Policy Review Committee**

**Next meeting: November 4, 1-5pm, Portland**

The Health Equity Policy Review Committee held review meetings on Oct 5 and Oct 21.

**Issues Discussed**

**October 5:**

- The Oregon Health Improvement Plan Committee also presented and HEPRC members offered initial policy recommendations and key concepts for creating equity in their work. Those recommendations are:
- The work of racially and ethnically diverse community-based organizations must be prioritized in health reform efforts and they must be engaged throughout the planning, implementation and evaluation processes in order to most effectively eliminate health inequity.
  - The collaboration cannot just take place between the state and geographically determined communities, but also must engage communities of racial, ethnic, ability, occupational and sexual identity in order to truly meet the specific needs of Oregon’s culturally diverse populations.
  - Create a community advisory/oversight commission in order to ensure that community involvement is integrated in the evaluation process, creating a long-term feedback loop, to guarantee accountability for outcome overtime.
  - Be specific as to who the actors are when mentioning the importance of community partnerships so that the OHA assures transparency and shared leadership in this area. s
- Expand beyond “evidence-based” practices when choosing programs to implement as there is not necessarily hard “evidence” for the success of culturally specific models due to lack of research evaluation funding. Include “promising” or “emerging” practices so that options are not limited when choosing health equity strategies to support.

- Collect cultural data at the most granular level in order to truly understand the various issues impacting Oregon’s diverse populations. Create culturally-specific solutions that focus on individual sub-communities:
  - Avoid general demographic splits (ie/Latino, Black, Asian, etc) that are not necessarily adequate indications of the issues facing various populations. These categories must be broken down further to include nationality and language (ie/Cuban, Mexican, Laotian, Hmong, etc) as the health problems facing these populations differ from one another and require culturally-specific or culturally-tailored solutions.
  - Collect data regarding sexual orientation, income, occupation and ability as we must better understand the disparities facing the LGBTQ, low income, seasonal farm worker and disabled communities in order to create equitable solutions.
- Caution should be used in relying on Public Health Accreditation Standards alone as they do not include standards for eliminating health inequities. Hold local and state health departments accountable to achieving health equity through additional standards, such as Culturally and Linguistically Appropriate Health Services Standards (CLAS).

**Goal I:** Achieve health equity and population health by improving social, economic and environmental factors.

**Outcome:** Increase high school graduation rates and college degrees for populations with disparities outcomes (OHA, ODE)

**Metrics:** high school graduation rates, 2 and 4-yr college degrees

- Use metrics that speak to the racial and ethnic disparities surrounding high school graduation rates and degrees from two and four year colleges in order to create culturally-specific solutions that target these communities.
  - Remove barriers to higher education for undocumented youth. Remove colleges’ requirements of citizenship documentation for enrollment. Find pipelines through community colleges that may not require documentation and allow students to transfer to four-year colleges without an additional application.
  - Inventory, expand and improve educational/mentorship K-12/college programs among racially and ethnically diverse communities as a pipeline to higher education and ultimately to health careers. This is an opportunity to not only reinforce healthy behaviors in culturally diverse communities but to address economic inequities the economy through increasing access to living-wage healthcare jobs among underserved communities.
- Mandate that the state require physical education and culturally-relevant health classes for all K-12 grade levels in order to foster healthy lifestyles among ethnically and culturally diverse populations at a young age.
- In addition to the promotion of stable, low-income housing, emphasize the importance of culturally-specific housing programs and cultural centers.

**Goal II:** Prevent chronic diseases by reducing Obesity prevalence, Tobacco use, and Alcohol abuse.

**Obesity Outcome:** Reduce obesity in children and adults

**Metrics:** Obesity (BMI, sugar-sweetened beverage consumption, meet CDC physical activity recommendations)

- Include the explicit mention of reducing health disparities as part of Goal 2 in order to emphasize health equity as a framing value of Oregon's Health Improvement Plan.
- When examining obesity prevention, expand "evidence-based" obesity prevention education, to include "promising"/"emerging" practices and "culturally-defined" obesity prevention education. Culturally specific obesity and health issues must be addressed through racially and ethnically targeted community-based initiatives.
- If taxing low-income individuals to encourage behavioral change (ie/sugar sweetened beverage tax), *all*, not simply a portion, of the revenue must be invested back into services that directly benefit the people who are suffering the most due to existing health disparity. Culturally diverse communities impacted by disparities should be engaged in allocating revenue raised.
- Include correctional facilities in the implementation of healthy food and beverage requirements
- Implement more stringent zoning/licensing regulations for fast food and convenient stores that sell alcohol/tobacco, predominately in low income and racially and ethnically diverse communities. The prevalence of these establishments has vast negative ramifications for the health of underserved communities.
- Create a culturally specific food and economic development plan with partners and community business owners to provide culturally-specific healthy food and support healthy eating habits among racially and ethnically diverse populations without gentrification or assimilation.
- Emphasize the importance of utilizing public health systems and community-based approaches to help the private health systems become more population-based in order to create community-based system-wide health improvements and health equity.

**October 21:**

- During the October 21 meeting, Gretchen Morley gave an overview of the Oregon Health Blueprint.
- The Health Incentives and Outcomes Committee and Public Employer's Health Purchasing Committee also presented and HEPRC members offered initial policy recommendations and key concepts for creating equity in their work. Those recommendations are:

**Health Incentives and Outcomes Committee:**

- Work with racially and ethnically diverse community-based organizations to generate quality standards for cultural competency and offer payment incentives for providers to meet these standards.

- Develop a “health burden coefficient” that would use differential payment methods according to the population that is being served and the culturally specific services they will need in order to incentivize offering culturally competent care.
- Instate a reimbursement policy for Community Health Workers, who come from the communities they serve and work at the grassroots level to build trust and vital relationships, making them effective culture brokers between their own communities and systems of care. Community Health Workers reduce cultural and linguistic barriers to health care, improve quality and cost effectiveness of care, and increase the number of healthcare workers who come from diverse backgrounds or underserved communities.
- Use payment incentives to encourage patient-provider cultural matching as there is evidence that demonstrates increased efficiency and better health outcomes when providers and patients come from the same or similar cultural backgrounds.
- When applying a patient-centered care model, work with racially and ethnically diverse community-based organizations in order to ensure that the needs of patients from diverse backgrounds are met; pilot test culturally specific patient centered care home models.
- Expand quality standards to include standards for culturally and linguistically appropriate service, such as, Culturally and Linguistically Appropriate Health Services Standards (CLAS), and create payment incentives to reward providers who meet these standards.
- Require that providers collect cultural data at the most granular level in order to truly understand the various issues impacting Oregon’s diverse populations:
  - Conduct satisfaction surveys by race and ethnicity, including questions about perceptions of bias in regards to race, gender, documentation status, employment and insurance status, in order to determine which providers are offering culturally competent care.
  - Collaborate with non-profit organizations that serve undocumented populations, and other uninsured people, to gather data about these populations in order to better understand their health needs, health beliefs, health literacy, protective factors, experience with health care and the health disparities they are facing.
  - Contract a third party to collect and analyze data in order to ensure neutrality, inclusivity and transparency in the process of data collection and analysis
  - Engage racially and ethnically diverse communities in the development of data-sharing agreements, including the collection, analysis and dissemination of data.
  - Use data to assure accountability for health equity outcomes and incentivize provider payments to address health disparities.
- The Health Incentives and Outcomes Committee should use race/ethnicity-conscious metrics and language to demonstrate the high priority given to equity. Eliminating health disparities most importantly saves lives, but also saves money:
  - Recommendation 5: Under outcomes, “Reduce costs by eliminating complications and waste.” Add ...complications, waste “and inequities” as evidence shows that maintaining racial health disparities puts an unnecessary financial burden on the system. Communities of color are disproportionately burdened by disease yet have limited access to health services, resulting in excessive medical expenditures and decreased efficiency leading to higher costs.

- Recommendation 6: Under objective, “Stop consuming an ever-greater share of public and private resources on health care expenditures” add, “with the exception of addressing health disparities,” while investing in the elimination of disparities may generate costs on the front end, it will save valuable resources, and human lives, in the long run.

### **The Public Employer’s Health Purchasing Committee**

- Develop differential treatment standards by race and ethnicity in order to most efficiently address culturally-specific health issues that emerge at earlier ages for some population groups.
- Develop a committee to take leadership on improving standards for data collection.
  - Data must be collected on the most granular level of race, ethnicity, language, occupation, sexual orientation and citizenship status, in order to understand the issues facing these diverse populations and devise culturally-specific solutions to addressing these problems.
  - Collect patient data overtime regardless of whether the patient has switched carriers, in order to truly understand the patient’s history of care.
- Expand quality standards beyond “evidence-based practices” to include culturally-specific “emerging” and/or “promising” practices as this is integral to serving communities from diverse racial and ethnic backgrounds and eliminating health disparities
- Implement a culturally/linguistically competent referral clause into insurance policies to ensure that if the patient’s provider cannot meet his/her needs, he/she will be referred to someone either inside or outside the system for culturally appropriate care.
- Collect patient satisfaction data by race, ethnicity, language, ability, occupation and sexual orientation in order to track which plans are providing culturally competent care. Make this information available to individuals so that they can choose a health plan based upon which plan has shown the best outcomes and culturally competent care.
- Oregon must implement the federal government’s Culturally and Linguistically Appropriate Health Services Standards (CLAS)

### **Points of agreement and areas for continued discussion**

- The Committee members continued discussing recommendations for the Healthcare Workforce Committee and will be presenting at their October 28 meeting.

### **Next steps for the Committee**

- The committee will continue to finalize policy suggestions for all of the committees that have presented thus far.
- On October 28, the committee will be presenting their recommendations before the Health Care Workforce Committee. The HEPRC representatives who will be presenting will meet on Tuesday, October 25 to finalize plans for the meeting.
- On November 4, the committee will begin their work on the Health Blueprint.
- On November 4, the committee will hear from representatives of the Health Information Technology Oversight Committee.
- On November 16, the committee will present at the OHPB meeting.

## **Healthcare Workforce Committee**

**Next meeting: 9 am – noon December 8<sup>th</sup> in Portland**

**Portland State Office Building, Room 1C, 800 NE Oregon Street**

The Healthcare Workforce Committee met last on October 28th.

Recent Committee decisions and agreements:

- At the October meeting, the Committee confirmed the draft short-and long-term recommendations that the Chairs will present to the Health Policy Board on November 16<sup>th</sup>. The recommendations support three priorities that the Committee had defined earlier, namely:
  - preparing the current and future workforce for new models of care delivery;
  - improving the capacity and distribution of the primary care workforce; and
  - expanding the size of the workforce through education, training, and regulatory reform
- Short-term recommendations are to:
  - Fund Oregon’s primary care loan repayment program to meet at least 5% of projected workforce need
  - Standardize the administrative requirements for student clinical training
  - Enable educational institutions to respond quickly to health care workforce training needs (by revising interpretation of the “adverse impact” policy)
  - Maintain resources for health professions education programs, despite budget woes
  - Expand healthcare workforce data collection
- Longer-term recommendations are:
  - Use delivery system and payment reform pilots to build evidence for new workforce models and to refine projections of future workforce demand
  - Define new standards for health care workforce competencies
  - Adopt a payment system that encourages the most efficient use of the health care workforce
  - Identify barriers that prevent health care professionals from practicing to the full scope of their licenses
  - Stimulate local creativity and resource sharing for health care workforce development
  - Enhance resources for health professions education programs
  - Maintain and enhance resources for K-12 math, science, and health career exposure
- The Committee agreed to incorporate many recommendations from the Health Equity Policy Review Committee into its draft report. There was broad support for the idea of improving cultural competency among health care professionals but some disagreement about whether a re-licensure course requirement was the best way to make that improvement.

#### Issue areas discussed

- Committee members discussed the need for payment reform to help catalyze some of the workforce changes that are necessary. For example, it will be difficult for providers to organize inter-professional teams that use the most appropriate practitioner for a given patient need if payment is limited to cases in which a doctor provides the care.
- Members also discussed the desire to balance making recommendations to address the state's current workforce needs and the needs we might have in the future, when health care delivery looks different than it does today.

#### Areas for continued discussion

- In reviewing long-term recommendations, the Committee identified several issues to add to its 2011 work plan, including reviewing evidence from delivery reform pilots to inform workforce development needs and plans and considering mechanisms for and barriers (e.g. antitrust laws) to cooperative health care professional recruitment and retention across employers and communities.

#### Next steps for the Committee

- Committee chairs will present draft recommendations to the Health Policy Board on November 16<sup>th</sup>. Any revisions or clarifications requested will be discussed with the Committee at its December 8<sup>th</sup> meeting, before final recommendations are delivered to the Board on December 14<sup>th</sup>.

## Health Equity Policy Review



HEPRC Committee Report  
November 9, 2010




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## What is Health Equity?

*Health equity is the attainment of the highest level of health for all people.*

*Achieving health equity requires valuing everyone equally with **focused and ongoing societal efforts to rectify historical and contemporary socially patterned injustices, and the elimination of health disparities***

The Department of Health and Human Services

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## Why should we care about health inequities?

- \$1.24 trillion  
(2003 – 2006)
- 139.8 excess deaths per 100,000 due to income inequities (1998)
- 83,570 excess African American deaths (2000)

Source: Joint Center for Political and Economic Studies, September 2009  
David Satcher, et al. *Health Affairs*, 24, no. 2 (2005): 459-464  
J W Lynch, et al. *Am J Public Health*, 1998 July; 88(7): 1074-1080.

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## How does Health Equity relate to the Triple Aim?

Oregon's Triple Aim:

1. Improve lifelong health of all Oregonians

### Oregon Life expectancy by race/ethnicity

	1996	2006
Non Hispanic White	77.02	78.96
Hispanic	83.90	87.53
Asian and Pacific Islander	81.52	85.73
Native American	74.31	76.89
African American	71.43	76.80

Life expectancy of migrant/seasonal farm workers: 49 years

Source: Oregon Department of Human Services, Office of Health Statistics (2007)

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## Current Challenges to Health Equity

Oregon health rankings:

- 14<sup>th</sup> in the number of **African American heart disease deaths** per 100,000 population
- 26<sup>th</sup> in the percentage of **African American and Latino live births by cesarean delivery**.
- 47<sup>th</sup> in the number of **African American diabetes deaths** per 100,000 population by race/ethnicity
- 47<sup>th</sup> in the number of African American number of deaths caused by **stroke** and other cerebrovascular diseases.

Source: Kaiser Family Foundation, 2006

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## Age at Onset of Chronic Conditions

### COLORECTAL CANCER:

- African Americans were more than twice as likely as whites to present with advanced Colorectal Cancer before age 50
  - HOWEVER, The American Cancer society suggests that screening begin at age 50.

### BREAST CANCER:

- In the age groups, 30-54 and 55-69 years, African-American women have the highest death rate from breast cancer, followed by Hawaiian women, and white non-Hispanic women.
- African American women are more likely to be diagnosed with a later stage of breast cancer than white women.
  - HOWEVER, The American Cancer Society suggests that yearly mammograms do not begin until age 40.

SOURCE: The American Cancer Society (2010), Jancin, Bruce. "Early colorectal ca screen advised for key groups: African Americans, diabetics, and female smokers are found to be at substantially above-average risk" OBGYN News. (2005)

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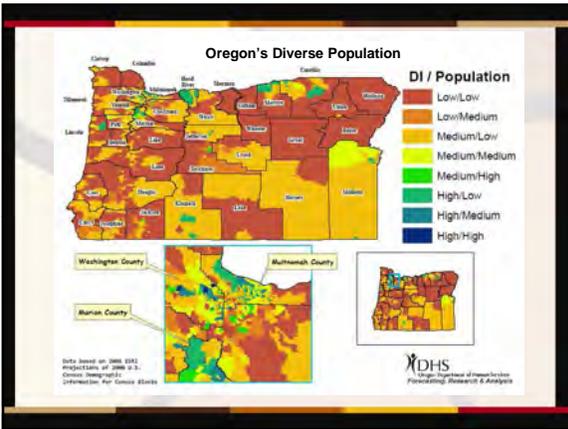
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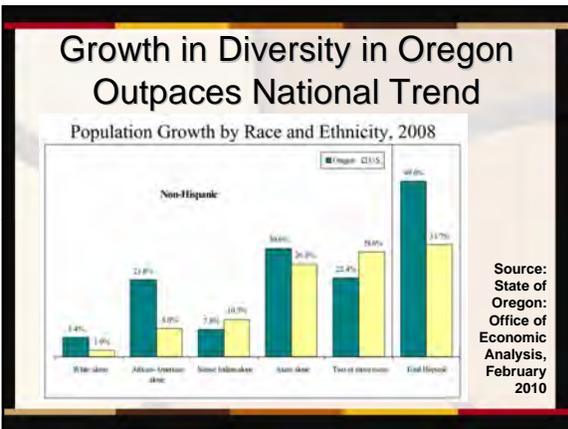
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### Oregon's Diversity by Age

Distribution Within Racial/Ethnic Groups by Age – 2006-2008

	Under 18	Over 65
White	20.1%	15.1%
Black	30%	7.5%
American Indian, Eskimo, or Aleut	28.3%	6.7%
Asian or Pacific Islander	22.1%	8.5%
Hispanic or Latino origin (of any race)	39.6%	2.9%
Two or more races	42.6%	4.9%

Source: American Community Survey 2006-2008

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**Oregon ranks 44<sup>th</sup> in the country with 8% of doctors internationally trained**



Source: American Medical Association, 2004

**How does Health Equity relate to the Triple Aim?**

Oregon's Triple Aim:

**3. Lower or contain the cost of care so it is affordable to everyone**

**Income Inequities in Oregon**

	White	Hispanic	Black	Native American
<b>Poverty Rate</b>	7.4%	23.6%	27.2%	19.3%
<b>Median Household Income</b>	\$51,492	\$37,205	\$29,841	\$38,351

Source: American Community Survey (2006-2008)

**OMHS Health Equity Policy Priorities**

- Implement and strengthen **Oregon's Health Care Interpreter (HCI) Law**
- Develop and sustain model **Community Health Worker** programs and include them in patient-centered primary care teams.
- **Cultural competence** continuing education for Oregon's health care providers.
- Improve collection and analysis of health care quality and health outcomes **data by granular equity indicators**.
- **ALL pregnant women in Oregon** must have equitable access to prenatal care .
- **ALL children in Oregon** must have equitable access to affordable, quality health care.

## Health Equity Policy Review Committee

- Convened in September 2010, conclude in February 2011
- Culturally, geographically, and professionally diverse
- **Evaluate all recommended policy improvements** prior to their presentation to the OHPB to assure they fully promote the elimination of inequities and promote health equity.
- Identify both **near-term and long-term opportunities to promote health equity in Oregon** by strengthening and modifying recommendations, expand or tailor approaches.

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## Health Equity Recommendations

- Inclusivity
  - Work with racially and ethnically diverse community-based organizations to generate **quality standards that include cultural competence and payment incentives** for providers to meet these standards
  - Require a racially and ethnically diverse **consumer majority (51%) on the Oregon Health Insurance Exchange** and other consumer and governing boards
  - OHPB and committees should use **race/ethnicity conscious metrics** and language to emphasize priority of ending health inequities

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## Health Equity Recommendations

- Inclusivity
  - Support health care workforce development programs to **recruit and retain a racially and ethnically diverse workforce**
  - Assure and sustain **Community Health Workers** as a critical member of the health care workforce

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**Health Equity Recommendations**

- **Accountability**
  - Collect, compile, analyze, and share accurate and granular demographic data in order to effectively measure and ensure progress towards ending health inequities.
  - Expand quality standards to Culturally and Linguistically Appropriate Health Service (CLAS) Standards and create payment incentives to ensure that health care systems meet these standards.
  - Develop differential screening standards by race/ethnicity in order to address culturally specific health inequities at an earlier stage

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**Short-term Next Steps for HEPRC**

The Committee recommends that it

- **be formally chartered** to have an ongoing and formal role aligned with the structure of other OHPB committees to provide an on-going, timely, and tailored equity review
- interact directly to the OHPB to **highlight priority and cross-cutting equity issues and recommendations**
- develop strategies to **implement emerging, promising, and best practices for promoting health equity** to be delivered to the Oregon Health Policy Board, committee members, and OHA staff

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Excellence is an art won by training and habituation.

We do not act rightly because we have virtue or excellence, but we rather have those because we have acted rightly. We are what we repeatedly do.

Excellence, then, is not an act, but a habit.

*Aristotle*

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## Questions?

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[www.oregon.gov/dhs/ph/omh](http://www.oregon.gov/dhs/ph/omh)

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# Oregon Health Improvement Plan Committee Recommendations

Presentation to  
Oregon Health Policy Board

Tammy Bray and Lila Wickham  
November 9, 2010



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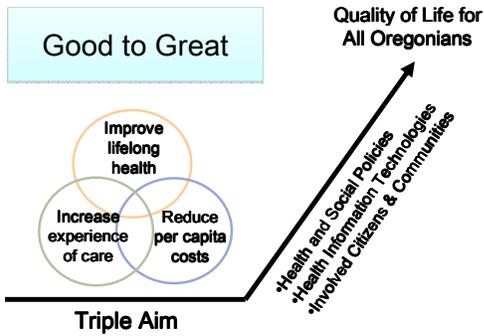
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Good to Great



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## Primary Goal of Health Improvement Plan Committee Defined by Oregon Health Policy Board

“Improve the health of Oregonians by promoting and supporting lifestyle choices that prevent and manage chronic diseases”

Measured by:

- Self Report of good or Excellent Health Status
- Premature Death

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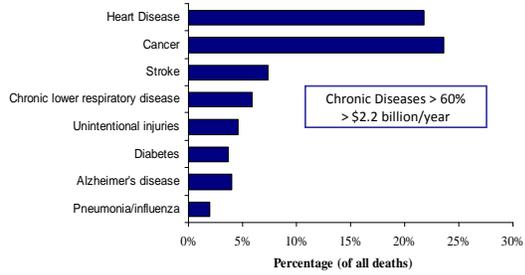
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## Leading Causes of Death in Oregon



Source: National Center for Health Statistics

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## HIP Committee Process to date

- 26 Committee members
- 10 committee meetings from March 30 – October 8, 2010
- 8 Community Listening Sessions
- Website Community Input Survey (for those not able to attend a listening session)
- Website Public Input for review of final draft, through October 29, 2010

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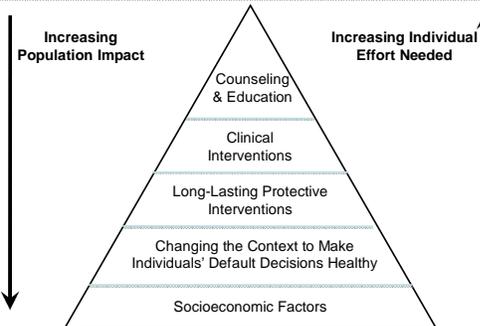
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## The Health Impact Pyramid

Frieden, *AJPH*, 100 (4):590-595 (2010)



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### Criteria for Setting Priority of Actions

<b>Consistent w/ HB 2009 Mandate, HIP Charter &amp; OHPB feedback</b>	Not mentioned or supported (+)	Specifically mentioned and supported by OHPB (++++)
<b>Based on evidence, best practice &amp; promising practice</b>	Little to none (+)	Solid literature based evidence (++++)
<b>Can be tracked with data by population groups &amp; counties</b>	Data does not exist (+)	Data exists for most population & readily accessible (++++)
<b>Attuned to state budget situation for 2011-2013 &amp; future</b>	Revenue to support does not exist (+)	Revenue to support exceeds program costs (++++)
<b>Total Scores</b>		
<b>Incorporated or transferred to other committee</b>	OHA/DMAP; HITOC; Public Employers Health Purchasing Committee; Health Incentives and Outcomes Committee; Healthcare Workforce Committee.	

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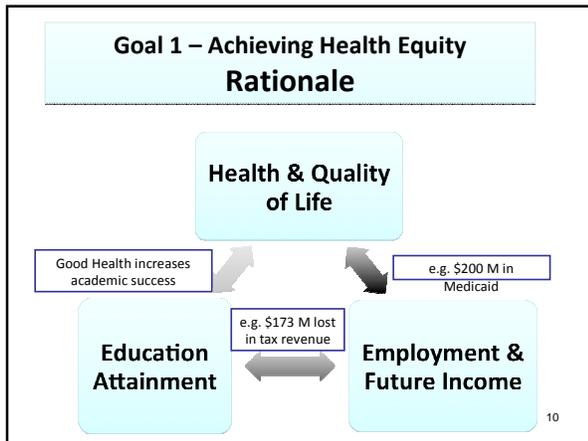
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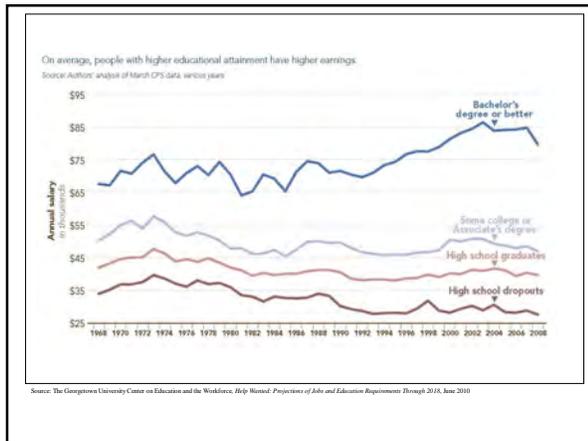
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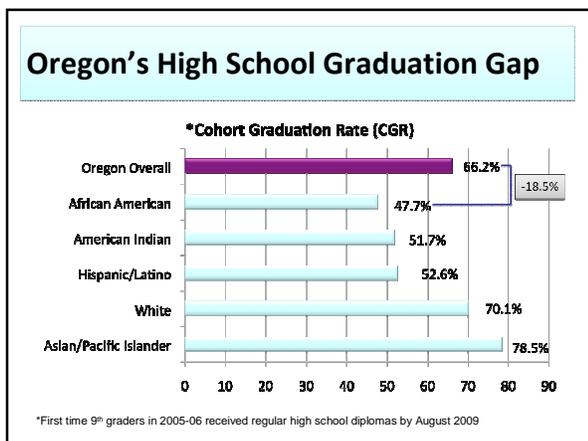
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### Goal 1 – Achieving Health Equity Rationale

- By focusing on the health of youth in school settings we create an equitable **“health empowerment zone”** that **reduces disproportionate disparities** in health status and health care.
- Targeting school-aged youth has the greatest potential of improving the long-term socioeconomic status and yield significant returns on investment.

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### What Oregon Health Authority (OHA) can do to achieve Goal 1 in Year 1?

- Advocate that the legislature maintain funding for Headstart Programs
- Support legislation that promotes health in the school setting
- Require partnerships among and between state and community agencies
- Inventory, expand and improve K-12/college programs aimed at diversifying the health and health care workforce

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### Goal 1 – Action Timeline After Year 1

#### 2012-2014

- Expand early childhood education
- Implement strategies to improve educational attainment and address the racial and ethnic disparities in high school and post-high school success
- Perform **‘Health Impact’** Assessments for school building projects
- Provide prompt access to **mental health** services for school and transitional age youth

#### 2015-2020

- Promote **stable housing** for low-income families and emphasize the importance of **culturally-specific** housing programs and cultural centers

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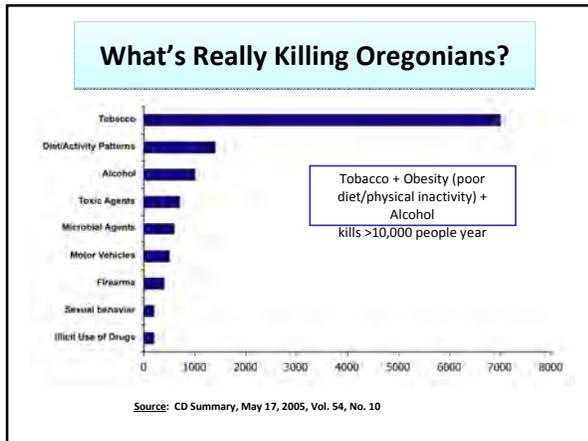
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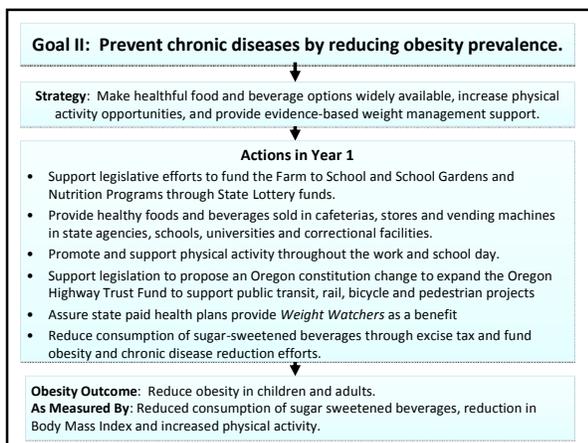
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## Goal II (Obesity) – Action Timeline after Year 1

### 2012-2014

- Adopt healthy food standards in additional settings
- Expand the availability of weight management programs (Weight Watchers)
- Promote active transportation
- Reduce sodium content in packaged/restaurant foods

### 2015-2020

- Supplement SNAP to provide incentives for purchase of healthier foods
- Develop healthy food markets in low-income neighborhoods and create a **culturally specific food** and economic development plan that partners with community business owners to provide culturally-specific healthy food

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## Goal II: Prevent chronic diseases by reducing tobacco use

**Strategy:** Create tobacco-free environments, prevent initiation of tobacco use, support cessation, and counter pro-tobacco influences.

### Actions in Year 1

- Tobacco-free campus policies in state agencies, addictions and mental health facilities contracting with OHA, and hospitals
- Smoke-free policies for all public multiunit housing
- Evidence-based tobacco cessation health insurance benefits are available in all state paid plans.
- Prevent initiation and reduce consumption of tobacco by raising the price of cigarettes by \$1/pack excise tax; 10% of revenues will be dedicated to best/emerging practice interventions by counties, regions, tribes, schools, coalitions and community-based organizations.

**Tobacco Outcome:** Reduce Tobacco Use in children and adults.  
**As Measured By:** Oregon Healthy Teens Survey, BRFSS,

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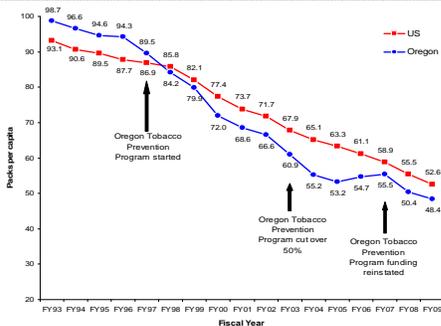
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## Annual Per Capita Cigarette Consumption



Source: Data from the Oregon Department of Revenue

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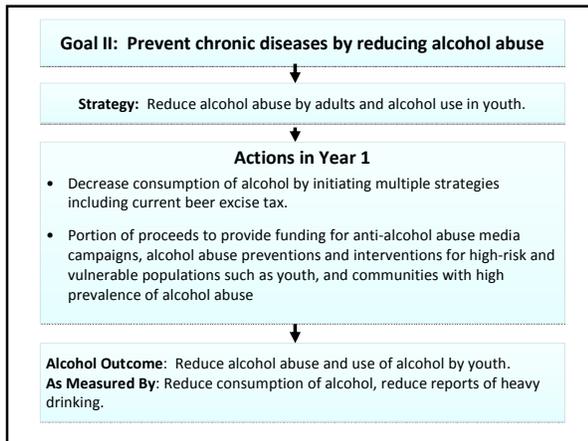
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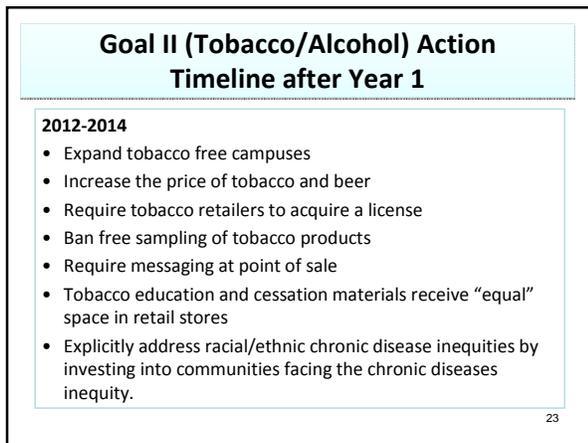
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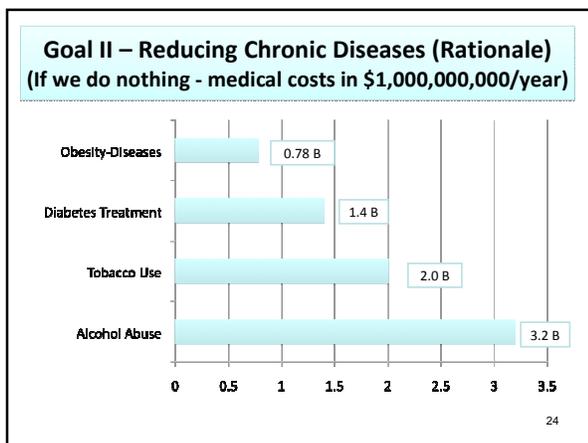
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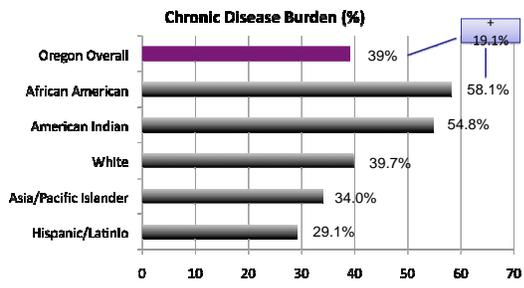
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**Racial/Ethnic Health Inequity in Tobacco- & Obesity-Related Chronic Disease Burden**




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**If we do prevention - How much does prevention program cost? (per year in \$1,000,000)**




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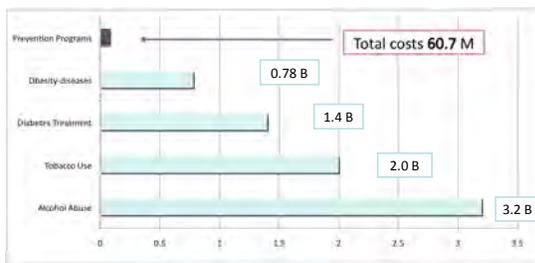
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**Goal II – Reducing Chronic Diseases (Rationale)  
(Comparison of Prevention Costs to Medical Costs)**




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### What Oregon Health Authority (OHA) can do to achieve Goal II in Year 1?

- Support legislative efforts to fund Farm to School and Nutrition Programs
- Assure healthy foods are sold in state funded agencies
- Support legislation to use Oregon Highway Trust Funds to support active transportation
- Implement tobacco-free campuses in state agencies and agencies contracting with OHA
- Support smoke-free policies for public multi-unit housing
- Explicitly address racial/ethnic chronic disease inequities

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### What Oregon Health Authority (OHA) can do to achieve Goal II in Year 1?

- Support legislative efforts to create a sugar-sweetened beverage tax that is known to be effective in reducing consumption
- Support legislative efforts to raise the price of tobacco to further reduce consumption
- Convene multi-sector group to develop legislative language to raise the beer tax to a level that is known to be effective in reducing consumption

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### Goal III: Stimulate linkages, innovation and integration among public health, health systems and communities

↓  
**Strategies:** Increase the effectiveness and efficiency of Oregon's public health system integration between health care systems and community support systems

#### ↓ Actions for Year 1

- Utilize community health workers, public health nurse home-visiting, case managers to create a bridge between medical home and community resources
- Create Community Health Assessments and resultant Health Improvement Plans using the expertise of hospitals, public health and community organizations
- Create regional health collaboratives that support integration, reduce duplication, assure community participation, produce strong data sets that support policy decisions
- Require the collection of racial and ethnic data at the most granular level

↓  
**As Measured By:** The presence of the actions described above, hospital readmissions and preventable hospital admissions

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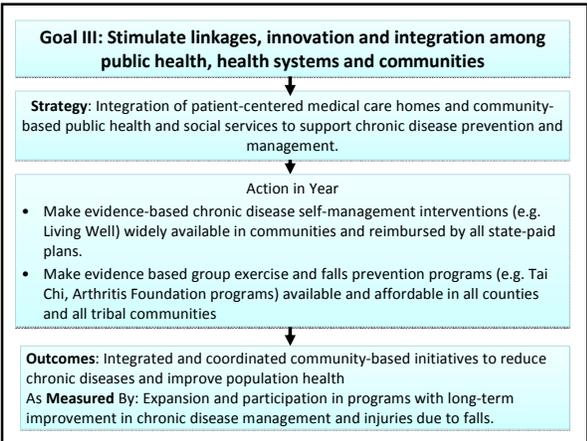
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**Goal III Stimulate system innovations**

**Rationale**

Supporting communities to develop local coordinated and collaborative solutions to community health problems will improve:

- Planning that reflects data and outcomes
- Priority setting
- Force the analysis of existing resources
- Promote system integration
- Focus on prevention and management of chronic diseases

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**What Oregon Health Authority (OHA) can do to achieve Goal III in Year 1?**

- Develop community level Health Improvement Plans (CHIP) capitalizing on the CDC Public Health Capacity grant
- Redirect resources acquired from savings achieved from integration, coordination and regional collaboration to CHIPS that focus on prevention of chronic disease
- Provide ongoing funding for current community based chronic disease prevention efforts like Healthy Eating Active Living
- Designate Health Information Technology funding to assure racial and ethnic health data is collected

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### Goal III – Action Timeline after Year 1

#### 2012-2014

- Seek national accreditation by state and local health departments
- Expand Public Health Accreditation standards to include 'culturally and Linguistically Appropriate Service' (CLAS) standards
- Fund local Health Improvement Plans that support vulnerable populations to improve health equity and explicitly support the 'Community Health Worker' model
- Reimburse for Healthy Homes asthma prevention programs
- Develop "Community Health Team" models that coordinate, navigate, integrate and track referrals and outcomes between medical homes and community services
- Measure the savings resulting for chronic disease interventions and redirect the savings to expansion to primary prevention and the OHP
- Expand statewide programs that demonstrate improved health outcomes resulting from community coordination and communication.

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### Recommendations Referred to Other Committees (separate report)

- *Health Information Technology Oversight Council*
- *Public Employers Health Purchasing Committee*
- *Health Incentives and Outcomes Committee*
- *Healthcare Workforce Committee*

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### Website Survey Respondents

300 respondents

- 27% concerned citizens
- 17% non-profit organizations
- 3% business
- 33% state or local government
- 12% health care
- 2% school/higher education

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### Survey Results

- 86% of respondents agreed that Goal 1 moves Oregon in the right direction
- 84% of respondents agreed that Goal 2 moves Oregon in the right direction
- 88% of respondents agreed that Goal 3 moves Oregon in the right direction
- 78% agreed the HIP moves Oregon forward in improving the health of all Oregonians
- 76% rated support of the OHIP as high

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### Recurring themes from OHIP Survey

- Primary prevention is the way to impact future generations
- Health equity is more than education
- Plan should (and does not) include mental health and addictions as a chronic disease/problem
- Broaden the stakeholders
- Emphasize prevention across the lifespan
- Include oral health
- Community based collaborations are key
- Get government out of health it is an individual responsibility
- Taxes will not improve anything
- Make the plan easier to understand/eliminate the jargon

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### Suggestions for Moving the Plan Forward

- Bring the goals back to the community, use local coalitions
- Mental Health, Addictions and Substance Abuse are related to health improvement
- Show taxpayers how it will save money
- Fund prevention
- Share the plan widely and continue to involve communities
- Broad based support is important to move the agenda
- Incorporate the Health Equity Policy Review Committee recommendations into the final HIP Plan

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**Thank you!**  
**謝謝!**

Oregon  
**Health**  
Anthem

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Oregon Health Policy Board  
HEALTH IMPROVEMENT PLAN  
OHPB Staff Recommendations

**Date:** November 9, 2010

**Recommended Board Action:** The Committee should be commended for their great work in gathering broad input from around Oregon and finalizing this report in such a compressed time.

Accept the attached final report from the Health Improvement Plan Committee.

The report will be used to inform the Board's "Blueprint for Health".

**Background:** The Health Improvement Plan Committee, a group consisting of 26 members who represent schools, government agencies, tribes, businesses, and communities throughout the state, was established in January 2010 by the Oregon Health Policy Board. The committee was charged with developing an overarching plan with short- and long-term actions to improve the health of all Oregonians.

Nationally, 83 cents and 96 cents of Medicaid and Medicare dollars respectively, are spent treating chronic diseases, and hospitalization costs in Oregon for chronic diseases alone are estimated to exceed \$2.2 billion a year. To achieve the Triple Aim, the OHA must address more than the provision of health care and shift its approach to also creating environments and systems that improve the public's health and support both the prevention and management of illness. The OHA must address the social factors that impact the places in which Oregonians live, play, learn and work, and create innovations and new collaborations within our current systems.

Based on extensive research and community input, the Oregon Health Improvement Plan is organized into three goals with corresponding outcomes, strategies, actions and timelines:

1. **Achieve health equity and population health by improving social, economic and environmental factors.** **Outcome:** Increase high school graduation rates and college degrees for populations with disparities. **Strategy:** Target resources to improve child and student health (birth through higher education) to support improved education outcomes.
2. **Prevent chronic diseases by reducing obesity prevalence, tobacco use and alcohol abuse.** **Obesity Outcome:** Reduce obesity in children and adults. **Strategy:** Make healthful food and beverage options widely available, increase physical activity opportunities, and provide evidence-based weight management support. **Tobacco Outcome:** Reduce tobacco use and exposure. **Strategy:** Create tobacco-free environments, prevent initiation of tobacco use, support cessation, and counter pro-tobacco influences. **Alcohol Outcome:** Reduce alcohol abuse. **Strategy:** Reduce alcohol abuse by adults and alcohol use in youth.

3. **Stimulate linkages, innovation and integration among public health, health systems and communities.** ***Outcome:*** Implementation of integrated and coordinated community-based initiatives to reduce chronic diseases and improve population health. ***Strategy 1:*** Increase the effectiveness and efficiency of Oregon’s public health system. ***Strategy 2:*** Establish and fund systemic integration between patient-centered medical care homes and community-based public health and social services resources to support chronic disease prevention and management.

# **Oregon Health Improvement Plan**

*Improving the health of all Oregonians  
where they live, work, learn and play*

October 2010

A report of the  
Oregon Health Improvement Plan Committee

Oregon Health Policy Board  
Oregon Health Authority

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[The appendices for this document can be found here](#)

October 20, 2010

Dear Oregon Resident,

In the coming months, you will be hearing a lot about the Oregon Health Improvement Plan. With all of the health care reform that is currently taking place across the nation, you may be wondering what this Plan is. First let me tell you what it is not. This is not a plan to eliminate or control the care you receive from your doctor. It is not a plan focused on health insurance or prescription drugs.

The Oregon Health Improvement Plan is a series of recommendations to improve the lifelong health of Oregonians, prevent chronic disease, and stimulate innovation and collaboration within our communities. Its focus is on finding ways to ensure people's health long before health *care* is needed. Its goal is to create environments and systems that provide every Oregonian, regardless of their income, education, or racial/ethnic background, with the opportunity to make healthy choices for themselves and their families.

What does this Plan mean for you? It means that over the next 10 years, you'll find more early childhood education opportunities, such as Head Start and pre-kindergarten, and you'll see more restaurants and vending machines offering foods that meet national nutrition standards. It means play time will be a part of every school day, and walking, bicycling or riding the bus to work or school will be more convenient. It means that wherever you go, you won't breathe secondhand smoke. It means the cost of your medical care won't continue to grow.

These aren't pie-in-the-sky goals. They are all achievable, but we need your help. Think about how you would draw the ideal community in which people are able to eat better, move more and breathe clean air. Think about how you design sidewalks, transit systems, bike paths, schools, restaurants, parks and workplaces, not just about the availability of health clinics. Then get involved. For more information, please visit our website to stay informed of HIP progress and activities (<http://www.oregon.gov/DHS/ph/hpcdp/hip/index.shtml>).

Every Oregonian can be a leader of the health of their community. Our legacy demands it.

Sincerely,

Tammy Bray, Chair  
Oregon HIP Committee

Lila Wickham, Vice Chair  
Oregon HIP Committee



## Executive Summary

In recent years there has been a major shift in the way we perceive health in our communities - Instead of waiting until we are sick to *treat* an illness, we are working together to *prevent* illness. Our old approach has been a costly endeavor: Nationally, 83 cents and 96 cents of Medicaid and Medicare dollars respectively, are spent treating chronic diseases, and hospitalization costs in Oregon for chronic diseases alone are estimated to exceed \$2.2 billion a year. To have a meaningful and lasting impact on the cost of care and the overall health of our communities we need to change our approach to create environments and systems that support both the prevention and management of illness. To help address these issues, the Oregon Health Policy Board created the Oregon Health Improvement Plan (HIP) Committee in January 2010 with the charge of recommending innovative solutions to improve the lifelong health of all Oregonians; increase the quality, reliability and availability of care; and lower or contain the cost of care so it is affordable to everyone. To achieve these objectives, it is essential that we address more than the provision of care. We must also address the social factors that impact the places we live, play, learn and work, and we need to create innovations and new collaborations within our current systems. The Oregon Health Improvement Plan is organized into three goals with corresponding outcomes and strategies that are based on extensive research and community input.

1. **Achieve health equity and population health by improving social, economic and environmental factors.** **Outcome:** Increase high school graduation rates and college degrees for populations with disparities. **Strategy:** Target resources to improve child and student health (birth through higher education) to support improved education outcomes.
2. **Prevent chronic diseases by reducing obesity prevalence, tobacco use and alcohol abuse.** **Obesity Outcome:** Reduce obesity in children and adults. **Strategy:** Make healthful food and beverage options widely available, increase physical activity opportunities, and provide evidence-based weight management support. **Tobacco Outcome:** Reduce tobacco use and exposure. **Strategy:** Create tobacco-free environments, prevent initiation of tobacco use, support cessation, and counter pro-tobacco influences. **Alcohol Outcome:** Reduce alcohol abuse. **Strategy:** Reduce alcohol abuse by adults and alcohol use in youth.
3. **Stimulate linkages, innovation and integration among public health, health systems and communities.** **Outcome:** Implementation of integrated and coordinated community-based initiatives to reduce chronic diseases and improve population health. **Strategy 1:** Increase the effectiveness and efficiency of Oregon's public health system. **Strategy 2:** Establish and fund systemic integration between patient-centered medical care homes and community-based public health and social services resources to support chronic disease prevention and management.

The completion of the Oregon Health Improvement Plan is just the beginning. A path forward has been identified, but it will take the efforts of every Oregonian to put the plan into practice. In the coming years, the HIP Committee will be working with state and local public health agencies, education and transportation agencies, health care systems and Oregon residents to tailor the strategies and actions within the Plan to the needs of individual communities, and then put them into practice. As progress is made, the Committee will also work with appropriate agencies to collect data to ensure our ability to measure the impact of this important work on Oregon's diverse populations.

**Background, Community Engagement, and Areas of Focus**

**Background**

The Oregon Health Policy Board (OHPB) and the Oregon Health Authority (OHA) were recently created through the passage of House Bill 2009. The OHPB is a nine-member citizen Board that serves as the policy-making and oversight body for the Oregon Health Authority, a new state agency that will encompass all of the health related programs in the state. The OHPB has a triple aim: 1) Improve the lifelong health of all Oregonians; 2) Increase the quality, reliability and availability of care for all Oregonians; and 3) Lower or contain the cost of care so it is affordable to everyone.

In January 2010, the Oregon Health Policy Board (OHPB) created the Health Improvement Plan (HIP) Committee, a group consisting of twenty-six members who represent schools, government agencies, tribes, businesses, and communities throughout the state. The Committee was charged with developing an overarching plan with short- and long-term actions to improve the health of all Oregonians. The Plan must use evidence-based interventions that incorporate policy, systems, and environmental approaches to promote the overall health of Oregonians across the state; and emphasize coordination among health care delivery systems, public health, community-based organizations, and individual communities. This document contains the Committee's first draft of Oregon's Health Improvement Plan. It is scheduled to be finalized and submitted to the OHPB after a public comment period.

The HIP Committee utilized a set of guiding principles to direct its work throughout the development of the Plan. These principles called for a focus on: 1) prevention; 2) evidence and data; 3) health equity; 4) addressing social, economic and environmental factors; 5) respecting cultures and traditions; 6) empowering local communities; and 7) creating short- and long-term policy actions. These principles were echoed by the community and participating stakeholders, and are reflected in the recommendations of the Plan. Additional information on the guiding principles and other key theoretical frameworks the Committee used can be found in the Appendices.

**Community Engagement Process**

The HIP Committee recognizes and values the wisdom and experiences of both individuals and organizations, and has diligently worked to ensure that this critical information is included in its recommendations and built upon previous community engagement. In addition to reviewing numerous statewide plans and reports, national guidelines, and evidence-based and best/promising practices, the HIP Committee conducted an extensive community engagement process to inform the Health Improvement Plan. To gain local and regional perspectives, the Committee hosted a series of community listening sessions in Pendleton, Medford, Hillsboro, Portland, Bend, Madras, Prineville, Grand Ronde, and at the Health Commission of the Confederated Tribes of Umatilla, between the months of April and August, 2010. The Committee also conducted a web-based Community Input Survey in June 2010. In both the sessions and the survey, participants were asked the following questions:

1. What are the issues in your community that have the greatest impact on your health and that of others in the community?

2. What is happening in your community that promotes health and supports a thriving community?
3. What 3-5 changes in policy would make your community healthier and thrive?

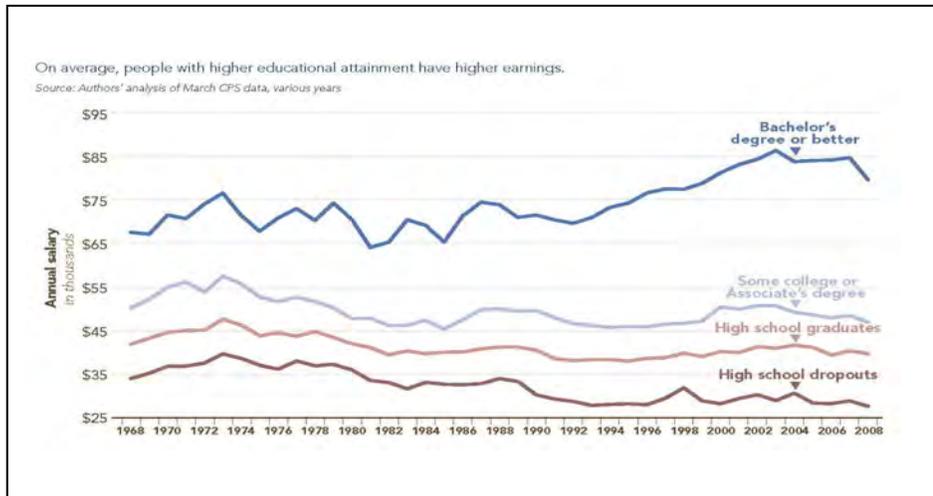
An analysis of the data showed that Oregonians believe core issues such as poverty and education, and chronic conditions including diabetes and addiction, have the greatest impact on the health of their communities. These findings, which are also supported by local and national research, have been woven into all of the components of the plan. However, the community engagement process does not end here. Over the next several years, the Health Improvement Plan Committee will be working with state and local public health agencies, education and transportation agencies, businesses and worksites, health care systems, community- and faith-based organizations, and Oregon residents to tailor the strategies and actions within the Plan to the needs of individual communities, and then put them into practice.

### **Identified Areas of Focus**

The Health Improvement Plan is organized into three areas of focus: Achieving Health Equity and Population Health; Preventing Chronic Disease; and Stimulating Innovation and Integration. Each area has corresponding goals, outcomes, strategies, and actions which are laid out in the Plan. The following narrative provides a brief description of each area of focus.

**I. Achieving Health Equity and Population Health** – Our health is determined by much more than individual behavior, health care, or genetics. Though we don't usually associate social factors with health, the places we live, play, learn and work have huge impacts on our health and are shaped by economics, social policies and politics. Efforts to get people to eat right, exercise more, and stop smoking can only go so far without addressing the significant health disparities and health inequities seen in the U.S. Health *disparities* are differences between population groups with regard to disease and health outcomes, or access to care<sup>1</sup>. These disparities may be the result of health *inequities*, differences that result from social factors such as economic forces, educational quality, environmental conditions, individual health behavior choices, and access to health care. As the name suggests, health inequities are unfair; they are also reversible<sup>2</sup>. Policies and decisions about education, employment, housing, transportation, land use, economic development, and public safety can either mitigate or widen health disparities and inequities. To effectively address health equity and population health, both health expertise and community wisdom must be a part of all policy and programmatic decisions in Oregon.

After reviewing the research and considering the input from Oregonians throughout the state, the need to focus on education initiatives was clear. Research has shown that the link between education and health is strong, though complex. Educational attainment is negatively impacted by the effects of poor health in childhood, positively impacts future income levels and social networks, and contributes to the understanding and practice of good health behaviors. No other single factor will improve health more, for all of Oregon's many populations, than increased educational attainment and the employment and income benefits it creates.



Source: The Georgetown University Center on Education and the Workforce, *Help Wanted: Projections of Jobs and Education Requirements Through 2018*, June 2010

The Health Improvement Plan proposes several activities to create explicit linkages between the health of young people and education in order to increase the educational attainment by Oregon's youth. For example, Oregon's public health system and community-based organizations can partner with the state Department of Education and local school districts to ensure students are healthy and able to achieve their fullest potential; early childhood education programs can be strengthened and expanded; and schools can be utilized as community meetings spaces to promote community engagement and support healthy lifestyles. Throughout this process, improved ability to collect and analyze current data to monitor and evaluate health, social, economic and environmental factors among Oregon's diverse populations will be critical.

**II. Preventing Chronic Diseases** – Medical care will always be a part of health. However, to improve the overall health of Oregonians and ensure the availability of affordable, high-quality medical care we must increase our focus on preventing chronic disease. The cost of treating chronic diseases is staggering. Nationally, 83 cents and 96 cents of Medicaid and Medicare dollars, respectively, are spent treating chronic diseases<sup>3</sup>, and hospitalization costs in Oregon for chronic diseases alone are estimated to exceed \$2.22 billion a year<sup>4</sup>. Almost half of Oregon adults (45%) have at least one chronic disease<sup>5</sup>, and in 2007, chronic diseases caused more than 60 percent of the deaths in Oregon<sup>6</sup>.

Obesity, tobacco, and alcohol abuse are responsible for 50 percent of the chronic disease deaths in Oregon each year<sup>7</sup>. An analysis of data from the 2009 Behavioral Risk Factor Surveillance System and the Oregon Healthy Teen Survey produced the following results. Since 1990, obesity in Oregon adults has increased 121 percent, and between 2001 and 2009, obesity jumped 54 percent among middle and high school students. Though comprehensive strategies have significantly reduced tobacco use in Oregon, the 2009 data reports that 17.5% of adults and 9.9% of 8<sup>th</sup> graders and 14.9% of 11<sup>th</sup> graders continue to smoke. Alcohol abuse, defined as having had more than one drink per day for women, or more than two drinks per day for men, has been identified in approximately 6% of Oregon adults, and has significant impacts on individual health, the health and well-being of families, and broader social and

economic issues including public safety and worker productivity. Today, the number of Oregon 8<sup>th</sup> graders who have had a drink in the past 30 days is twice the national average. Addressing these three risk factors is the most promising strategy for improving population health and lowering future chronic disease costs.

The Health Improvement Plan makes several recommendations to address the high rates of obesity, and tobacco and alcohol use in Oregon. Creating environments that are tobacco free and provide access to healthy, affordable, culturally appropriate choices for foods and beverages, and safe places for daily physical activity will have the highest impact in preventing these chronic diseases and preventing further complications. Though strategies and actions have been identified for each issue, it is critical that we look at the prevention of these chronic disease risk factors as a single initiative to create environments where making healthy choices is common, affordable, safe and accessible for all Oregonians.

**III. Stimulating Innovation and Integration** – The health issues described throughout this document are complex issues with numerous contributing factors that no single person or agency can adequately address alone. As a result, the expertise and active participation of numerous stakeholders, including individual community members, community and faith-based organizations, and governmental agencies, need to be part of the response. As part of this collaboration, public health agencies can play a key leadership role in supporting the development of local solutions by assessing conditions at the community level, assuring data is available to analyze and prioritize actions, coordinating system integration efforts, and developing local health improvement plans. To be effective, all stakeholders must be involved in the creation of new collaborations, ideas, and ways of doing things.

Many of the ideas and solutions that will arise from this new collaborative approach will take several years to implement. However, the HIP Committee has identified several areas for immediate action within the Plan. These include developing mechanisms to collect accurate population health and risk factor data by race, ethnicity and economic status and link it to clinical, emergency, and hospital data at the community and state levels; strengthening the ability to link public health with the health care delivery system; and providing opportunities for collaboration among multiple stakeholders.

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<sup>1</sup> Department of Health and Human Services (US). *Healthy People 2010: Understanding and Improving Health*. 2<sup>nd</sup> ed. Washington: DHHS; 2000 Nov.

<sup>2</sup> Baker, Metzler, Galea. 2006. Addressing Social Determinants of Health Inequities: Learning from Doing. *American Journal of Public Health*, 95(4), 553-555.

<sup>3</sup> Chronic Conditions: Making the Case for Ongoing Care, September 2004 Update. Robert Wood Johnson Foundation. <http://www.rwjf.org/files/research/Chronic%20Conditions%20Chartbook%209-2004.ppt>

<sup>4</sup> 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.

<sup>5</sup> 2009 Oregon Behavioral Risk Factor Surveillance System.

<sup>6</sup> Oregon Department of Human Services analysis of 2007 Death Certificate data.

<sup>7</sup> Oregon Department of Human Services analysis of 2003 Death Certificate data.

## Goals, Strategies, Actions

The Oregon Health Improvement Plan consists of a series of recommendations to improve the lifelong health of all Oregonians; increase the quality, reliability and availability of care; and lower or contain the cost of care so it is affordable to everyone. The Plan is based on extensive research and community engagement and uses evidence-based interventions that incorporate policy, systems, and environmental approaches and emphasizes coordination among health care delivery systems, public health, community-based organizations, and individual communities.

The Health Improvement Plan is organized under three distinct goals:

1. Achieve health equity and population health by improving social, economic and environmental factors;
2. Prevent chronic diseases by reducing obesity prevalence, tobacco use and alcohol abuse; and
3. Stimulate linkages, innovation and integration among public health, health systems and communities.

Each goal has at least one corresponding outcome that includes specific strategies, actions, evaluation metrics, and return on investment information. Actions are broken out into three distinct time categories, 2011 Actions, 2012-2014 Actions, and 2015-2020 Actions. Additional information, including definitions and supporting data, can be found in the Appendices.

**Goal I: Achieve health equity and population health by improving social, economic and environmental factors.**

**Outcome:** Increase high school graduation rates and college degrees for populations with disparities

**Strategy:** Target resources to improve child and student health (birth through higher education) to support improved educational outcomes.

**2011 Actions:**

- Support maintenance of current funding for access and participation in early childhood education such as Oregon Prekindergarten, Early Head Start and Migrant Head Start.
- Support passage of legislation that requires districts and schools to assess and address physical, social, and environmental health barriers that impede learning. Principles of such legislation should include:
  - Inclusion of specific student health measures and routine reporting on these measures (e.g., Oregon School Report Card);
  - Creating a mechanism for the provision of training and technical assistance to support school districts in developing and implementing plans;
  - Ensuring that all actions are based on student health data and are connected to measurable outcomes; and
  - Employing best available evidence to inform policies and programs.
- Support partnerships among state and local public health agencies, community-based organizations, Oregon Department of Education, and local school districts to support health improvement of students and staff.

**2012-2014 Actions:**

- Support expanded funding for access and participation in early childhood education such as Oregon Prekindergarten, Early Head Start and Migrant Head Start.
- Support organizations with expertise in educational systems, such as the Oregon Department of Education, schools districts, Chalkboard Project, in implementing strategies to improve educational attainment among all Oregon children, with particular attention paid to populations experiencing educational disparities.
- Support Health Impact Assessments and plans to remediate identified health impacts for building and transportation projects in geographic proximity to school sites.
- Improve early intervention through prompt access to mental health services so that school and transition age youth receive help at the onset of mental illness to help achieve overall health as well as educational and vocational attainment.

### 2015-2020 Actions:

- Promote stable housing by prioritizing existing resources to build new, affordable housing and preserve and rehab existing affordable housing to accommodate families who make less than 30% under median income. (Oregon Housing and Community Services)

Metrics: Participation in early childhood education, high school graduation rates, post-secondary degrees

Return on Investment: Nothing will improve health for all of Oregon's various populations more than being well-educated and employed. Less education predicts higher levels of health risks, such as obesity, tobacco and alcohol use, and violence. At the same time, good health is associated with academic success. Health risks such as teenage pregnancy, poor dietary choices, inadequate physical activity, physical and emotional abuse, substance abuse, and gang involvement have a significant impact on how well students perform in school.

Educational attainment is directly related to future income of individuals and of the State. In Oregon, on average working-age people who did not complete high school earn \$10,000 less each year than those who graduate from high school. The personal implications of this type of wage disparity are many. The implications to the state are also significant. Approximately \$173 million dollars in tax revenue is lost each year due to the decreased earnings of individuals that did not earn a high school diploma.

There are additional costs incurred to provide social and medical services to Oregonians that do not complete high school. Those who did not complete high school and are over the age of 24 are reported to be in worse health than adults that completed high school. As a result of this health disparity, costs for state supported social and medical programs are higher for this population. For example, Oregon spends more than \$200 million providing Medicaid services to people who did not graduate from high school.

### **Goal II: Prevent chronic diseases by reducing Obesity prevalence, Tobacco use, and Alcohol abuse.**

**Obesity Outcome:** Reduce obesity in children and adults

**Strategy:** Make healthful food and beverage options widely available, increase physical activity opportunities, and provide evidence-based weight management support.

#### **2011 Actions:**

- Support legislative efforts to fund the Farm to School and School Gardens and Nutrition Programs through State Lottery funds.
- Adopt and implement nutrition standards for foods and beverages sold in cafeterias, stores and vending machines in state agencies, schools, universities, including eliminating the sale of sugar-sweetened beverages.
- Make an evidence-based weight management health insurance benefit (e.g. Weight Watchers) available to DMAP managed care and fee-for-service clients, as well as to PEBB and OEBC members and promote its use at workplaces.
- Reduce consumption of sugar-sweetened beverages by raising the price through a \$0.005 per ounce excise tax in 2011-2013 (increasing to \$0.01 per ounce in 2013). Dedicate a portion of the proceeds to reach recommended funding (\$22 million 2011-13) for comprehensive efforts to reduce obesity and chronic diseases in adults and children including media campaigns and implementation of best and promising practice interventions by counties, regions, tribes, schools, coalitions and community-based organizations.
- Promote and support physical activity throughout the work and school day for employees and students including accessible stairs, breaks for stretching, walking meetings, recess, physical education and after school play time.
- Support legislation to propose an Oregon constitution change to expand the Oregon Highway Trust Fund to allow for use of funds for active transportation projects outside of the road right of way. Funds could be used to support public transit, inter-city rail, and bicycle and pedestrian projects.

#### **2012-2014 Actions:**

- Expand the adoption of nutrition standards and elimination of the sale of sugar-sweetened beverages to additional settings including county and city agencies, community colleges, tribal agencies, health care facilities, childcare settings, community based organizations, worksites.
- Expand availability of an evidence-based weight management health insurance benefit through other public and private agencies and organizations.

## ***DRAFT*** Oregon Health Improvement Plan: 2011 - 2020

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- Promote and support active transportation options for employees and students including mass transit, bicycling and walking.
- Begin steps to reduce the sodium intake of Oregonians by decreasing sodium in packaged and restaurant foods produced in Oregon by 25% over five years through voluntary strategies.

### 2015-2020 Actions:

- Supplement the current federal food stamp program (SNAP) with state funds and provide incentives for purchasing healthful foods with state-funded program.
- Fund a Healthy Food Financing Initiative similar to the successful Pennsylvania program that funds development of grocery stores and corner “healthy food” markets in low-income neighborhoods/“food deserts”.

Metrics: BMI, sugar-sweetened beverage consumption, meet CDC physical activity recommendations

Return on Investment: One-third of the recent increase in medical costs in Oregon is attributed to obesity. In 2003, estimated medical costs related to obesity in Oregon among adults were \$781 million. Costs in Oregon for treating diabetes are \$1.4 billion/year. CDC estimates that persons who are obese have medical costs that are \$1429 higher than those of normal weight. By reducing obesity and obesity-related chronic diseases like diabetes, Oregon stands to realize a significant return on investment.

Public health programs have been successful at reducing the prevalence of tobacco use by adults in Oregon by 22% in 10 years. A fully funded obesity prevention program that achieved similar success in preventing diabetes would save at least \$215 million a year in medical costs by 2020. Savings from diabetes reduction alone from 2011-2020 would total \$1.18 billion, a return on investment of over 6:1. Savings relating to diabetes are just one component of the total benefit from reducing obesity rates, so this estimate is conservative.

The benefits of establishing health-promoting environments go far beyond reducing the prevalence of obesity and diabetes. Such environments also support treatment and management of diabetes and help reduce its dire complications such as heart disease, blindness, amputations and kidney disease. Likewise, prevention and management of other chronic diseases like hypertension, heart disease, strokes, cancer and arthritis would improve and provide additional savings in health care cost

Sugar-sweetened beverages are empty calories, a major contributor to the increase in obesity in children and adults. Oregonians consume over 136 million gallons of sugar-sweetened soda each year, equivalent to more than 63 million pounds of excess weight gained in the state. This figure does not include other beverages such as energy drinks and sugar-sweetened fruit drinks. Price increases are being shown to reduce consumption of sugar-sweetened beverages. Raising the price of sugar-sweetened beverages by 10% through taxation is projected to decrease consumption by over 12%. Because sugar-sweetened beverages are one of the main drivers of weight gain in America, taxing these products is an appropriate means for reducing their consumption and funding comprehensive efforts to reduce obesity and related chronic diseases like diabetes.

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Focusing prevention efforts and providing weight management benefits for the 850,000 OHA covered lives (DMAP, PEBB, and OEBC) will enable significant savings to accrue directly to the state budget. PEBB estimates more than \$2 million savings in health care costs from a \$1.4 million investment in AY 09.

**Tobacco Outcome:** Reduce tobacco use and exposure

**Strategy:** Create tobacco-free environments, prevent initiation of tobacco use, support cessation, and counter pro-tobacco influences.

**2011 Actions:**

- Adopt and implement tobacco-free campus policies in state agencies, addictions and mental health facilities contracting with OHA, and hospitals.
- Adopt and implement smoke-free policies for all public multiunit-housing settings in partnership with public housing authorities and community development corporations.
- Prevent initiation and reduce consumption of tobacco by raising the price of cigarettes by a \$1/pack excise tax (and a proportionate amount on other tobacco products), and dedicate 10% (\$40 million) to comprehensive efforts at the state and local level to reduce tobacco use and exposure in adults and children, including implementation of best practice interventions by counties, regions, tribes, schools, coalitions and community-based organizations.
- Assure that evidence-based tobacco cessation health insurance benefits are available and promoted to DMAP managed care and fee-for-service clients, as well as to PEBB and OEBC members.

**2012-2014 Actions:**

- Expand implementation of tobacco-free campus policies to additional settings including county and city agencies, community colleges, universities, medical clinics, childcare settings, tribal agencies, private sector worksites, multi-tenant office properties, and community-based organizations.
- Continue to increase the price of tobacco through excise tax and dedicate a portion of the proceeds to expand comprehensive efforts to reduce tobacco use and exposure in adults and children, until the CDC recommended level of funding for tobacco control in Oregon is reached (\$43 million/year).
- Require tobacco retailers to obtain a license at the local, state, and/or tribal level before selling tobacco in order to monitor, implement, and enforce local, state, federal and tribal laws regulating tobacco sales, marketing, and promotions.
- Ban free sampling of tobacco products, tobacco coupon redemption, and other tobacco price reduction strategies.

## ***DRAFT*** Oregon Health Improvement Plan: 2011 - 2020

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- Require tobacco prevention messages at the point-of-sale, such as Quit Line or hard hitting graphic warnings.
- Require that tobacco education and cessation materials be given “equal time” in tobacco retail stores, such that anti-tobacco marketing materials take up the same amount of space as tobacco advertising and promotional materials including “powerwall” displays.

Metrics: Tobacco use and exposure in children, adults, pregnant women

Return on Investment: Increasing the cost of tobacco is a proven practice for preventing initiation and reducing tobacco use in youth and adults. Oregon’s current tobacco tax is below the national average, making it easier for youth to begin using tobacco and more difficult for tobacco users to quit. Oregon’s low tobacco tax rate, unchanged since 2004, also limits funds available for tobacco prevention and other important state services. Without an on-going substantial and dedicated source of funding, the relentless efforts of the tobacco industry to recruit new smokers and promote tobacco use will overcome current tobacco prevention efforts.

Tobacco use continues to be the leading cause of illness and premature death in Oregon. For each one percentage point decline in adult and youth smoking rates, Oregon can expect to see 28,400 fewer adult smokers, 460 fewer pregnant smokers, and 2,000 fewer high school smokers. This will result in a \$269.8 million reduction to future health care costs from adult smoking declines and a \$148.8 million reduction in future health costs from youth smoking declines.

Focusing prevention efforts and providing evidence-based cessation benefits for the 850,000 OHA covered lives (OHP, PEBB, and OEBC) will enable significant savings to accrue directly to the state budget. For every dollar Oregon spends on providing tobacco cessation treatments, it has an average potential return on investment of \$1.32.

**Alcohol Outcome:** Reduce Alcohol Abuse

Strategy: Reduce alcohol abuse by adults and alcohol use in youth

2011 Action:

- Decrease consumption of alcohol consumed in the form of beer by raising the price of beer by doubling the current excise tax from 8 cents per gallon to 16 cents in 2011-2013. Dedicate a portion of the proceeds to provide funding for comprehensive efforts to reduce the health and economic burden of alcohol abuse, including implementation of media campaigns and evidence-based community alcohol abuse prevention interventions for high-risk and vulnerable populations such as youth, and communities with high prevalence of alcohol abuse.

2012-2014 Actions:

- Continue to increase the excise tax on beer bi-annually indexed to inflation and dedicate funding for comprehensive efforts to reduce the health and economic burden of alcohol abuse, including

implementation of media campaigns and evidence-based community alcohol abuse prevention interventions for high-risk and vulnerable populations such as youth, and communities with high prevalence of alcohol abuse.

Metrics: Alcohol abuse

Return on Investment:

The return on this investment would be lower levels of alcohol related damage in our society, and increased funding to cover the costs of damage that does occur. The Oregon Liquor Control Commission (OLCC) reports that alcohol abuse alone cost Oregon's economy approximately \$3.2 billion in 2006. This is approximately eight times greater than the \$395.0 million in tax revenues collected in fiscal year 2006 from the sale of alcohol. A substantial return could be gained by reducing consumption, especially in youth. The actual amount in financial terms needs to be determined by an economic and health analysis assessing the unique contribution of beer and other malt beverages, estimating the potential drop in consumption given tax increase, and estimating the savings in health care and social service agencies. However, the 2010 report to the Governor has indicated that "prevention and recovery programs are very cost effective".

**Goal III: Stimulate linkages, innovation and integration among public health, health systems and communities to increase coordination and reduce duplication.**

**Outcome:** Implementation of integrated and coordinated community-based initiatives to reduce chronic diseases and improve population health

**Strategy 1:** Increase the effectiveness and efficiency of Oregon's public health system

2011 Actions:

- Coordinate funding and programs available through federal health reform that would contribute to establishing systemic integration between primary care homes, public health, mental health, and other health services (dental, vision) and social services such as public health nurse home visiting, community health workers, community health teams.
- Collaborate with local (non-profit) hospitals, local agencies, and community-based organizations to conduct community health assessments, develop local coordinated and integrated Health Improvement Plans focused on reducing obesity, tobacco use and exposure, and chronic disease prevention and management, and evaluate the results.
- Create regional health collaboratives that track and are responsible for local policy, health improvement planning, priority setting, system development, financial investment and health outcomes.
- Ensure that state data systems to collect, manage, and analyze public health performance measures and quality improvement processes include demographic data on race, ethnicity, income, and education level and tie them to clinical, emergency and hospital data through state and regional HIEs.
- Designate Health Information Technology funding to assure clinicians and admissions staff are trained on the collection of racial and ethnic data for inclusion in electronic health records by hospitals and clinics using standards developed in 2010 by Quality Corporation Task Force.

2012-2014 Actions:

- Advance the quality and performance of Oregon public health departments by the state and all county/regional health departments seeking and achieving national accreditation.
- Require that local pilot programs resulting from local Health Improvement Plans be funded to target resources for Oregon populations that are most vulnerable and have the greatest disparities due to income, race, ethnicity, and/or geographic region.

**Strategy 2:** Establish and fund systemic integration between patient-centered medical care homes and community-based public health and social services resources to support chronic disease prevention and management.

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### 2011 Actions:

- Make evidence-based chronic disease self-management interventions (e.g. Living Well) widely available in communities and reimbursed by OHA for DMAP managed care and fee-for-service clients, as well as PEBB and OEBC members.
- Make evidence based group exercise and falls prevention programs (e.g. Tai Chi, Arthritis Foundation programs) widely available and affordable in all counties and all tribal communities through collaboration with county/regional health departments, Area Agencies on Aging, tribal agencies, community-based organizations.

### 2012-2014 Actions:

- Expand upon the current pilot programs to reimburse for evidence-based home-based multi-trigger, multi-component interventions with an environmental focus for people with asthma available through targeted case management programs in all local health departments and tribal health authorities in Oregon.
- Establish pilots to develop, test, and evaluate “community health team” models that coordinate, navigate, integrate and track patient referrals and outcomes between primary care homes, public health and social services.
- Establish a mechanism to measure the savings resulting from implementing chronic disease health prevention benefits associated with the Health Improvement Plan and redirect the savings for further expansion of OHP and funding of proven intervention strategies.
- Expand statewide programs that demonstrate improved health outcomes through successful coordination, navigation, integration and evaluation of patient referrals and outcomes between primary care homes, public health and social services.

Metrics: community assessments done in collaboration with local health departments and hospitals, health collaboratives established and tracking health outcomes, state/local health departments applying for accreditation, participation in evidence-based chronic disease self-management programs, hospital readmissions and preventable hospital admissions

Return on Investment: A focus on community health assessment and community health improvement plans resulting from inter-related community collaborations that include public health, hospitals, land grant university extension services and community based organizations, will focus community interventions on identified needs and will be embraced by the community because they are driven at the local level. The collaborations with population based public health measures and decreased hospitalization use will reduce costs and focus on primary prevention. A public health system focused on utilization of prevention and meaningful outcome measures will assure the focus on prevention at the community level. The return on investment is well documented by Trust for America’s Health. Healthy people spend less on medical care. Investing \$10 per person annually in community programs that

increase physical activity, improve nutrition, and prevent smoking could save Oregon more than \$193 million in the next five years.

Persons living with chronic conditions who have the tools to effectively self-manage their conditions feel an increased sense of efficacy, are more able to follow-through with their health care provider's recommendations, and use fewer high-cost health care services. A recent OSU report on Oregon's evidence-based Living Well program estimates the following five-year effects if only 5% (78,300) of eligible Oregonians were to participate in the program: 2,138 quality adjusted life years gained, 11,119 avoided ED visits saving \$13 million, 55,593 avoided hospital days saving \$130 million. Reimbursement by OHA of \$750,000 (\$375/participant for 2000 people) would support the expansion of Living Well workshops across the state. Potential ROI would include 280 avoided ED visits (saving \$317,000) and 1390 avoided hospital days (saving \$3.25 million).

Evidence based healthy homes programs improve overall quality of life and productivity, specifically improving asthma symptoms and reducing the number of school days missed due to asthma. The Community Guide for Preventive Services found that healthy homes programs with a combination of minor or moderate environmental remediation with an educational component provide good value for the resources invested and have benefit-cost ratios ranging from 5.3 to 14.0.

## Recommended Actions Referred to Other OHPB Committees

Many recommended actions were generated during the plan development process, by HIP Committee members, through the Community Listening Sessions and from stakeholder input. Below is the list of recommendations that have been referred to DMAP and other Oregon Health Policy Board Committees as actions determined by the committee to be important but are outside the scope of the HIP Plan.

### **HIP Committee Recommendations to OHA/DMAP**

Enroll all eligible tribal members onto the Oregon Health Plan outside of the lottery system because of 100% federal reimbursement

DMAP purchased health care benefits for managed care and fee-for-service clients should reimburse:

- evidence-based tobacco cessation that meets US Preventive Services Task Force recommendation
- evidence-based chronic disease self-management programs such as Living Well
- evidence-based weight management programs such as Weight Watchers
- lactation-related durable medical equipment and lactation specialists to provide lactation services
- evidence-based home-based multi-trigger, multi-component interventions with an environmental focus for people with asthma

### **HIP Committee Recommendations to other Oregon Health Policy Board Committees**

#### **Health Information Technology Oversight Council (HITOC)**

- Require public health participation on Health Information Exchange initiatives.
- Require county level demographic data (income, race/ethnicity, education) that supports identification of populations vulnerable to chronic disease disparities and chronic disease risk factors.
- Create Health Information Exchanges and fund data collaborations that support HIP metrics and indicators for all populations including demographics and qualitative data that support assessment and improvement of health equity.
- Assure that Health Information Exchanges include a wide range of health measures for use at the county/regional level including income, education, race/ethnicity, health risks (tobacco use, BMI, physical activity, sugar sweetened beverage and fruit/vegetable consumption at a minimum), clinical services, and emergency and hospitalization data, so that outcomes and return on investment of interventions can be measured for all populations including those most vulnerable to chronic diseases and risk factors.

### **Public Employers Health Purchasing Committee**

Organize OHA services such that full integration of mental health, addictions, oral and physical health care is achieved.

OHA purchased health care benefits reimburse:

- evidence-based tobacco cessation that meets US Preventive Services Task Force recommendation
- evidence-based chronic disease self-management programs such as Living Well
- evidence-based weight management programs such as Weight Watchers
- lactation-related durable medical equipment and lactation specialists to provide lactation services
- nutrition consultation with a registered dietitian and physical activity consultation with a certified exercise physiologist, and consider other medical and surgical treatment options following evidence-based reviews
- asthma trigger reduction incentives
- health care benefits provided by all employers include tobacco cessation, lactation services and equipment, preventive screenings, chronic disease self-management, mental health, addictions and dental care.

### **Health Incentives and Outcomes Committee**

- Integrate the Chronic Care Model into the medical home model
- Establish referral and care coordination systems between medical/behavioral health homes and community services and resources
- Insurers provide coverage for tobacco cessation, lactation services and equipment, preventive screenings, chronic disease self-management, mental health, addictions and dental care
- Insurers reimburse for evidence-based chronic disease self-management programs (e.g. Living Well, Asthma Home Visits)
- Standardized clinical practices are established for chronic disease prevention, such as BMI calculations, oral health screening, tobacco use prevention and cessation
- Health care providers provide screening and anticipatory guidance for adolescents recommended by the Guidelines for Health Supervision for Adolescents (Bright Futures by AAP and DHHS), such as BMI, lipid screening, tobacco use and cessation, social-emotional health, and alcohol and drug use
- Require all birthing hospitals to meet WHO/UNICEF breastfeeding-friendly criteria

- Collect and make available emergency transport, emergency department, and hospitalization data
- Disseminate Childhood Hunger Coalition's "Childhood Hunger" toolkits and CME training to pediatric and family practice providers across Oregon, including local resources to refer those with food insecurities
- Family planning services include preconception health assessment and education to prevent chronic diseases in future generations

### **Healthcare Workforce Committee**

- Develop a required standard or competency for health professional licensing/certification that includes preventive practices about physical activity, nutrition, breastfeeding, oral health, mental health, and healthy and safe home environments
- Develop and implement a PH internship program for high school and college students in local and state public health agencies.
- Workforce needs for a fully functioning, robust public health system in Oregon include the following (from Oregon State University and Conference of Local Health Officials, CLHO):
  - Oregon needs an accredited school of public health to train and retain a high functioning public health workforce. Establishing a school/college of public health at one or more universities is a critical step if Oregon is to produce the estimated 240 graduates per year that it will need.
  - Many among the workforce lack public health training and are not well prepared to conduct population based approaches, which is the heart of the profession. Oregon needs to establish and offer continuing education and certification opportunities for the current public health workforce.
- The use of community health worker programs is a strategy that has been demonstrated to be effective at reducing the disparities of care that occur within the context of health care delivery (referenced from the Oregon Health Fund Board report, Building Block 5, Ensure Health Equity for All, November 2008). Oregon should explore the following:
  - Providing direct reimbursement for Community Health Workers (CHWs) for publicly-sponsored health programs.
  - The Oregon Health Authority, in coordination with the Oregon Healthcare Workforce Institute and other groups builds a culturally competent workforce that reflects the diversity of Oregonians.
  - The Legislature supports Community Health Worker programs that recruit and train members of underserved communities to provide culturally and linguistically competent health services within that community.

## Next Steps

By June 2011, the HIP Committee, in accordance with its charter and with guidance from the Oregon Health Policy Board, will develop a two-year operational plan.

In the long term, developing a process for implementing the Health Improvement Plan in collaboration with multiple partners in communities across the state will be essential to achieving the plan's goals. Public health agencies, tribes, community-based organizations, hospitals, health plans, clinics, social service agencies, employers, schools, early childhood education and child care programs, colleges and universities, housing, transportation, land use and economic development agencies all have a stake in improving conditions so all Oregonians can live as healthy as possible. Building relationships, common goals and commitments among these sectors is crucial to the Oregon Health Improvement Plan's success.

Equally important in this effort will be developing the evaluation and continuous quality improvement processes to track success of implementation efforts and impact of their health equity components on Oregon's diverse populations. Collecting and reporting data for population groups by age, race, ethnicity, geographic location, ability, income and education will be challenging, but critical to ensuring that resources and actions are directed where they are most needed, and that these actions bring about real change and improvement sought in the Health Improvement Plan.

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OREGON HEALTH AUTHORITY

## Medical Liability Task Force

### Report and Recommendations

*Oregon Health Policy Board  
November 9, 2010*

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Oregon Health Authority

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OREGON HEALTH AUTHORITY

### The Board's Charge to the Task Force

- Investigate the current medical liability system
- Suggest opportunities for reform
- Prioritize patient safety and reduction of medical errors
- Encourage better physician-patient communication
- Reduce frequency of frivolous lawsuits
- Ensure patients are compensated adequately

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Oregon Health Authority

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OREGON HEALTH AUTHORITY

### The Enormity of the Challenge

- Strongly held points of view
- Decades-long battle over tort reform proposals
- Commitment to a high-road, patient-centered approach

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Oregon Health Authority

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### Framework for Task Force Deliberations

**Task Force Goals for results of reform:**

- The medical liability system becomes a more effective tool for improving patient safety
- The medical liability system more effectively compensates individuals who are injured as a result of medical error
- The collateral costs associated with the liability system are reduced (including costs of insurance administration, litigation, and defensive medicine)

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### Patient safety

**The starting point:**

- As many as 98,000 people die in American hospitals every year due to medical errors (Institute of Medicine)
- Oregon hospitals reported 32 deaths from medical errors in their facilities last year (Patient Safety Commission)
- Thousands are probably harmed due to medical errors in Oregon hospitals alone every year (State Health Officer)
- Fear of malpractice claims interferes with efforts to prevent errors from happening over and over again

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### Compensating patients harmed by medical errors

**The starting point:**

- The medical liability (tort) system is designed to compensate patients harmed by negligence—not patients harmed by preventable errors
  - Definitions: “Medical negligence” means failure to provide the standard of care that would be provided by like professionals
  - “Preventable error” means provide medical care consistent with best practices.
- Only about 2% of patients injured due to medical negligence in the United States even file a claim

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### The collateral costs associated with the liability system

**The starting point:**

- Cost of payments to Oregon patients - About \$46 million (=0.24% of health care spending)
- Cost of malpractice insurance administration and defense of claims – About \$34 million (=0.18% of health care spending)
- Cost of defensive medicine – National estimates range from 0.3% to more than 7% of health care spending
  - Definition: Defensive medicine is tests and procedures performed primarily to protect the provider against malpractice claims.

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### Issues Selected for Study

- Disclosure and offer programs
  - Concept: Health care providers and facilities disclose errors, investigate cause, and make early offer of payment when negligence is clear.
- Evidence-based guideline safe harbors
  - Concept: Physicians are expected to follow state-designated evidence-based guidelines; if they do, they cannot be found liable for malpractice.
- Health courts
  - Concept: Specialized courts or an administrative system replaces the tort system for compensating victims of negligence. New system would involve a trade-off: Tort system would be eliminated but more patients injured by errors would be compensated.

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### Concepts not selected for development

- Many traditional tort reform concepts not selected because they would not advance the three key goals.
- Caps on damages
  - Caps limit amounts that can be awarded in a case
  - Evidence suggests caps may reduce premiums but they don't accomplish other goals
  - Caps cannot be imposed without amending Oregon's constitution (and voters have refused to do it)
- Excess liability fund
  - A state fund would pay verdicts in excess of insurance limits, relieving physicians of exposure
- 9 – Fund is not realistic in current budget environment

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### Disclosure and Offer

- **Concept:** Health care providers and facilities disclose errors, investigate cause, and make early offer of payment when negligence is clear.
- **Rationale:**
  - Disclosing errors to patients is a must for patient-centered care
  - Prompt investigation of the cause of adverse events supports patient safety
  - Offering payment up-front speeds up compensation and reduces litigation costs
  - Some evidence suggests paying up-front actually reduces total costs for the provider

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### Disclosure and Offer

- Recommendations:**
- Enact new law: Disclosing an error to a patient is not non-cooperation with insurer.
  - Consider amending “apology” law: Protect facilities (not just physicians) and clarify what is not admissible
  - Consider enacting new law: Physicians must disclose to patients adverse events that occur as a consequence of their care and explain what happened
  - Clarify what it means to disclose an adverse event: The Patient Safety Commission should experiment with disclosure protocols
  - Consider amending the Patient Safety Law: Allow physician practices to participate in the voluntary reporting program (which includes a requirement to disclose reportable errors)

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### Evidence-based Guideline Safe Harbor

- **Concept:** Physicians are expected to follow state-designated evidence-based guidelines; if they do, they cannot be found liable for malpractice.
- **Rationale:**
  - If more providers followed evidence-based guidelines, fewer medical errors would occur
  - By designating guidelines, the malpractice system would give providers clearer direction
  - By providing physicians who follow designated guidelines protection from malpractice liability, we could encourage physicians to practice good medicine and reduce defensive medicine

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### Evidence-based Guideline Safe Harbor

Recommendations:

- Support completion of AHRQ planning grant activity
- Include broadly representative set of individuals in planning.

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### Replace medical liability system with an administrative compensation system

- **Concept:** Implement administrative method for compensating patients harmed by medical errors.
  - Compensate more injured patients, including patients who could not prove medical negligence.
  - Compensate both economic and non-economic injury.
  - Probably eliminate right to sue for negligence in court.
- **Rationale:**
  - Trade-off is compensating more people and (probably) eliminating right to sue
  - (Probably) reduced insurance administration and litigation expense
  - Could facilitate medical error reporting and prevention programs
  - Elimination of "fault" basis for compensation might encourage disclosure of errors, foster prevention efforts, and reduce defensive medicine.

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### Replace medical liability system with an administrative compensation system

Recommendation:

- Sponsor an adequately funded study to address:
  - How to design an administrative system for compensating patients harmed by medical errors to replace the legal and insurance systems for address medical malpractice
  - Financial, legal, and politically feasibility of both voluntary and mandatory programs

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## Summary

As the Board considers its recommendations, we encourage you to use the framework adopted by the Task Force. Reforms should:

- Help reduce injuries to patients
- Help get assistance to patients who are injured
- Reduce collateral system costs

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**Oregon Health Policy Board**  
**Office for**  
**Oregon Health Policy and Research**



**Oregon Medical Liability Task Force**  
**Report and Recommendations**

**DRAFT**  
**October 2010**

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[The appendices for this document can be found here](#)

## Medical Liability Task Force Membership

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## Executive Summary

The Medical Liability Task Force was appointed by the Oregon Health Policy Board in March 2010 to develop medical liability reform proposals for consideration by the Policy Board and the Legislature.

The Task Force identified three patient-centered goals for system improvement and agreed that successful medical liability reform should further those goals. They are:

1. The medical liability system becomes a more effective tool for improving patient safety;
2. The medical liability system more effectively compensates individuals who are injured as a result of medical errors; and
3. The collateral costs associated with the medical liability system (including costs associated with insurance administration, litigation, and defensive medicine) are reduced.

The Task Force prioritized three reform concepts for consideration because they seemed to hold some promise for helping achieve the goals for system improvement: Disclosure and offer programs, evidence-based guideline safe harbors, and health courts.

The Task Force chose not to look for ways to reduce indemnity payments (that is, payments to injured patients) primarily because non-economic damage caps—which have been imposed in some states to reduce indemnity payments—cannot be imposed in Oregon without a constitutional change that the state’s voters have rejected twice. In addition, many members of the Task Force believe that the system should compensate more, not fewer, individuals harmed by medical errors.

The Task Force makes the following recommendations designed to spur providers and facilities to disclose medical errors to their patients and, where possible, to offer compensation to patients harmed by those errors:

- The legislature should enact a statute explicitly providing that a health care facility or provider’s duty to cooperate with an insurer does not preclude disclosure of an adverse event or the reasons underlying it to a patient or the patient’s family and that such disclosure may not be the grounds for refusal to defend or for cancellation or nonrenewal of coverage. This should remove insurance concerns as a barrier to full disclosure.
- The legislature should consider amending Oregon’s “apology” law, which precludes use of statements made to a patient that express “regret or apology” for harm that occurred during treatment to prove liability in a negligence case so that the law clearly protects facilities in addition to physicians and more clearly describes what statements are included in its protection.

- The legislature should consider requiring professionals and facilities to disclose to patients adverse events occurring as a consequence of their treatment and to provide explanations for them.
- The Oregon Patient Safety Commission should work with health care facilities that participate in its voluntary error reporting program to experiment with disclosure protocols that specify what they should disclose to patients under the reporting program.
- The legislature should consider expanding Oregon’s voluntary reporting program to permit physician practices to participate, recognizing that confidential reporting of medical errors serves a different although complementary purpose than disclosure of errors to patients.

The Task Force makes the following recommendation concerning the work that has been funded by a grant from the Agency for Healthcare Research and Quality to develop a “safe harbor” program that changes medical liability rules to encourage physicians to use evidence-based practice guidelines:

- To explore the potential value of using evidence-based guidelines as the legal standard of care, policymakers should support the completion of the grant activity.
- As the grant moves forward, a broadly representative set of individuals should be included in the planning process.

The Task Force considered proposals to replace the existing medical liability system with a new system for compensating patients harmed by medical treatment, even if their care was not negligent. It is assumed that such a program would compensate more individuals than the current system and would involve an administrative rather than a court-based system for adjudicating claims. The Task Force reached this conclusion:

- It would be worthwhile for the Legislature or the Oregon Health Authority to sponsor a study to determine whether or not an administrative system could be designed that would achieve the reform objectives the Task Force has enunciated and if so, whether implementation is financially, legally, and politically feasible. The study should be overseen by an unbiased entity that has not taken a position for or against the health courts concept. It should be conducted by a well-qualified team with knowledge of the existing medical liability system, knowledge of administrative compensation systems in the United States and elsewhere, skill in economic and social research and modeling, legal and actuarial expertise, and funding sufficient to do a thorough job.

The Task Force appreciates the opportunity to study these issues and encourages the board to continue this work.

## **I. Charge to the Task Force**

The Medical Liability Task Force was appointed by the Oregon Health Policy Board in March 2010 to develop medical liability reform proposals for consideration by the Policy Board and the Legislature.

The Board instructed the Task Force to be guided by the Triple Aim, seeking to improve population health by “improving access to care;” improve access to and experience of care by “assuring healthcare providers do not cease to provide specific services in response to liability concerns;” and reduce per capita costs by “reducing the costs associated with defensive medicine.”

The charter read:

“The Medical Liability Task Force will investigate the current medical liability system and suggest opportunities for reform in Oregon including, but not limited to, caps on non-economic damage awards, disclosure-and-offer programs, shifting the adjudication of medical malpractice claims to administrative panels or specialized judicial courts, and the creation of “safe harbors” where physicians are insulated from liability if they adhere to evidence-based practices or practice according to findings from credible comparative-effectiveness research (CER).

\* \* \*

“Recommendations should prioritize patient safety and the reduction of medical errors, encourage better communication between physicians and patients, reduce the occurrence of frivolous lawsuits, and reduce liability premiums, while also ensuring that patients are compensated in an equitable and timely way for medical injuries.”

## **II. Framework for Deliberations**

The Task Force chose to focus its attention on finding ways to further three goals for system improvement. The goals were identified with the Policy Board’s patient-centric focus in mind. Successful reform will mean

1. The medical liability system becomes a more effective tool for improving patient safety;
2. The medical liability system more effectively compensates individuals who are injured as a result of medical errors; and
3. The collateral costs associated with the medical liability system (including costs associated with insurance administration, litigation, and defensive medicine) are reduced.

The Task Force identified five questions that should be asked about any proposal to change the medical liability system. They are:

1. What is the likely effect of the proposal on patient safety?
2. What is the likely effect of the proposal on access to compensation for patient injury?
3. What is the likely effect of the proposal on health care costs?
4. Is the proposal feasible?
5. Can the proposal be implemented without statutory or constitutional changes? If not, what changes are necessary?

### **III. Background**

The Task Force would have preferred to begin its work with a complete understanding of the problem of medical errors in Oregon, the performance and costs of the medical liability system in Oregon, and the collateral costs of the medical liability system, including costs of administration, litigation, and defensive medicine.

Unfortunately, the Task Force found that information is not available to support a thorough understanding of the systems we have today—which may be one reason there is no consensus around proposals for change. Oregon does not track medical errors in a comprehensive way. The Oregon Medical Board tracks payments in claims against physicians, but the state does not track payments in claims against institutions or other licensed professionals. Oregon knows something about the cost to physicians of the liability system because medical liability insurers licensed in Oregon must file premium rates and total premium written; but increasing numbers of physicians are employed by self-insured health care institutions. This confounds efforts to trend cost or generate aggregate cost figures.

The Task Force proceeded with its work based on the personal knowledge of participants, national estimates of errors and liability system costs, and preliminary information supplied by staff from public and insurer sources. We offer the following paragraphs to help inform our readers.

#### **A. Patient Safety**

The seminal authority on the issue of medical errors remains the 1999 Institute of Medicine's landmark report entitled "To Err Is Human". Relying on the Harvard Medical

Practice Study's review of a random sample of 1984 hospital records in New York State,<sup>1</sup> the IOM estimated that as many as 98,000 individuals die every year from preventable medical errors in American hospitals.<sup>2</sup> The Harvard Medical Practice Study count included patients who died in hospitals due to diagnostic and other errors that occurred on an outpatient basis.

The Harvard research team estimated the national economic burden of 1984 medical errors at \$50 billion in 1989 dollars. About half the cost was for additional health services; about half for lost earnings and household productivity.<sup>3</sup> A similar study was done using 1992 hospital records from Colorado and Utah. An article describing the study estimated the national burden of 1992 medical errors in 1996 dollars at \$37.6 billion for all adverse events and \$17 billion for preventable ones. Again, about half of the costs were for additional health services and half for lost earnings and productivity.<sup>4</sup>

No study comparable to the New York or Colorado/Utah studies has been done to measure the frequency or cost of medical errors in Oregon. The Oregon Patient Safety Commission (OPSC) operates medical error reporting programs. While the programs provide important information to support facility improvement programs, they cannot yet generate a comprehensive picture of the medical errors that occur. Hospitals, nursing homes, ambulatory surgery centers, and pharmacies may participate in the OPSC programs, but physician practices may not. In 2009, the Patient Safety Commission received reports of 32 medical errors resulting in patient death.<sup>5</sup> Relying on data from Pennsylvania, where a mandatory hospital error reporting system has been in place since 2004, Oregon's Public Health Officer estimated that 1600 serious adverse events resulting in patient harm occurred in 2008 in Oregon hospitals alone.<sup>6</sup> Many of these injuries can and should be prevented.

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<sup>1</sup> Brennan, T.A., Leape, L.L., Laird, N.M., Hebert, L., Localio, A.R., Lawthers, A.G., Newhouse, J.P., Weiler, P.C., & Hiatt, H.H. (1991, February 7). Incidence of adverse events and negligence in hospitalized patients: results of the Harvard Medical Practice Study I. *New England Journal of Medicine*, 324(6):370-6.

<sup>2</sup> Kohn, L.T., Corrigan, J.M., & Donaldson, M.S. (1999). *To Err Is Human: Building a Safer Health System*. Institute of Medicine. Washington, DC: National Academy Press.

<sup>3</sup> Johnson, W.G., Brennan, T.A., Newhouse, J.P., Leape, L.L., Lawthers, A.G., Hiatt, H.H., & Weiler, P.C. (1992, May 13). The Economic Consequences of Medical Injuries. *The Journal of the American Medical Association*. 267(18):2487–2492.

<sup>4</sup> Thomas, E.J., Studdert, D.M., Newhouse, J.P., Zbar, B.I.W., Howard, K.M., Williams, E.J., & Brennan, T.A. (1999, Fall). Costs of Medical Injuries in Utah and Colorado. *Inquiry*.

<sup>5</sup> In 2009, Oregon hospitals reported 127 serious adverse events, 32 of which resulted in death. Oregon Patient Safety Commission. (2010, August). Hospital Report. Available: <http://oregon.gov/OPSC/docs/Reports/Hospital-Report-081910.pdf> [2010, October 14]

<sup>6</sup> Oregon Department of Human Services, Public Health Division. (2009, August). Public Health Officer Certification Report 2008 – Oregon Patient Safety Commission Adverse Event Reporting Programs. Available: [http://oregon.gov/PHOCertificationReport2008\\_Final\\_1.pdf](http://oregon.gov/PHOCertificationReport2008_Final_1.pdf) [2010, October 14]

## B. Access to Compensation

Our current tort system's principal purpose is to provide compensation to victims of negligence. As it applies to medical claims, it is a fault-based system, meaning that compensation may be awarded only if the medical provider is shown to have rendered unreasonable care. Because there is no comprehensive data on the numbers of *negligent* medical errors occurring in Oregon each year, it is impossible to calculate the degree to which the tort system accomplishes its goal.

There is no question, however, that many people who are harmed by medical negligence do not receive compensation through the tort system. Several studies using data from other states have been conducted. For each, physicians examined hospital records to identify adverse events caused by medical negligence. Researchers then map the events against records of malpractice claims. The studies have found that 97.5-98% of patients injured by medical negligence did not file claims.<sup>7</sup>

This suggests that the system as it now functions is a less-than-perfect vehicle for compensating victims of medical negligence and probably an even less satisfactory vehicle for compensation victims of preventable medical errors—that is, errors that could have been prevented had best practices been followed. The reasons why so few are compensated, however, is an issue requiring further study.

## C. Collateral Costs

### 1. Total system costs

The costs of the medical liability system (as opposed to economic burden of the treatment-related injuries themselves) include both compensation paid for injury and the system's collateral costs—primarily the costs of insurance administration and litigation and costs associated with diagnostic and treatment activities undertaken primarily to avoid malpractice liability or claims (that is, “defensive medicine”).

At least three estimates of the national cost of the medical liability system have been published recently. The estimates of “direct cost” range from .43% to 2% of national health care spending. Public Citizen, relying on estimates of malpractice premiums alone, estimated direct costs at 0.46% of health care spending.<sup>8</sup> Michelle Mello and colleagues at the Harvard School of Public Health estimated total direct costs (that is, indemnity

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<sup>7</sup> Localio, A.R., Lawthers, A.G., Brennan, T.A., Laird, N.M., Hebert, L.E., Peterson, L.M., Newhouse, J.P., Weiler, P.C., & Hiatt, H.H. (1991, July 25). Relation Between Malpractice Claims and Adverse Events Due to Negligence. *New England Journal of Medicine*. 325(4):245-251. Studdert, D.M., Thomas, E.J., Burstin, H.R., Zbar, B.I.W., Orav, E.J., & Brennan, T.A. (2000, March). Negligent Care and Malpractice Claiming Behavior in Utah and Colorado. *Medical Care*. 38(3):250-60.

<sup>8</sup> Public Citizen. (2010, March 3). Medical Malpractice Payments Fall Again in 2009. Available: [www.citizen.org/documents/NPDBFinal.pdf](http://www.citizen.org/documents/NPDBFinal.pdf) [2010, October 14]

payments plus administrative costs) at \$9.85 billion in 2008—or 0.43% of total health care spending. Their estimate was based on data on payments, studies of defense costs, and studies of insurance overhead costs—all cited in a paper published in *Health Affairs*.<sup>9</sup> The Congressional Budget Office offered a much larger estimate of direct cost in a letter concerning the potential savings from specific tort reform proposals. The method CBO used to generate its estimate of \$35 billion—or about 2% of health care spending—is not explained in detail.<sup>10</sup>

Mello and colleagues sought to estimate the indirect as well as the direct costs of the medical liability system. To do that, they added estimates of lost physician productivity and defensive medicine to their estimates for direct costs. They pegged total cost at \$55.6 billion a year—with almost 80% of it resulting from defensive medicine. If their estimate is correct, the direct and indirect costs of the liability system are 2.4% of total health care spending.

The problem with all of these estimates is that they include both compensation and collateral cost; so while they are a good measure of the burden of the system on health care practitioners, they are not particularly useful in identifying the collateral costs that the Task Force seeks to reduce. Therefore, we turn to studies that seek to parse these costs.

## 2. Cost of indemnity payments

Mello et al estimated the total national cost of indemnity payments—that is payments to compensate for the economic and noneconomic consequences of patient injuries -- at \$5.7 billion a year or 0.25% of national health care spending. The calculation started with the total indemnity payments reported to the National Practitioner Data Bank and a multiplier developed from the literature and insurer records to account for indemnity payments on behalf of institutions (which are not reported to the data bank).

Using Mello's methodology and National Practitioner Data Bank figures for Oregon, the Office for Oregon Health Policy & Research estimates that indemnity payments paid in claims against professionals and facilities in Oregon totaled about \$46.4 million in 2008 -- that is, 0.24% of estimated Oregon health care spending.<sup>11</sup>

Total indemnity payments made for incidents involving claims against Oregon physicians appears to have trended upward over the last decade according to data reported to the Oregon Medical Board. Whether this truly reflects a growing cost burden, however, would require adjusting these payments for inflation and for growth in population or in volume of

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<sup>9</sup> Mello, M.M., Chandra, A., Gawande, A.A., & Studdert, D.M. (2010, September.) National Costs of the Medical Liability System. *Health Affairs*. 29(9):1569-77.

<sup>10</sup> Congressional Budget Office. (2009, October 9). Letter to Honorable Orrin G. Hatch. Available: [www.cbo.gov/ftpdocs/106xx/doc10641/10-09-Tort\\_Reform.pdf](http://www.cbo.gov/ftpdocs/106xx/doc10641/10-09-Tort_Reform.pdf) [2010, October 14]

<sup>11</sup> The Office for Oregon Health Policy and Research has estimated total health care spending for 2008 at \$19.3 billion.

health services provided—an exercise the Task Force did not undertake. For more detail on trends in claim frequency and indemnity payments, see Appendix 1.

### 3. Costs of insurance administration and litigation

Mello et al estimated the total national cost of insurance administration and defendant legal expenses at \$4.13 billion in 2008—with an additional \$2.0 billion in legal costs borne by injured patients out of their recoveries.<sup>12</sup>

If the relationship between indemnity cost and administration and litigation costs in the Mello estimates holds true for Oregon, malpractice insurance administration and defense litigation costs would have consumed about \$33.6 million in Oregon in 2008.

### 4. Costs of defensive medicine

Increased health care costs associated with defensive medicine are notoriously difficult to measure. Estimates of share of health care spending attributable to defensive medicine range from about 0.3% to more than 7%.

Defensive medicine results in performance of tests and procedures primarily to avoid malpractice liability. Measuring it requires assessing why physicians make the diagnostic and treatment decisions they make. It would be difficult enough to determine in any particular case whether a decision to order a particular diagnostic imaging study was made primarily because the physician believed it to be necessary for the patient's care or primarily to ensure that his diagnosis would not be questioned in a malpractice suit. The analysis is yet more difficult because good patient care and fear of malpractice suits are not the only factors affecting physician decision-making. For example, fee-for-service payment incentives can reinforce medical malpractice incentives to order unnecessary services. Because of the difficulty of measuring the extent of defensive medicine, members of the Task Force agreed not to attempt to agree on its prevalence. Nevertheless, because defensive medicine is a large component of most estimates of total medical liability cost, we address it briefly here.

In a 2006 paper published by the Robert Wood Johnson Foundation, Michelle Mello, wrote:

“There are no reliable estimates of the national costs of defensive medicine. Many analysts have attempted to estimate these costs; all have failed to do so reliably. All of the available measurement methodologies have serious shortcomings (10, 18). For example, some national estimates are based on the incremental cost increases associated with just two or three medical procedures or diagnoses. It is simply not possible to extrapolate so widely to other procedures, because some are more amenable to defensive medical practice than others. The Office of Technology

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<sup>12</sup> See footnote 9.

Assessment conducted a comprehensive review of the evidence about defensive medicine costs in 1994 and concluded that none of available estimates were reliable (32). Much additional research has been conducted since then, but the conclusion remains the same.”<sup>13</sup>

Nevertheless, a number of attempts have been made to quantify the defensive medicine phenomenon. We mention several below.

One of the larger estimates is described by the Stuart L. Weinstein, past president of the American Society of Orthopedists, in a posting on the society’s website. He writes:

“The study quoted most often is by Daniel P. Kessler and Mark B. McClellan. To really understand actual costs, Kessler and McClellan analyzed the effects of malpractice liability reforms using data on Medicare beneficiaries who were treated for serious heart disease. They found that liability reforms could reduce defensive medicine practices, leading to a 5 percent to 9 percent reduction in medical expenditures without any effect on mortality or medical complications.

“If the Kessler and McClellan estimates were applied to total U.S. healthcare spending in 2005, the defensive medicine costs would total between \$100 billion and \$178 billion per year.”<sup>14</sup>

Most experts would concede that Weinstein’s is a high estimate, built on an assumption that findings of Kessler and McClellan with respect to a small class of cases can be extrapolated to the system as a whole.

More conservative estimates have been authored by the Congressional Budget Office and J. William Thomas and colleagues at the Cutler Institute for Health and Social Policy. The Congressional Budget Office, based on a review of published research, estimated that enactment of a package of traditional tort reforms—including caps on damages—would reduce total health spending by 0.3%.<sup>15</sup> Thomas et al, based on an extensive analysis of health insurance claims data, predicted that while reductions in medical liability premiums would result in a significant reduction in costs for 2% of conditions, “across all thirty-five specialties [studied], savings associated with a 10% percent reduction in medical malpractice premiums would be just 0.132 percent.”<sup>16</sup>

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<sup>13</sup> Mello, M.M. (2006, January). Understanding Malpractice Insurance: A Primer. Robert Wood Johnson Foundation. Available: [www.rwjf.org/pr/synthesis/reports\\_and\\_briefs/pdf/no10\\_primer.pdf](http://www.rwjf.org/pr/synthesis/reports_and_briefs/pdf/no10_primer.pdf) [2010, October 14]

<sup>14</sup> Weinstein, S.L., The Cost of Defensive Medicine. Available: <http://www.aaos.org/news/aaosnow/nov08/managing7.asp> [October 21, 2010]

<sup>15</sup> See footnote 10.

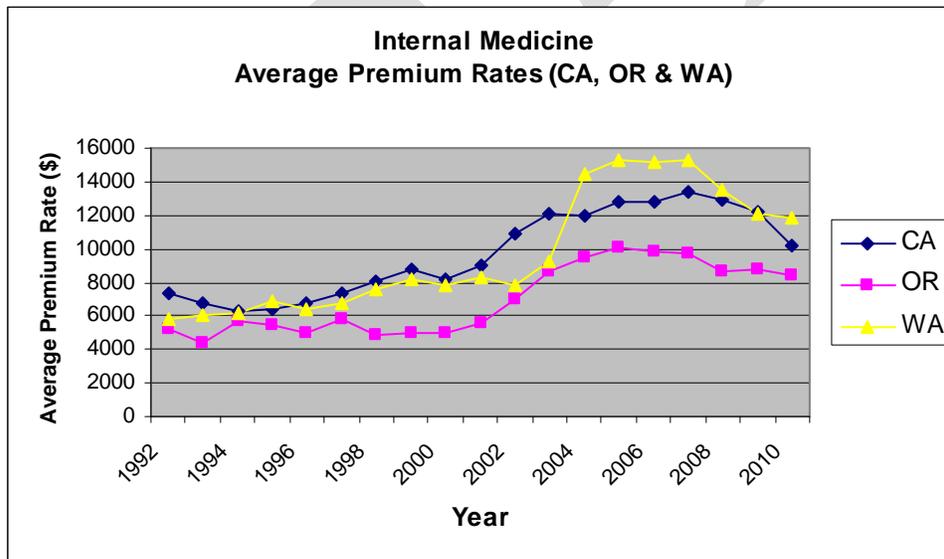
<sup>16</sup> Thomas, J.W., Ziller, E.C., and Thayer, D.A. (2010, September). Low Costs of Defensive Medicine, Small Savings From Tort Reform. *Health Affairs* 29(9):1578-1584.

As part of their 2010 study of the costs of the medical liability system, Mello and colleagues also attempted to estimate the cost of defensive medicine. Relying on the Kessler study and others, they pegged annual defensive medicine costs for hospitals and physicians at \$45.49 billion—or about 1.97% of total health care costs. They warned, however, that “Although our figure was based on methodologically strong studies, because the hospital spending estimates were derived from a narrow range of diagnoses, the quality of evidence supporting our system-wide estimate is best characterized as low.”<sup>17</sup>

#### D. Medical Liability Premiums in Oregon

Medical liability premium levels are set by insurers. Rates differ greatly by provider specialty. We examined premium trend and Oregon premiums compared with premiums in neighboring states.

The Medical Liability Monitor reports premium rates for major carriers by state for three specialties—internal medicine, obstetrics and gynecology, and general surgery. Comparing average rates for these specialties in Oregon, Washington, and California shows premiums have been lower in Oregon than in neighboring states for every year of the last two decades with the exception of three years, when average Oregon rates for obstetrics and gynecology exceeded California rates, and one year, when average Oregon rates for general surgery were the same as California’s. To illustrate, see the chart below. For additional charts and an explanation of the Monitor’s reporting, see Appendix 2.



Although Oregon medical liability premium rates are low relative to rates in neighboring states, premium rates tend to be volatile, reflecting what is known as the insurance cycle. This volatility makes it difficult for physicians to predict their costs. During “soft” phases of

<sup>17</sup> See footnote 9.

the cycle, insurers keep premiums low in an effort to build market share. During “hard” phases of the cycle, premiums rise as insurers protect their profitability, often during periods where investment returns are low.<sup>18</sup> Oregon is currently in the soft phase of the cycle. Some national commentators are predicting increases in claims frequency and costs, however, which could presage a return to the hard phase of the cycle.

According to the Department of Consumer and Business Services, Oregon’s insurance regulator, Oregon’s two dominant medical liability carriers, representing 57% of the professional liability market in Oregon, have dropped their premiums an average of 20% over the past five years.<sup>19</sup> The chart below is taken from a DCBS press release:

Medical Liability Premium Rate Trends in Oregon

Year	NPIC/Doctors Company*	CNA
2006	-8.3%	+1.9%
2007	-10.2%	-3.2%
2008	-8.9%	-7.6%
2009	0%	-2.5%
2010	-5.1%	0%

During the last hard phase of the cycle, Oregon physicians delivering babies in rural Oregon reported soaring premiums. The legislature responded by creating a malpractice premium subsidy program for rural physicians in 2003. The program is scheduled to expire in 2011. For more detail about the program, see Appendix 3.

#### IV. Reform Concepts Selected for Consideration

The Task Force prioritized three reform concepts for consideration. They were disclosure and offer programs; evidence-based guideline safe harbors; and health courts. These concepts are discussed in detail below.

The Task Force chose not to look for ways to reduce indemnity payments (that is, payments to injured patients) for at least three reasons: First and most importantly, non-economic damage caps—although favored by some groups nationally—cannot be imposed in Oregon without a constitutional change that the state’s voters have rejected twice. Therefore, all members of the Task Force agreed that pursuing a caps strategy would not be fruitful. Second, while some Task Force members are more comfortable than others with who gets compensated and how much in today’s liability environment, most members of the group

<sup>18</sup> Mello, M.M. (2006, January). Understanding Malpractice Insurance: A Primer. Robert Wood Johnson Foundation. Available: [www.rwjf.org/pr/synthesis/reports\\_and\\_briefs/pdf/no10\\_primer.pdf](http://www.rwjf.org/pr/synthesis/reports_and_briefs/pdf/no10_primer.pdf) [2010, October 14]

<sup>19</sup> Oregon Department of Consumer & Business Services (2010, April 15). Press release: Oregon medical malpractice rates continue to decrease. Available: [http://egov.oregon.gov/DCBS/docs/news\\_releases/2010/nr\\_ins\\_04\\_15\\_10.pdf](http://egov.oregon.gov/DCBS/docs/news_releases/2010/nr_ins_04_15_10.pdf) [2010, October 14]

do not believe the total amount of money spent to compensate victims of medical negligence is excessive. Most believe that more people should be compensated. Third, some physician members of the Task Force noted that while the volatility of medical liability premiums is troublesome for health care professionals, most have been able to manage the current premium levels. According to the Department of Consumer and Business Services, most physicians and surgeons in Oregon have seen declines or no change in medical professional liability insurance rates for the last four years.<sup>20</sup>

The Task Force also chose not to address the imminent expiration of Oregon's premium subsidy program for rural physicians. The issue is being studied by a legislative committee. Rather than attempting to weigh in on a subject the Task Force has not thoroughly studied, the Task Force chose to defer to that committee.

The following sections of the report summarize the Task Force's recommendations, the thinking behind them, and differences of opinion among members of the Task Force. Recommendations are shown in boldface type.

## **V. Recommendations to Support and Encourage "Disclosure and Offer" Programs**

### **A. Discussion of Disclosure and "Disclosure and Offer Programs"**

Health care providers are trained to tell patients about unanticipated outcomes that occur in the course of their medical care. That means they should explain events that cause their patients harm—including the treating professionals' understanding about the cause of the event: Was it occasioned by progression of the underlying disease process or by the treatment itself? If by medical treatment, was it an anticipated risk of treatment—that is, something that is expected to happen in some but not all cases? Or was it a result of a defect in the care that was provided? Could it have been prevented?

Nevertheless, historically, medical culture coupled with provider fear of medical liability lawsuits has meant that most providers have been reluctant to discuss these issues openly with patients. This culture of nondisclosure has been reinforced by liability insurers, some of whose personnel instruct providers they insure not to discuss adverse events with patients or others.

There is increasing interest, however, in fostering disclosure because it is consistent with a transparent, patient-centered approach to health care. Disclosure is useful whether or not it is required. It facilitates patient participation in decision-making about their care and enables informed consent. In addition, organizations with a culture that fosters discussion of mishaps are better positioned to explore the causes of patient injuries and prevent avoidable recurrences.

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<sup>20</sup> *Ibid.*

Disclosure may be a good business practice as well: Research suggests that disclosure of errors to patients may reduce rather than increase the incidence of lawsuits; and, when disclosure is coupled with early offers of compensation, it may reduce litigation costs and the size of indemnity payments. An article published in the September issue of *Annals of Internal Medicine* examined the experience of the University of Michigan Health Systems, finding that the number of claims resulting in lawsuits, the cost of compensation, and total program costs declined significantly after adoption of a disclosure and offer program.<sup>21</sup>

Finally, disclosure of some adverse events is required by agencies like the Joint Commission, which accredits hospitals, and the Oregon Patient Safety Commission, which operates a voluntary error reporting program for health care facilities.<sup>22</sup>

The Task Force concludes that providers and facilities should be encouraged to disclose adverse treatment events and discuss them openly with patients. They should further be encouraged to offer fair compensation as soon as possible to patients who have clearly been injured due to medical negligence. When patients are asked to give up their right to sue in exchange for an offer of compensation, providers should encourage patients to consult a lawyer to assist them in negotiating a fair agreement. This “disclosure *and* offer” approach has been adopted by some self-insured hospitals and integrated health systems in Oregon. Providers and facilities that do not self-insure, however, will need the cooperation of their insurers to adopt this approach.

State policymakers should remove obstacles to disclosure and consider requiring it in some circumstances. The choice to make early offers of compensation will necessarily remain with individual self-insured entities and insurers.

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<sup>21</sup> Kachalia, A., Kaufman, S.R., Boothman, R., Anderson, S., Welch, K., Saint, S., & Rogers, M.A.M. (2010, August 17). Liability Claims and Costs Before and After Implementation of a Medical Error Disclosure Program. *Annals of Internal Medicine*. 153(4):213-221. Kraman, S.S., & Hamm, G. (1999, December 21). Risk Management: Extreme Honesty May Be the Best Policy. *Annals of Internal Medicine*. 131(12):963-967.

<sup>22</sup> Joint Commission accrediting standards provide that hospitals must inform patients of “unanticipated outcomes of care, treatment, and services that relate to sentinel events considered reviewable by the Commission.” Licensed practitioners responsible for managing a patient’s care (or their designee) must inform “the patient about unanticipated outcomes of care, treatment, and services related to sentinel events when the patient is not already aware of the occurrence or when further discussion is needed.” Joint Commission Standard: RI.01.02.01-21. Oregon statute provides that “After a serious adverse event occurs, a participant [in the Patient Safety Commission’s reporting program] must provide written notification in a timely manner to each patient served by the participant who is affected by the event. Notice provided under this subsection may not be construed as an admission of liability in a civil action.” ORS 442.837(4).

## B. Specific Recommendations to Remove Barriers to Disclosure

The Task Force considered three policy concepts for increasing disclosure to patients and thereby facilitating early resolution of malpractice claims. Each would build on the “apology” law enacted in 2003. That law provides that expressions of regret or apology made by physicians or others on their behalf cannot be used to establish liability in a negligence lawsuit against a physician.<sup>23</sup>

The apology statute, while useful, has proved insufficient to eliminate liability system barriers to disclosure. Some physicians report that malpractice insurers continue to instruct physicians not to discuss events that could lead to lawsuits. These physicians fear that if they disclose errors they will be guilty of “noncooperation” and their insurers may be entitled to refuse to defend them in court.

**To remove insurance concerns as a barrier to full disclosure, the legislature should enact a statute explicitly providing that a health care facility or provider’s duty to cooperate with an insurer does not preclude disclosure of an adverse event or the reasons underlying it to a patient or the patient’s family and that such disclosure may not be the grounds for refusal to defend or for cancellation or nonrenewal of coverage.** (For language that could be used, see Appendix 4.)

**The legislature should also consider amending the “apology” law to expressly protect facilities as well as physicians and to more clearly describe what statements made to a patient are inadmissible expressions of “regret or apology”.**<sup>24</sup>

**The Task Force believes the legislature should also consider requiring professionals and facilities to disclose to patients adverse events occurring as a consequence of their treatment and to provide explanations for them.**<sup>25</sup> If a mandatory disclosure law were

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<sup>23</sup> The law reads:

ORS 677.082 (1) For the purposes of any civil action against a person licensed by the Oregon Medical Board, any expression of regret or apology made by or on behalf of the person, including an expression of regret or apology that is made in writing, orally or by conduct, does not constitute an admission of liability for any purpose.

(2) A person who is licensed by the Oregon Medical Board, or any other person who makes an expression of regret or apology on behalf of a person who is licensed by the Oregon Medical Board, may not be examined by deposition or otherwise in any civil or administrative proceeding, including any arbitration or mediation proceeding, with respect to an expression of regret or apology made by or on behalf of the person, including expressions of regret or apology that are made in writing, orally or by conduct.

<sup>24</sup> The general concept of offering broad protection appears in Mastroianni, A.C., Mello, M.M, Sommer, S., Hardy, M., & Gallagher, T.H. (2010, September). The Flaws in State ‘Apology’ and ‘Disclosure’ Laws Dilute Their Intended Impact on Malpractice Suits. *Health Affairs*. 29(9):1611-1619.

<sup>25</sup> One member expressed the view, however, that mandatory disclosure should not be considered because the voluntary reporting and disclosure law is working well now.

**enacted, Oregon would join seven other states—among them California, Florida, Nevada, New Jersey, Pennsylvania, and Vermont.<sup>26</sup>**

At present, Oregon facilities that choose to participate in the Oregon Patient Safety Commission’s error reporting program are required to disclose reportable adverse events to the patient. ORS 442.837(4). Neither health care facilities declining to participate in the commission’s voluntary program nor individual health care professionals have any legal obligation to make any disclosure. Moreover, the commission has not spelled out what is to be included in the disclosure.

**Finally, the Task Force recommends that the Oregon Patient Safety Commission work with health care facilities to experiment with disclosure protocols that specify the elements of the required disclosure to patients.**

### C. Recommendations Relating to Reporting Laws

Members of the Task Force debated the value of strengthening Oregon’s reporting programs as a strategy for encouraging disclosure.

Oregon law permits but does not require hospitals, ambulatory surgery centers, long term care facilities, outpatient renal dialysis facilities, free-standing birthing centers, and pharmacies to participate in the Patient Safety Commission’s reporting program. Physician practices—regardless of size—may not participate in the program.<sup>27</sup>

Most states now require health care facilities to report medical errors to a patient safety organization which uses the data to measure the prevalence and type of errors and develop prevention strategies. Most states make the reports confidential to encourage candor. Some reporting programs, like Oregon’s voluntary program, require the error to be disclosed to the patient while protecting the reports themselves from disclosure to either the patient or the public.

Expanding participation in Oregon’s reporting program might result in increased disclosure because the reporting program includes a requirement that facilities notify patients in writing when a serious adverse event occurs. Nevertheless, a disclosure requirement could be enacted independent of the reporting program. Therefore, the Task Force discussed whether an expanded reporting program would have any value as a tool to encourage disclosure apart from the program’s notice requirement.

The values and objectives supported by reporting, disclosure, and disclosure and offer programs are summarized in the table below. (An “x” suggests the program will further the value or objective listed in the left column. The table does not reflect variation in the

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<sup>26</sup> For a summary of disclosure laws, see Appendix 5.

<sup>27</sup> ORS 442.837.

degree to which a program furthers a particular objective. For example, while disclosure by itself may reduce litigation cost, savings are presumably greater if an offer and settlement occur as well.)

	Reporting	Disclosure	Disclosure/offer
Patient right to know		X	X
Improved access to compensation		X	X
Reduced litigation cost		X	X
Support for culture of safety	X	X	X
Support for cross-institutional prevention efforts	X		

Some members of the Task Force believe that reporting requirements have supported development of a culture of openness about medical errors that fosters development of disclosure programs in participating institutions. Some of them are open to the possibility that mandatory reporting laws would increase the practice of disclosure that the Task Force supports.

Others members are reluctant to view reporting laws as tools for encouraging disclosure. Many of them oppose expansion of reporting requirements either by making reporting mandatory or opening the existing voluntary program to participation by additional providers.

**The Task Force recommends that the legislature consider expanding Oregon’s voluntary reporting program to permit physician practices to participate, recognizing that this would involve developing approaches to reporting that fit this new site of care and dealing with a large number of separate entities. It would also be a major workload increase for the Commission. Two members expressed reservations, although for differing reasons.<sup>28</sup>**

#### D. Other measures to encourage disclosure

Some nationally recognized advocates for early disclosure and offer programs have suggested that states offer state-funded financial incentives to facilities adopting the programs. Some suggest creating state reinsurance or excess liability funds for providers

<sup>24</sup> Several members of the task force believe that changes in the reporting law should not be considered. One believes a change would be unwise, the other that it is beyond the scope of the task force’s charge.

and facilities that implement model early disclosure and offer programs.<sup>29</sup> Such a fund would be designed to protect facilities from the risk that disclosing more errors would increase their medical liability costs. The Task Force does not recommend pursuing this option, primarily because creating a new source of payment for claims would not seem to further the priority objectives adopted as a framework for the Task Force’s work. In addition, the evidence to date suggests that disclosure and offer programs may make business sense and expenditure of public dollars may not be needed to encourage them.

## **VI. Evidence-Based Guideline Safe Harbor Approach**

Oregon health care leaders and policy makers have a long history of commitment to evidence-based approaches to health care policy making. This has included use of evidence-based practice guidelines to improve the quality of care and reduce costs in the health care delivery system. The legislature has instructed the Health Resources Commission, Oregon’s medical technology assessment entity, to develop evidence-based guidelines for use by providers, consumers, and purchasers in Oregon and directed the health authority to use the guidelines in purchasing for care in all of the programs it manages. We believe that increased use of evidence-based clinical practice guidelines and process standards by providers may improve quality and reduce medical errors.

Oregon has been awarded an Agency for Healthcare Research and Quality planning grant to explore evidence-based guidelines as a safe harbor. The grant supports development of a proposal for a specific medical liability reform that is designed to improve patient safety. Over the course of the next year, the Office for Oregon Health Policy and Research – with assistance from the Patient Safety Commission and the Center for Evidence-based Policy at Oregon Health & Sciences University – will lead the planning process.

The purpose of the planning grant is to craft a broadly supported legislative proposal that will encourage use of guidelines by offering a safe harbor from medical liability when they act in reliance on state-endorsed evidence-based guidelines. The project will explore a method for adopting guidelines to address the clinical situations that result in significant numbers of patient injuries or medical liability claims. The project will also explore linking the legal standard of care to compliance with the guidelines to:

- provide physicians with greater clarity about the standard of care expected of them and assure them that, if they adhere to the guidelines, they will not be found liable for harm resulting from failure to do something that is inconsistent with the guidelines,
- give patients greater protection from substandard care, and

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<sup>29</sup> Winter, A. (2010, April 1). The Medical Malpractice System: A Review of the Evidence. Presentation to the Medicare Payment Advisory Commission. Available: [http://www.medpac.gov/transcripts/medical%20malpractice%20April%202010\\_public.pdf](http://www.medpac.gov/transcripts/medical%20malpractice%20April%202010_public.pdf) [2010, October 14]. Conversation between the Medical Liability Task Force and Allen Kachalia, MD, Harvard School of Public Health (2010, September 8).

- reduce the frequency of medical liability claims.

**To explore the potential value of using evidence-based guidelines as the legal standard of care, the Task Force recommends that policymakers support the completion of the grant activity.**

**As the grant project moves forward, the Task Force recommends that a broadly representative set of individuals be included in the planning process.**

The Task Force has raised some specific questions it expects the grant team to address:

- Are there collections of similar adverse events that could be prevented if a single evidence-based guideline was consistently followed? Have those adverse events historically resulted in significant malpractice cost?
- Would treating a guideline as the standard of care be likely to increase compliance with the guideline? Reduce adverse events? Reduce litigation cost?
- How and by whom should guidelines be selected for special status in the medical liability system? Based on what criteria?
- Although guidelines could not apply to all situations or supplant the traditional standard of care in all instances, could such guidelines establish the standard of care in specific situations? If so, would compliance with such standards insulate a physician from liability or merely be evidence of a lack of negligence? Conversely, would deviation from the guideline establish liability or merely be evidence of negligence?
- Would guidelines used for safe harbors need to be protocols in order to play the role of safe harbor in the legal system?
- How can it be assured that the guidelines will remain up to date and not hold up desirable innovation?

## **VII. An Administrative System for Compensating Patient Injuries**

### **A. Background**

In Oregon and around the country, critics of the medical liability system are proposing to replace the tort system for compensating victims of medical negligence and the medical liability insurance system with what some call “health courts.” Most “health courts” proposals would create an administrative system for compensating injuries to patients from some or all unanticipated adverse outcomes of medical care—not just medical negligence. The Task Force studied the arguments offered by both proponents and opponents of health courts proposals.

The Task Force rejected the concept of creating a new court system but believes there may be value in developing an administrative system for compensating patient injuries. Some believe that the changes in our nation's health care insurance system occasioned by passage of the Patient Protection and Accountable Care Act can be leveraged to improve the liability system and reduce costs.

Proponents of health courts believe implementing an administrative system is likely to significantly improve the collection of data on unanticipated adverse outcomes thereby supporting safety improvement programs; foster development of consensus around best practices for avoiding patient injury; increase the number of individuals compensated by lowering the bar for recovery to something less than negligence; reduce the legal costs incurred by patients to establish their claims; result in speedier resolution of claims; produce more consistent decisions and awards; reduce administrative costs, including defense costs; and reduce overutilization of medical procedures driven by the practice of defensive medicine.<sup>30</sup>

Commentators critical of health courts share the proponents' desire to improve patient safety programs, improve access to compensation for victims of medical errors, and reduce collateral costs, including insurance-related costs and the costs of defensive medicine; but they doubt that an administrative compensation system will result in the hoped-for improvements. They believe that estimates of defensive medicine are greatly exaggerated. They point out that both deeply rooted medical culture and powerful fee-for-service payment incentives drive overutilization of medical procedures, confounding efforts to measure the effect of fear of lawsuits on utilization. In addition, they are concerned that administrative decision-makers may display pro-physician bias and that benefits available in an administrative system may be inadequate.<sup>31</sup>

Task Force members, for the most part, are neither proponents nor opponents of replacing the tort system with an administrative compensation system. They are persuaded, however, that the magnitude of the benefits envisioned by advocates for replacing the existing system are great and warrant giving the concept a hard look. They also believe that the anticipated benefits are not certain to materialize. The design issues are many and complex and the potential pitfalls are serious.

The value of replacing the existing liability system is probably not something that can be tested through pilot projects because it involves establishing a new and elaborate decision-making infrastructure and identifying new sources of revenue to fund the program. Additionally, experience with Florida's birth injury compensation system suggests that, in a

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<sup>30</sup> Mello, M.M., & Kachalia, A. (2010, April). Evaluation of Options for Medical Malpractice System Reform. Medpac. Available: [www.medpac.gov/documents/Apr10\\_MedicalMalpractice\\_CONTRACTOR.pdf](http://www.medpac.gov/documents/Apr10_MedicalMalpractice_CONTRACTOR.pdf) [2010, October 14]. Common Good. (2006). Windows of Opportunity. Available: [http://commongood.org/assets/attachments/Windows\\_of\\_opportunity\\_web.pdf](http://commongood.org/assets/attachments/Windows_of_opportunity_web.pdf) [2010, October 14]

<sup>31</sup> Peters Jr., P.G. Health Courts? *Boston University Law Review* 88:227-286 (2008) Available: [www.bu.edu/law/central/id/organizations/.../PETERS.pdf](http://www.bu.edu/law/central/id/organizations/.../PETERS.pdf) [2010, October 27]

voluntary system, those who cannot establish fault will elect an administrative remedy. However, those who have suffered injuries they believe may stem from negligence may elect the tort remedy, thereby undermining the financial sustainability of the program. Finally, many members of the Task Force believe that the changes in physician culture necessary to support great increases in error disclosure and reduction in defensive medicine are unlikely to occur in a voluntary system. Unless further study suggests that a pilot program would be workable and productive, it appears that replacing the medical liability system with an administrative system to compensate patient injuries will work only if it applies to all patients statewide.

## B. Recommendation

**The Task Force, with one member in dissent, concludes that it would be worthwhile for the Legislature or the Oregon Health Authority to sponsor a study to determine whether or not an administrative system could be designed that would achieve the reform objectives the Task Force has enunciated and if so, whether implementation is financially, legally, and politically feasible.**<sup>32</sup>

**The study should be overseen by an unbiased entity that has not taken a position for or against the health courts concept. It should be conducted by a well-qualified team with knowledge of the existing medical liability system, knowledge of administrative compensation systems in the United States and elsewhere, skill in economic and social research and modeling, legal and actuarial expertise, and funding sufficient to do a thorough job.**

## C. Scope of the recommended study

The primary component of the study should assume that an administrative compensation system would include the following basic features and be implemented statewide:

- Compensable events would embrace a defined class of patient injuries broader than the class of injuries caused by medical negligence. While it may be unlikely that a pure “no-fault” system is economically feasible, a “low-fault” threshold could make more people eligible for benefits. Compensable events might include a very broad class of events arising out of encounters with medical professionals or facilities such as “treatment injuries” (as in New Zealand), “undesired” or “unexpected” outcomes,” or “avoidable” injuries (as in Sweden).<sup>33</sup>

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<sup>32</sup> One member of the Task Force dissents from this recommendation. He believes that the elimination of the jury system for adjudicating claims of medical negligence should not be considered—no matter what the trade-offs.

<sup>33</sup> One member of the Task Force suggests that instead of changing the definition of the harm or wrong for which the administrative system provides a remedy, the medical negligence standard could be retained while reducing the burden of proof from the “preponderance of the evidence” to something less such as “substantial evidence.” Note, however, that the burden of proof applicable to lawsuits for negligence is

- The system would compensate victims for both economic damages and non-economic damages caused by the injury.
- The administrative system would be the exclusive remedy for events that are compensable under the administrative scheme. Individuals injured as a result of medical negligence could no longer bring a suit for negligence in court.

The study should also examine whether a voluntary program can be designed that allows individuals to opt into or out of an administrative adjudication system while achieving the system change objectives of the proposal and managing costs.

A host of system design issues would need to be considered in both the primary study and consideration of voluntary program options. (For a list of some of the design issues that should be studied, see Appendix 6.)

The study should address, first and foremost, the impact of each design choice on the value of the administrative system for achieving the goals for system improvement and the key questions identified by the Task Force at the outset of its work and whether the cost of such a system is sustainable.

#### D. Timing of the study

For years, Oregonians have discussed the merits and demerits of the medical liability system in the context of proposed legislation and proposed ballot measures to change the system. It is critically important to ground this discussion in fact. A professional study of the feasibility of establishing an administrative compensation system and the effectiveness of such a system as compared with the existing one for improving patient safety, improving access to compensation for injured patients, and reducing collateral costs of the medical liability system will be challenging but, if well done, it will serve the state well. The study should be funded as soon as possible—either by the Legislature or by other parties whose funding would not bias the project.

### VIII. Conclusion

The Task Force appreciates the opportunity to study this issue. The recommendations are designed to further the goals of improving patient safety, improving the system for

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the same “preponderance of the evidence” standard that is generally employed by finders of fact in Oregon’s administrative agencies; the “substantial evidence” standard is used by reviewing courts to determine whether or not the evidence is sufficient to sustain the decision of an administrative finder of fact. See *Armstrong v. Asten-Hill Co.*, 90 Or App 200 (1988)(defining substantial evidence) and *Gallant v. Board of Medical Examiners*, 159 Or App 175 (1999)(discussing the concepts of burden of proof and standard of review).

compensating injuries sustained as a result of medical errors, and reducing insurance administration, litigation, and defensive medicine costs associated with the medical liability system.

The Task Force hopes that the effort to achieve these goals will continue by adoption of these recommendations, including the development of legislative proposals relating to disclosure, full exploration of the evidence-based guideline safe harbor concept, and commissioning of a study of the design and feasibility of an administrative substitute for the medical liability system.

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November 5, 2010

Eric Parsons, Chair  
Oregon Health Policy Board  
500 Summer Street NE  
Salem, OR 97301

Dear Chairman Parsons and Members of the Oregon Health Policy Board:

The OMA appreciates the work of the Health Incentives and Outcomes Committee and the sizable task that was before them. Health system reform has been hotly debated among our membership, and our members have shared their own unique perspectives and insights on all sides of this issue. The OMA is pleased to offer the following comments on the Health Incentives and Outcome Committee report dated October 12, 2010.

While we appreciate the work that is represented in the recommendations, the report does appear to be short on details. While it makes strong points about primary care and primary care funding, it is not at all specific about how to change the payment system to create the environment where positive change in the primary care delivery system can occur. The OMA looks forward to participating in the further development of the proposals needed to transform the health care delivery system. Our comments related to the six proposals are included below.

**Recommendation #1: Standardize payment methods (but not rates) to Medicare for hospital inpatient and outpatient, ASCs, and physician and professional services.**

Relevant OMA Principles:

- Oregon should implement one standard payment system.
- The payment system should increase simplicity and decrease complexity.
- Only follow Medicare where it makes sense.
- The new payment system should be transparent, and should be created in a transparent process.
- Out-of-state insurers and self-insured entities need to comply with Oregon's standard.

The OMA supports the notion of trying to implement one standard payment method for Oregon's payers. While we understand why the Resource Based Relative Value Scale (RBRVS) was selected as the base payment system from which to build, the Medicare systems methodology often falls short in several areas. There is currently not consistent use of the RBRVS components – different payers choose whether or not to use fully or partially implemented

relative values, some use the geographic practice cost indices; others may implement use of the budget neutrality adjuster. Not every payer uses the same year's RBRVS. Additionally, the system does not work for some specialties such as pediatrics.

Oregon's system should not be constrained by Medicare, but should use it as a starting point to create a payment methodology system that works for Oregon and is simple to use for providers. In creating Oregon's system, we should be aware that changes in the current system could create unintended consequences, and our system should not be slow or unwilling to address those problems.

Oregon should also be bold in finding ways to require the same payment standards be applied to national payers, self-insured and other out-of-state insurers. If self-insured and out-of-state insurers are not held to the same standards, the goal of standardizing the system will be lost. If they cannot comply with the same payment methodologies, they should not be allowed to compete in the Oregon marketplace.

**Recommendation #2: Move forward decisively to transform the primary care delivery system.**

Relevant OMA Principles:

- A robust primary care system is essential in Oregon.
- The primary care system needs to be well-funded and sustainable.
- A traditional gatekeeper model is not what physicians or patients want.
- The Patient Centered Primary Care Home (PCPCH) should not be the sole purview of the primary care physicians (PCPs); primary care for chronic and other conditions could fall under either PCP or specialist purview depending on the situation.

The OMA believes that to achieve the goals of improving outcomes and reducing costs in PCPCHs, existing rules will need to be changed. For example, the current payment system inadequately compensates care that is not face-to-face. Physicians will need to be allowed to manage their patients by phone, e-mail or even Internet video calls and be paid for that management.

Administrative procedures should be created that allow both open and closed referral systems, and should be evaluated on effective care, patient experience and cost. In both systems, clear guidelines regarding the referral process should be established.

The OMA also wants to ensure that the certification and the documentation necessary to comply with the PCPCH do not burden the primary care system with administrative reports or with other barriers to providing efficient and effective care.

Patients will also need to take responsibility for their lifestyle choices. Patients need to be financially incentivized to become committed partners in maintaining a healthy life and meeting desired outcomes.

The PCPCH should allow whichever physician that can take care of a condition effectively for the lowest cost, be they a specialist or a PCP, to care for that patient. If specialists are performing primary care, they should be paid the same amount as a PCP provided they meet applicable PCPCH standards.

**Recommendation #3: Focus measurement and payment efforts in areas of significant cost impact or significant defects in the quality of care, where the potential for improvement is greatest.**

Relevant OMA Principles:

- Physicians potentially affected by any change should be involved in selecting common focus areas and that process should be transparent.
- Peer reviewed scientific evidence should be used to select common focus areas.
- Existing appropriate use criteria, guidelines, clinical data and registries that are developed by specialty societies and consensus bodies such as the US Preventative Services Task Force should be encouraged and adapted when available in a collaborative process with specialists and PCPs.
- Reducing cost should not trump providing clinically effective care.
- Reducing administrative costs and the burden of complying with administrative rules and regulations everywhere in the system, including patients, physicians, hospitals, purchasers and payers, should be a priority.
- Policies should be developed that create incentives that prioritize healthy lifestyles and recognize personal responsibility as well as improve medical quality and outcomes.

The OMA understands that this recommendation is intended to move towards cost effective and efficient case rates for common focus areas. However, specialists should participate in creating benchmarks and should also be included in a system that uses pay for performance to incent desired outcomes. We should be careful that we do not move from a fee-for-service system that sometimes incents more expensive care to a managed care system that sometimes prevents physicians from providing sufficient care.

**Recommendation #4: Patient and family engagement are critical. Encourage the delivery system to become more patient-and family-centered.**

Relevant OMA Principles:

- Patient and family-centered engagement is important in a reformed health care system.
- Patients need meaningful health care choices and they should have a stake in how health care dollars are spent.
- Patients need to be stakeholders in appropriate utilization of healthcare resources.
- Through benefit design, patients should be held accountable for the use of preference care versus necessary care.
- Policies should be developed that create incentives that prioritize healthy lifestyles and recognize personal responsibility as well as improve medical quality and outcomes.
- A system that limits patient access to high quality care is unacceptable and may not decrease costs.

- POLST forms and Advance Directives should be encouraged to make sure that everyone's end of life wishes will be known and respected.

The OMA is concerned about how patient and family engagement will be linked to payment reform. While involving patients is important, sometimes the patients will not agree with the accepted science and benchmarks. For example, many families and patients do not receive the appropriate immunizations. How will physicians be held accountable for outcomes when the patient portion of the decision network has different goals and a different knowledge base?

**Recommendation 5: Initiate use of new payment incentives and methodologies. Including pay-for-service performance, episode (bundled) payment, gain-sharing schemes, and the like.**

Relevant OMA Principles:

- Oregon's system should incent physicians and other health care providers to coordinate care.
- Physicians should have leadership roles in creating payment reform models and in the decision making authority over the distribution of shared savings and bonus payments.
- The planning and implementation of payment reform models should include broad participation by physician groups in all practice settings including independent practice, rural and other settings. This work should be conducted in a transparent manner.
- Innovation should be encouraged. Pilot programs should be used to experiment with alternative payment models. However, the pilots need to include a plan for how they are implemented state-wide, and evaluated using scientifically based evidence. Specialty societies that have robust data should be consulted in using those data to create policies and standards.
- Reform models should adequately compensate providers for care coordination and management services, including consultation with other providers and non face-to-face communication with patients.
- Exceptions should be considered for smaller independent offices as they are transitioned to a new payment system.

**Recommendation #6: To stop spending an ever-greater share of public and private resources on healthcare, a global health care spending target should be adopted.**

Relevant OMA Principles:

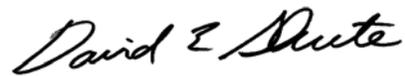
- The OMA supports the goal of controlling and reducing the costs of healthcare.
- An arbitrary limit on health care spending focuses reform on cost containment instead of appropriate value driven care.
- Rigorous cost benefit analysis should be used for all new technology and drugs.
- Policies should be developed that create incentives that prioritize healthy lifestyles and recognize personal responsibility as well as improve medical quality and outcomes.

What happens when the spending limit is reached? What is the plan for declining care? Rather than establishing an arbitrary spending target, the OHA should focus on eliminating inappropriate care that is not value driven. An arbitrary spending target seems to suggest that

cost containment is the highest priority of Oregon's health reform. While cost must always be considered, the OHA should strive to invest in payment reforms that create a healthier society that is focused on frugal, value-based care, and not cost cutting regardless of clinical outcomes. Congress's attempted implementation of a "sustainable growth rate" in Medicare spending has demonstrated that cost constraints that are not based on individual utilization are not enforceable.

The OMA appreciates the opportunity to comment on this report. We look forward to working with the Oregon Health Policy Board, the Oregon Health Authority and the many other stakeholders on implementing health reform that provides access to high quality care to all Oregonians.

Sincerely,

A handwritten signature in black ink that reads "David E. Shute". The signature is written in a cursive, slightly slanted style.

David Shute, MD  
Chair, OMA Committee on Health Care Finance

cc:  
Governor-Elect John Kitzhaber, MD  
Senator Alan Bates, DO  
Bruce Goldberg, MD  
Jeanne Smith, MD